Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System

The Honourable Eileen E. Gillese
Commissioner

Ontario

Commission d'enquête publique sur la sécurité des résidents des foyers de soins de longue durée

L'honorable Eileen E. Gillese
Commissaire

In the matter of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, pursuant to the Order in Council 1549/2017 and the *Public Inquiries Act, 2009*

Affidavit of Karen Mitchell

I, Karen Mitchell, of the City of Woodstock, in the County of Oxford, MAKE OATH AND SAY:

1. I am a witness to the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System (the "Inquiry"). I have firsthand knowledge of the matters to which I hereinafter depose. When I do not have firsthand knowledge, I have identified the source of my information and belief and believe it to be true.

2. I am a registered nurse (RN), having graduated from Mohawk College in 1994. In the fall of 1999, I began working as a visiting nurse for CarePartners providing nursing services to CCAC-funded home care patients. I remained in this position until 2005.

3. In the spring of 2005, I took a job as a Case Manager (a position that is today known as a Care Coordinator) with the Oxford Community Care Access Centre ("**CCAC**"). Initially I was hired as a casual Case Manager and I was trained in and worked in the access department, responsible for telephone intakes. In or about June of 2005 I became a

regular full-time Case Manager and I was assigned to a community Case Manager team responsible for chronic patients.

4. In 2006, the Oxford CCAC became the South West ("**SW**") CCAC, and I remained in the same position. In May 2017, the SW CCAC was transferred to the SW Local Health Integration Network ("**LHIN**"). As of that date, the SW LHIN assumed the responsibilities that formerly belonged to the SW CCAC.

5. I continue to be a community-based Care Coordinator with the SW LHIN, and am assigned to the chronic/community independent team. As a community-based Care Coordinator, I have always worked with chronic and community independent patients. I estimate that I currently have approximately 100 patients on my caseload.

6. There are approximately 14 community Care Coordinators on the chronic/independent team in my office, which is the Woodstock site of the SW LHIN. However, other Care Coordinators work on other teams, in other offices, or in hospitals, so the actual number of Care Coordinators in the SW LHIN is much higher.

7. As the events that form the subject matter of the inquiry pre-date the transfer of the CCAC to the LHIN, I will refer to the practice as it existed under the CCAC in this affidavit. Unless otherwise stated, the practices I explain as occurring under the CCAC remain the same today, but are now carried out by the LHIN.

THE ROLE OF CARE COORDINATORS

8. Care Coordinators assess patients and determine their eligibility for CCAC-funded home care services. If a patient is eligible, the Care Coordinator prepares a plan of care for the

patient that sets out what services the patient will receive and the timeframe in which the services are to be provided. Care Coordinators also provide patients and their families with information about and referrals to other services in the community. Care Coordinators are supported by Patient Care Assistants, who provide administrative support for the care coordination role.

9. Care Coordinators conduct both initial assessments and periodic reassessments of our assigned patients. We are the patient's main point of contact with the CCAC, and our patients may contact us when they have questions, complaints, or concerns about the services they are receiving. Care Coordinators may play a role in talking to Service Provider Organizations ("**SPOs**", discussed further below) if a client has an issue with their services, or if the Care Coordinator has questions or concerns about the detailed care plan developed by the SPO, based on the plan of care developed by the Care Coordinator.

10. All Care Coordinators must be regulated professionals, such as registered nurses, registered social workers, registered occupational therapists, registered dieticians, or registered physiotherapists. Although Care Coordinators have a variety of professional backgrounds, cases are not assigned to Care Coordinators based on their profession. In my experience in the community setting, a Care Coordinator is a Care Coordinator regardless of background, and may deal with any case that comes in.

11. Care Coordinators on the access team ("Access Coordinators") manage telephone and fax referrals. They conduct initial intake assessments and then refer patients to community-based Care Coordinators.

12. Community-based Care Coordinators are split into different teams according to the level

of care the patient requires, and will only deal with cases assigned to their team. The teams are:

- Short stay – someone who is receiving services for a short time and will likely be discharged (i.e. their patient file closed) in a few months.
- Chronic/Community Independent – someone who requires longer-term assistance, or someone with a deteriorating condition. If someone has been with the short stay team for more than a year, they will typically be transferred to the chronic team. This was the team I worked on, and Beverly Bertram was a chronic team patient in 2016.
- Complex – someone who has higher, more complex needs (often with multiple health issues), or palliative patients.
- Children – someone who is under the age of 18.

13. In addition to being assigned to one of these care teams, community-based Care Coordinators are organized by geography, and deal only with cases within their geographic area. I worked in Oxford County exclusively until May of 2018. Since May of 2018, community-based Care Coordinators are organized by both physicians and geography and I now work in Oxford County and in a small portion of Norfolk County.

14. Beyond the Care Coordinators who work on one of the community teams outlined above, there are other Care Coordinators who work in hospitals. Their primary role is to assess patients and determine their eligibility for home care services they will need on discharge from hospital, as well as reassessing patients, as required, before discharge. If the patient

cannot be supported at home, they may also assess and determine eligibility for long-term care home admission. Either hospital-based Care Coordinators or Patient Care Assistants review the names of individuals admitted to hospital to determine if they are CCAC patients and, if so, they alert the CCAC and SPOs so that home care services can be put on hold pending the patient's discharge from hospital.

STEPS IN THE LIFE OF A CCAC HOME CARE PATIENT'S FILE

A. The Initial Intake Assessment

15. The CCAC receives a referral for any new patient, including a patient who was previously on service but has since been discharged. Individuals can self-refer to the CCAC, or the CCAC can receive a referral from a physician. Family members, friends or other care providers can also make referrals. If the patient does not self-refer, the CCAC follows up with him or her to obtain consent to receive services.

16. After receiving a referral and obtaining consent, the CCAC assesses the patient to determine what services they need and whether they are eligible for CCAC-funded services. This initial intake assessment is typically done over the phone by an Access Coordinator. The only situation in which I am aware that an initial intake assessment would not be done over the phone is if the patient comes into the CCAC office in person or if the patient is in hospital and being assigned for CCAC services upon discharge. In the latter case, the initial assessment would be done by a hospital-based Care Coordinator in person.

17. During the initial intake assessment, the Access Coordinator, or the hospital-based Care Coordinator if the patient is in hospital, uses the Resident Assessment Instrument –

Contact Assessment ("**RAI-CA**") to assess the patient's service needs. A copy of a blank RAI-CA assessment form is attached as **Exhibit "A"** to my affidavit (LTCI00072839). The Access Coordinator or the hospital-based Care Coordinator determines both the nature and the urgency of the services needed by asking various questions about the patient's condition, cognition, mobility, allergies, and living situation (among others). If the patient is eligible for services, the Access Coordinator or the hospital-based Care Coordinator then develops the plan of care (including the necessary services, the frequency and timeframe for visits, and the length of time for which the services should be provided).

B. Assigning a Service Provider

18. After creating the plan of care, the Access Coordinator or the hospital-based Care Coordinator assigns the patient to one of the Care Coordinator community teams and sends a service offer to an SPO.

19. SPOs have contracts to provide one or more types of services in a particular geographic region. Patients are assigned to an SPO that has a contract to provide the type of services they need in the region in which they live.

20. In some cases there is only one SPO with a contract to provide a particular type of service (for example, personal support services) in a particular region. In other cases, two or more SPOs would be allocated a percentage of the service volume for a particular type of service in a geographic region. For chronic/community independent patients in Oxford County, there are two nursing SPOs, but only one PSW SPO and one therapies SPO.

21. The patient does not have input into which SPO is assigned to their care. Rather, SPOs are automatically assigned by the CCAC's Client Health and Related Information System

("**CHRIS**"). The system assigns SPOs to help ensure that, as far as possible, each SPO receives the service volume that is specified in the SPO's Services Agreement with the CCAC. I have only rarely overridden the system and manually assigned an SPO. One circumstance in which I might override the system in order to promote continuity of care is when a patient who has been recently discharged from a service needs to be brought back on the same service. Another rare situation that might cause me to manually select a different SPO is if an SPO requests a wound care specialist, then I would ask the same SPO to provide that service.

22. Once an SPO is assigned by CHRIS, a service offer is sent to that provider using the CCAC's electronic portal, Health Partner Gateway. The SPO then must accept or decline the offer. This initial offer does not include the patient's information, but includes the nature and frequency of services.

23. The timeframe within which the SPO must respond to an offer varies by the type of service, but is relatively short. Nursing referrals are typically accepted or declined in 30 minutes, while PSW referrals are typically accepted or declined within 45 minutes.

24. After an SPO accepts a service offer, the CCAC sends the patient's information to the SPO electronically. Patient Care Assistants send this complete referral package to the SPO once the referral is accepted.

C. The Care Coordinator's Assessment and Reassessments of the Patient

25. After the Access Coordinator or the hospital-based Care Coordinator has performed the initial intake assessment and assigned the patient to a team, a Care Coordinator within that team is assigned to the patient. The goal is for the Care Coordinator to visit the patient

to perform a face-to-face assessment within 10 days, although this is not always possible. As a Care Coordinator, I may do the initial face-to-face assessment either before or after the SPO has begun visiting the patient to provide services. During my initial visit with one of my patients, it is my practice to always leave my card with the patient so he or she knows how to contact me. If the SPO has already visited the home, I will also ensure the patient has the SPO's contact information.

26. During the initial face-to-face assessment, Care Coordinators use the Resident Assessment Instrument – Home Care ("**RAI-HC**") assessment tool, which is more detailed than the RAI-CA used by the Access Coordinators. Even if a patient has been a CCAC patient in the past, if he/she has a new referral, we will do a new initial assessment using the RAI-HC, instead of treating the situation as a reassessment.

27. The RAI-HC is completed primarily by speaking with the patient, not by performing a physical examination. In my experience, the RAI-HC typically takes about an hour to complete, although the time required varies from patient to patient. A copy of a blank RAI-HC assessment form is attached as **Exhibit "B"** to my affidavit (LTCI00071823). As of the beginning of May 2018 the LHIN now uses a newer version the RAI-HC assessment tool called the Inter-RAI-HC.

28. After completing the RAI-HC, I will modify the plan of care as needed, including the necessary services, the frequency and timeframe for visits, and the length of time for which services are to be provided. I have not often needed to make changes to the initial plan of care established by the Access Coordinator or the hospital-based Care Coordinator. When I have felt changes are needed, it has typically involved adjusting the frequency of visits

or, occasionally, the addition of other services.

29. If a Care Coordinator adds a new service to the plan of care, the Care Coordinator will send a new service offer through the electronic portal to the SPO assigned by CHRIS. If the Care Coordinator modifies a service already in the plan of care, the Care Coordinator sends this update electronically directly to the SPO.

30. Once the RAI-HC is completed, the SPO will be notified that the RAI-HC has been completed. The SPO is able to access a copy of the completed RAI-HC as well.

31. As a Care Coordinator, I also conduct periodic reassessments of my patients. The timing for conducting a reassessment varies. The results of the RAI-HC assessment will automatically trigger the reassessment time in the CCAC's system, and I will get an electronic notification when one of my patients is due for a reassessment.

32. Within the chronic/community independent team, lower needs patients are reassessed every 12 months, those with higher needs every 6 months, and patients waiting for admission to long-term care homes are reassessed every 3 months. However, if the patient is admitted to hospital or if the CCAC is informed that the patient's condition has changed, I would apply my professional judgment to the patient's specific circumstances and I may conduct a reassessment before the scheduled date.

D. The SPO's Assessments of and Provision of Services to the Patient

33. SPO staff obtain access to a home care patient's home in different ways. In most cases, they will simply ring the doorbell and the patient will answer. However, if a patient has mobility issues, they might set up a lock box with a key in it that the SPO worker can

retrieve to let him/herself into the house, or they might have a family member or a friend answer the door.

34. When the SPO conducts its first visit with the patient, its staff will conduct an assessment and fill out an Automated Provider Report ("**APR**"), which is then sent to the CCAC electronically. The APR indicates whether the service provider feels that any changes to the plan of care are needed. The SPO is required to send this report within five days of the initial visit to the patient.

35. The person in SPOs sending APRs varies depending on the personnel concerned. Nurses and occupational therapists working for SPOs send APRs to the CCAC themselves. For PSWs employed by SPOs, it is typically their manager who sends the APRs to the CCAC.

36. Once the APR has come in for one of my patients, I review the report and approve or decline any changes requested. I usually approve the adjustments requested by the SPO, unless they seem out of the ordinary. I generally rely on the judgement of the SPO workers who are responsible for providing the care that I have determined is necessary and set out in the plan of care. I would consider an adjustment to be out of the ordinary if, for example, there was an excessive amount of visits requested in a particular time frame.

37. In addition to the initial APR, SPOs send APRs to provide interim updates if there is a change in the patient's condition; if the SPO is asking to increase, decrease, or discontinue services; or if the SPO is asking to extend the service end date. When the end date for the patient's services nears, the SPO sends the CCAC an APR informing us of the patient's progress and any change in the patient's health.

38. It is the SPO's responsibility to assign their own particular staff members who will provide

services to the patient. The CCAC is not involved in assigning an SPO's staff members. In my experience, SPOs typically aim for consistency in the staff members they send. If a patient is receiving morning and evening visits, these would typically be different staff members. However, if a patient is receiving a visit once a week, most SPOs attempt to send the same staff member, or try to use the same roster of staff members to serve the patient.

39. The SPO keeps the patient's chart in the home, as each visiting nurse needs to access it. Even though the chart remains in the patient's home, the SPO is responsible for it as an agent of the CCAC. Registered nurses also have professional obligations to chart. SPOs providing services other than nursing typically chart electronically.

40. Visiting nurses from the SPO will reach out to the patient's doctor as needed, for example, if a wound is not healing properly or if they are having difficulty managing the patient's pain. They might also contact the doctor to keep him/her informed of certain developments, for example, if the patient's blood sugar is off.

E. Documentation in a Patient's CCAC File

41. Patients' electronic records are housed in CHRIS. Within CHRIS, the patient's file will contain a Client Notes Report in which CCAC personnel (including Care Coordinators) record any contact with the patient. In addition, notes may be added after conversations with family members, the patient, members of the care team, physicians, and SPOs. Referrals for new services are also recorded there. Only CCAC personnel have access to CHRIS.

42. A patient's file in CHRIS contains a variety of information, including:

- consents;
- contact information for the patient's physician(s);
- a list of CCAC services for which the patient has been referred, along with details of each of these services (including the assigned SPO, frequency of visits, referral date, and end date);
- details of the patient's plan of care, and the history of the services the patient has received;
- patient updates sent by the CCAC to the SPO containing information about the service referral, assessments completed by the CCAC, patient notes, and information about hospital admissions;
- copies of communications about the patient sent between the patient's physician and SPO staff;
- physician orders;
- documentation outlining changes in service frequency;
- APRs submitted by the SPO, including reports informing the CCAC of changes to the patient's condition and/or requesting changes to the patient's services; and
- discharge reports.

43. In addition to the patient's CHRIS file, the patient has an electronic record in Acutenet, a system that is maintained by the CCAC and to which the SPOs have access. The RAI assessments are housed in Acutenet so the SPOs can access them. The RAI assessment

includes a list of the patient's medications.

44. While SPOs do not have access to CHRIS, if CCAC personnel have checked a box in the Client Notes Report that says the note can be shared with the SPO, the SPO can access that note electronically. I do not know exactly how this works from a systems perspective.

F. Hospitalizations

45. It is important for the CCAC to track when its patients are admitted to hospital and the length of time during which they are in hospital, as this affects patients' existing services and, depending on the length of stay, may result in their discharge from CCAC services.

46. If a home care patient is suddenly hospitalized, the CCAC will be advised of this through the hospital-based Patient Care Assistants. Hospital-based Care Coordinators are responsible for monitoring patient admissions and, through the Patient Care Assistants, they update the CCAC office if a home care patient is admitted to hospital. The Patient Care Assistants then take care of putting the patient's services on hold and notifying the SPO. This notification typically happens within a few hours of admission. There is a Care Coordinator assigned to the Emergency Department and available for a face-to-face meeting with the patient if needed.

47. If the home care patient has been in the hospital for less than 14 days, the hospital-based Care Coordinator would typically meet with the patient before discharge to determine if any changes to the patient's plan of care are required. If a hospital-based Care Coordinator determines that changes are needed, the patient's community-based Care Coordinator will be notified, as will the SPO providing those services. In these circumstances, the community-based Care Coordinator typically would not visit the patient

to conduct another assessment after discharge.

48. The CCAC's Patient Care Assistants are responsible for tracking the length of a CCAC patient's hospital stay. If the patient is in hospital for 14 days or more, the patient is discharged from his/her existing CCAC services. The patient will need a new referral and initial intake assessment if services are to be provided when he/she re-enters the community. The initial intake assessment for hospital patients being discharged to the community (the RAI-CA) is done by the hospital-based Care Coordinator. After the patient is discharged, a Care Coordinator from the patient's assigned community team is expected to visit and conduct a RAI-HC assessment within 10 days, as with any new referral.

MEDICATION ADMINISTRATION AND STORAGE

49. The majority of CCAC home care patients self-administer their medication, and are therefore responsible for their own medications. Patients can choose how to store the medications in their home, and it is their responsibility to take their medications in accordance with the doctor's directions.

50. Even when a patient is self-administering their medications, Care Coordinators will do a medication review with them as part of the RAI-HC assessment. The purpose of the medication review is to ensure patients understand what medications they are on; that they know what medication to take, in what dose, and at what time; for some of the medications, that they know for what purpose they are taking it (for example, what to take for pain or bowel issues); and that they know how to remember to take their medications. A Care Coordinator will compare the list of medications obtained from the pharmacy

against the medications found in the home. If there are discrepancies or the patient has questions about the dose or what to take, the Care Coordinator recommends that the patient follow up with their physician or pharmacist. SPO nurses can also perform a medication review with a patient if needed.

51. In my experience with chronic/community independent patients, it is only in a minority of situations that an SPO nurse would be responsible for administering a medication to a patient and in many of those cases the SPO nurse teaches the patient or the patient's informal caregiver how to administer the medication. The SPO nurse may be responsible for medication administration if the patient has physical or cognitive limitations that prevent self-administration and there is no other informal caregiver who can assist. If the SPO nurse teaches the patient or the patient's informal caregiver how to administer the medication, the SPO nurse may continue to have some responsibility for oversight or may no longer be responsible for administration at all. An example of the former situation is intravenous medication administration. The SPO nurse will either assume full responsibility for this, or partial responsibility if the patient or the patient's informal caregiver is comfortable learning how to change the medication bag or flush the line. An example of the latter situation is medication administration by injection, such as insulin for blood sugar or heparin for blood clots. If this is a new medication for the patient, the SPO nurse may administer the initial injections while teaching the patient or the patient's informal caregiver how to administer the injection. Once the patient or other person learns how to inject the medication, the SPO nurse would no longer be involved.

52. If it is a situation where the SPO nurses are responsible for administering a medication to the patient, it is the SPO's obligation to ensure its nurses are giving the medications in the

right dose and at the right time. The SPO nurses must meet professional standards of practice to ensure they are administering medication properly. The CCAC does not do spot checks or audits to verify that SPO nurses are properly administering medications.

DETECTING ABUSE/NEGLECT BY SPO STAFF

53. There are two main mechanisms I can think of that would allow the CCAC to detect potential abuse or neglect by SPO nurses. Care Coordinators' home visits is one, and calls or complaints to the Care Coordinator or other CCAC personnel is the other. The purpose of our home visits is to assess what is going on inside the home. Potential abuse or neglect could be detected through a conversation with the patient, as I will typically ask the patient about his/her satisfaction with the services and if he/she has any concerns.

HOME CARE SERVICES PROVIDED TO BEVERLY BERTRAM

54. Ms. Bertram has been on and off CCAC services for many years, and has had several different Care Coordinators at the SW CCAC. I became her Care Coordinator in September 2015, and remained her Care Coordinator until May 23, 2018, when the SW LHIN changed the distribution of patients to be based on the patient's primary care physician in the community. I am now the Care Coordinator for the patients of four primary care physicians in Tillsonburg. Ms. Bertram's primary care physician is not one of the physicians assigned to me, so a different Care Coordinator is now responsible for her services.

55. During the time when I was Ms. Bertram's Care Coordinator, I had contact with her during scheduled assessments and reassessments, or when Ms. Bertram was discharged after being in hospital for more than 14 days (after which she would require a new assessment

and referral).

56. At the start of 2016, Ms. Bertram was receiving personal support services through CarePartners, and social work through CBI Home Health. In March 2016, she also received nursing services, provided through Saint Elizabeth. Ms. Bertram was admitted to hospital on July 7, 2016 and was discharged from these services because her hospital stay was more than 14 days.

57. Ms. Bertram was released from the hospital on August 19, 2016, and was assessed by the hospital-based Care Coordinator before her discharge. Because Ms. Bertram had been discharged from CCAC services, she required a new assessment and service referral. The hospital Care Coordinator was the one who put the plan of care in place upon Ms. Bertram's discharge. I was not involved in establishing that plan of care. An extract of the Client Notes Report from Ms. Bertram's CHRIS file for the period of July-August 2016 is attached as **Exhibit "C"** to my affidavit (LTCI00056651_01). It reflects Ms. Bertram's hospitalization in July, her resulting discharge from CCAC services, and her referral for nursing services upon discharge.

58. Saint Elizabeth was assigned as Ms. Bertram's SPO for nursing services after her discharge in August 2016. Saint Elizabeth would have been assigned because Ms. Bertram resides in Ingersoll and Saint Elizabeth is one of the two SPOs that provide nursing services in that area.

59. Saint Elizabeth would have been the one to assign EW to provide care to Ms. Bertram.

60. I visited Ms. Bertram to conduct the RAI-HC initial assessment for this new referral on September 8, 2016, by which point Saint Elizabeth had already been providing her with

services for a few weeks. By that point, EW had already attempted to murder Ms. Bertram by overdosing her with insulin, although I was not aware of this at the time of the assessment.

61. During the RAI-HC assessment I conducted on September 8 2016, neither Ms. Bertram nor any other member of her household raised concerns about the services she was receiving through Saint Elizabeth, and I did not see anything that caused me to be concerned. There were no red flags in Ms. Bertram's file that would have alerted us to EW's offence against Ms. Bertram. The CCAC did not receive any complaints about the services Saint Elizabeth was providing to Ms. Bertram in August 2016, or about EW's provision of services in particular. I do not believe the CCAC received any reports about Ms. Bertram's condition directly from EW.

62. My understanding is that the CCAC did not learn about EW's offence against Ms. Bertram until EW confessed to police. I do not recall precisely when I learned of EW's confession related to the offence against Ms. Bertram, but I believe I first heard of it from fellow CCAC staff. I was in shock and disbelief that this had happened. I felt sick to learn that someone would do something like this and I have never heard the like in my career. After learning of it, I spoke with my direct manager (Rebecca Sutcliffe) and the regional manager (Anita Cole) about how the situation should be addressed. I connected with Ms. Bertram on October 26, 2016 to discuss how she was coping and whether she needed additional supports.

63. I was not involved in the investigation of the care provided by EW to CCAC patients. I am not sure how many times EW had provided services to Ms. Bertram or whether EW visited

any of my other patients, because SPOs do not tend to inform Care Coordinators about which staff members are providing services to our patients.

64. Following this incident, Ms. Bertram chose to limit the number of new people who would come into her home. My understanding is that there is a small number of specified personal support workers (from CarePartners) and nurses (from Saint Elizabeth) who provide services to Ms. Bertram. Like any patient, Ms. Bertram has the option of declining a visit by an SPO nurse or PSW if she wishes.

SWORN BEFORE ME at the City of Woodstock, in the County of Oxford, on this 19th day of July, 2018.

Commissioner for Taking Affidavits

Karen Mitchell

This is Exhibit "A"
to the Affidavit of KAREN MITCHELL,
Sworn before me this 19th
Day of July, 2018

Meagan Williams LSO#64283G

interRAI Contact Assessment (CA)© Canadian Version

Screening Level Assessment for Emergency Department and Intake from Community/ Hospital

(CODE FOR LAST 24 HOURS UNLESS OTHERWISE SPECIFIED)

Addressograph

Section A: COMMON DEMOGRAPHIC INFORMATION

1	NAME	a. Last/Family b. First Name c. Middle Name/Initial
2	SEX	M. Male F. Female
3	BIRTH DATE	Year Month Day
4	NUMERIC IDENTIFIERS	a. Health card number b. Province or territory issuing health card number c. Case record number
5	PROVINCE OR TERRITORY ISSUING HEALTH CARD NUMBER	a. Province or territory b. Postal code of usual living arrangement

6	FACILITY/ AGENCY IDENTIFIER	
7	PRIMARY LANGUAGE	eng-English fre-French *(See manual for additional codes)*
8	INTERPRETER NEEDED	0. No 1. Yes
9	REASONS FOR REFERRAL/ PRESENTATION	
10	ASSESSMENT ADMINISTRATION	a. Location of intake or screen: 1. Community 2. Hospital inpatient 3. Emergency department 4. Other b. Assessment module: 1. Community or Hospital Intake -> Go to Section B(page 2)- Community or Hospital Intake 2. Emergency Department Screen -> Go to Section B(page 5)- Emergency Department Screen

INTAKE FROM COMMUNITY OR HOSPITAL

Section B. INTAKE AND INITIAL HISTORY

1	ASSESSMENT REFERENCE DATE	Year ☐☐☐☐ Month ☐☐ Day ☐☐
2	REFERRAL DETAILS	a. Treatments ordered to be initiated 0. Not needed 1. 72 or more hours 2. 48 to <72 hours 3. 24 to <48 hours 4. 12 to <24 hours 5. Less than 12 hours a. Administration of medication (other than IV) ☐ b. Indwelling catheter ☐ c. IV therapy ☐ d. Oxygen therapy ☐ e. Wound care ☐ f. Other (specify)_____ ☐
		b. Referral to initiate or continue rehabilitation services 0. No 1. Yes ☐
		c. Referral to initiate or continue palliative services 0. No 1. Yes ☐
3	EXPECTED LIVING ARRANGEMENT DURING SERVICE PROVISION	1. Alone 2. With spouse/partner only 3. With spouse/partner and other(s) 4. With child (not spouse/partner) 5. With parent(s) or guardian(s) 6. With sibling(s) 7. With other relative(s) 8. With non-relative(s) ☐
4	EXPECTED RESIDENTIAL/ LIVING STATUS DURING SERVICE PROVISION	1. Private home/apartment/rented room 2. Board and care 3. Assisted living or semi-independent living 4. Mental health residence (e.g. psychiatric group home) 5. Group home for persons with physical disability 6. Setting for persons with intellectual disability 7. Psychiatric hospital or unit 8. Homeless (with or without shelter) 9. Residential care facility (e.g. long-term care, nursing home) 10. Rehabilitation hospital/unit 11. Continuing care hospital/unit 12. Hospice facility/palliative care unit 13. Acute care hospital 14. Correctional facility 15. Other ☐

Section C. PRELIMINARY SCREENER

1	COGNITIVE SKILLS FOR DAILY DECISION MAKING	Making decisions regarding tasks of daily living - e.g. when to get up or have meals, which clothes to wear or activities to do 0. Independent or set-up help only 1. Supervision or any impairment ☐
2	ADL SELF PERFORMANCE	Most dependent episode over last 24 hours. If ADL did not occur in last 24 hours, code the most recent occurrence 0. Independent or set-up help only 1. Supervision or any physical assistance a. Bathing—How takes full-body bath/shower. Includes how transfers in and out of tub or shower AND how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area—EXCLUDE WASHING OF BACK AND HAIR ☐ b. Personal hygiene—How manages personal hygiene, including combing hair, brushing teeth, shaving, applying make-up, washing and drying face and hands—EXCLUDE BATHS AND SHOWERS. ☐ c. Dressing lower body—How dresses and undresses (street clothes, underwear) from the waist down, including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc. ☐ d. Locomotion—How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair. ☐
3	DYSPNEA (shortness of breath)	0. Absence of symptom 1. Absent at rest, but present when performed moderate activities 2. Absent at rest, but present when performed normal day-to-day activities 3. Present at rest ☐
4	SELF REPORTED HEALTH	Ask: *"In general, how would you rate your health?"* 0. Excellent 1. Good 2. Fair 3. Poor 8. Could not (would not) respond ☐
5	INSTABILITY OF CONDITIONS	0. No 1. Yes a. Conditions/diseases make cognitive, ADL, mood or behaviour patterns unstable (fluctuating, precarious or deteriorating) ☐ b. Experiencing an acute episode or a flare-up of a recurrent or chronic problem ☐
		Note: if <u>any</u> of C1 = 1 C2a = 1 C2 (b-d) = 1 or 8 C3 = 2 or 3 C4 = 3 or 8 C5 (a or b) = 1 complete sections D and E; otherwise go to C6
6	HOME CARE SERVICES MAY BE REQUIRED FOR THIS PERSON	0. No -> go to E10 1. Yes -> complete sections D and E ☐

Section D CLINICAL EVALUATION

1 CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT)
0. Improved
1. No Change
2. Declined
8. Uncertain

2 ABILITY TO UNDERSTAND OTHERS (Comprehension)
Understanding verbal information content (however able, with hearing appliance normally used)
0. Understands—Clear comprehension
1. Usually understands—Misses some part/intent of message BUT comprehends most conversation
2. Often understands—Misses some part/intent of message BUT with repetition or explanation can often comprehend conversation
3. Sometimes understands—Responds adequately to simple, direct communication only
4. Rarely or never understands

3 SELF REPORTED MOOD
Ask: *"In the last 3 days, have you felt sad, depressed or hopeless?"*
0. No
1. Yes
8. Could not (would not) respond

4 ADL CAPACITY
Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require speculation by the assessor
0. Independent or set-up help only
1. Supervision or any assistance during task

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

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

c. Managing medications—How medications are managed (e.g. remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)

d. Stairs—How full flight of stairs is managed (12 to 14 stairs)

5 CHANGE IN ADL STATUS AS COMPARED TO 90 DAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO
0. Improved
1. No Change
2. Declined
8. Uncertain

6 DISEASE DIAGNOSES
Disease code
1. Primary diagnosis/diagnoses for current referral
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment

		Disease code
a1. _____	b1.	
a2. _____	b2.	
a3. _____	b3.	
a4. _____	b4.	
a5. _____	b5.	

ICD-10-CA code — Disease code

c1. ____.___	d1.	
c2. ____.___	d2.	
c3. ____.___	d3.	
c4. ____.___	d4.	
c5. ____.___	d5.	

(Note: Add additional lines as necessary for other disease diagnoses.)

7 FALLS
0. No fall in last 90 days
1. 1 or more falls in last 90 days

8 PROBLEM FREQUENCY
Code for presence in last 3 days
0. Not present
1. Present but not exhibited in last 3 days
2. Exhibited on 1 of last 3 days
3. Exhibited on 2 of last 3 days
4. Exhibited daily in last 3 days

a. Dizziness
b. Chest pain
c. Peripheral edema

9 PAIN SYMPTOMS
(Note: Always ask the person about pain frequency, intensity and control. Observe person and ask others who are in contact with the person.)

a. Frequency with which person complains or shows evidence of pain (including grimacing, teeth clenching, moaning, withdrawal when touched or other non-verbal signs suggesting pain)
0. No pain
1. Present but not exhibited in last 3 days
2. Exhibited on 1–2 of last 3 days
3. Exhibited daily in last 3 days

b. Intensity of highest level of pain present
0. No pain
1. Mild
2. Moderate
3. Severe
4. Times when pain is horrible or excruciating

10 SMOKES TOBACCO DAILY
0. No
1. Not in last 3 days, but is usually a daily smoker
2. Yes

11 NUTRITIONAL ISSUES
a. In LAST 3 DAYS, noticeable decrease in the amount of food usually eaten or fluids usually consumed
0. No 1. Yes

b. Weight loss of 5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS
0. No 1. Yes

c. Special diet
0. No 1. Yes

INTAKE FROM COMMUNITY OR HOSPITAL (cont'd)

Section Q. CLINICAL EVALUATION (cont'd)

12 PRESSURE ULCER
0. No pressure ulcer
1. Any area of persistent skin redness
2. Any break in skin integrity (e.g. partial loss of skin layers, deep craters in the skin, breaks in skin exposing muscle or bone, necrotic eschar predominant)

13 MAJOR SKIN PROBLEMS
E.g. lesions, 2nd or 3rd degree burns, healing surgical wounds
0. No 1. Yes

14 TRAUMATIC INJURY
E.g. fracture, major physical injury resulting from assault or motor vehicle accident
0. No 1. Yes

15 TREATMENTS
Treatments received or scheduled in LAST 3 DAYS
0. Not ordered AND did not occur
1. Ordered, not implemented
2. 1–2 of last 3 days
3. Daily in last 3 days

a. Indwelling catheter	
b. IV therapy	
c. Oxygen therapy	
d. Wound care	

16 TIME SINCE LAST HOSPITAL STAY
Code for most recent instance in LAST 90 DAYS
0. No hospitalization within 90 days
1. 31 to 90 days ago
2. 15 to 30 days ago
3. 8 to 14 days ago
4. In last 7 days
5. Now in hospital

17 EMERGENCY DEPARTMENT USE
Code for number of times during the LAST 90 DAYS (not counting overnight hospital stay) ☐☐

18 SURGERY IN LAST 90 DAYS
0 No 1 Yes

19 TWO KEY INFORMAL HELPERS

a. Relationship to person — Helper 1 2 ☐☐
1. Child or child-in-law
2. Spouse
3. Partner/significant other
4. Parent/guardian
5. Sibling
6. Other relative
7. Friend
8. Neighbour
9. No informal helper

b. Lives with person — Helper 1 2 ☐☐
0. No
1. Yes, 6 months or less
2. Yes, more than 6 months
8. No informal helper

20 INFORMAL HELPER STATUS
0 No 1 Yes

a. Primary informal helper expresses feelings of distress, anger or depression	
b. Family or close friends report feeling overwhelmed by person's illness	

SECTION E SUMMARY

1 ALGORITHM SCORES
Record the computer-generated scores for each of the following
a. Assessment Urgency
b. Service Urgency
c. Rehabilitation

2 HOME CARE SERVICES REQUIRED FOR THIS PERSON
0 No 1 Yes
If no, go to E7

3 EXPECTED LENGTH OF STAY
0. 0 to 14 days
1. 15 to 60 days
2. 61 or more days

4 REQUIRES SHORT-TERM SERVICES
0 No 1 Yes

5 ASSESSMENT URGENCY
Urgency for comprehensive, face-to-face assessment
0. Not required
1. More than 14 days
2. 8 to 14 days
3. 4 to 7 days
4. 1 to 3 days
5. Same day

6 URGENCY OF NEEDED SERVICES
0. Not needed
1. 72 or more hours
2. 48 to <72 hours
3. 24 to <48 hours
4. 12 to <24 hours
5. Less than 12 hours

a. Nursing	
b. Personal support/homemaking	
c. Physiotherapy	
d. Occupational therapy	
e. Dietitian services	
f. Lab services, equipment and medical supplies	
g. Placement services	
h. Social work	
i. Speech language therapy	
j. Other (specify) _____	

7 CLIENT GROUP
1. Acute
2. End of life
3. Rehabilitation
4. Long-term supportive care
5. Maintenance
6. Not yet categorized

8 TYPE OF COMMUNICATION AT INTAKE
0 No 1 Yes

a. Telephone	
b. In person	
b. Fax/written/email	

9 SOURCES OF INFORMATION USED TO COMPLETE interRAI-CA
Code only ONE PRIMARY source and ALL APPLICABLE SECONDARY sources.
0. Not Applicable
1. Primary
2. Secondary

a. Client	
b. Spouse or partner	
c. Child or child-in-law	
d. Other relative	
e. Non-relative (e.g. neighbour)	
f. Physician	
g. Staff at physician's office	
h. Other home care program — e.g. a different jurisdiction	
i. Community support agency (specify)	
j. Hospital	
k. Other (specify)	

10 SIGNATURE OF PERSON COORDINATING/COMPLETING THE ASSESSMENT
1. Signature (sign on above line)
2. Date assessment signed as complete
Year ☐☐☐☐ Month ☐☐ Day ☐☐

END OF COMMUNITY OR HOSPITAL INTAKE MODULE

This is Exhibit "B"
to the Affidavit of KAREN MITCHELL,
Sworn before me this 19th
Day of July, 2018

Meagan Williams LSO#64283G

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[CODE FOR LAST 3 DAYS, UNLESS OTHERWISE SPECIFIED]

SECTION A. Identification Information

1. NAME
a. (Given name)
b. (Initial or middle name)
c. (Family name)
d. (Suffix)

2. GENDER
M Male **F** Female

3. BIRTHDATE Year — Month — Day

4. MARITAL STATUS
1 Never married
2 Married
3 Partner / Significant other
4 Widowed
5 Separated
6 Divorced

5. NUMERIC IDENTIFIERS [EXAMPLE — CANADA]
a. **Healthcare Identification Number**
b. **Province or Territory Issuing Healthcare Identification Number**
c. **Case Record Number**

6. AGENCY IDENTIFIER [EXAMPLE — CANADA]

7. CURRENT PAYMENT SOURCES [EXAMPLE — CANADA]
0 No **1** Yes

a. **Provincial or territorial government plan (this province or territory)**
b. **Provincial or territorial government plan (other province or territory)**
c. **Federal government**—Veterans Affairs Canada (VAC)
d. **Federal government**—First Nations and Inuit Health Branch (FNIHB)
e. **Federal government**—Other
f. **Workers' Compensation Board (WCB / WSIB)**
g. **Canadian resident, insurance pay**
h. **Canadian resident, public trustee pay**
i. **Canadian resident, self-pay**
j. **Other country resident, self-pay**
k. **Responsibility for payment unknown or unavailable**

8. REASON FOR ASSESSMENT
1 First assessment
2 Routine reassessment
3 Return assessment
4 Significant change in status reassessment
5 Discharge assessment, covers last 3 days of service
6 Discharge tracking only
7 Other—e.g., research

9. ASSESSMENT REFERENCE DATE
Year — Month — Day

10. LOCATION OF ASSESSMENT [Additional interRAI Item]
a. **Type of location**
1 Private home, condominium, apartment, assisted living setting
2 Hospital
3 Residential care facility
4 Other—e.g., hospice, correctional facility

b. **Facility admission date**
Date of admission to facility
[Leave blank if A10a is coded 1]
Year — Month — Day

11. PERSON'S EXPRESSED GOALS OF CARE
Enter primary goal in boxes at bottom

12. POSTAL CODE OF USUAL LIVING ARRANGEMENT [EXAMPLE — CANADA]

13. RESIDENTIAL / LIVING STATUS AT TIME OF ASSESSMENT [EXAMPLE — CANADA]
1 Private home / apartment / rented room
2 Board and care
3 Assisted living or semi-independent living
4 Mental health residence—e.g., psychiatric group home
5 Group home for persons with physical disability
6 Setting for persons with intellectual disability
7 Psychiatric hospital / unit
8 Homeless (with or without shelter)
9 Residential care facility (e.g., long-term care home, nursing home)
10 Rehabilitation hospital / unit
11 Hospice facility / palliative care unit
12 Acute care hospital / unit
13 Correctional facility
14 Continuing care hospital / unit
15 Other

14. LIVING ARRANGEMENT
a. Lives
1 Alone
2 With spouse / partner only
3 With spouse / partner and other(s)
4 With child (not spouse / partner)
5 With parent(s) or guardian(s)
6 With sibling(s)
7 With other relative(s)
8 With nonrelative(s)

b. As compared to 90 DAYS AGO (or since last assessment), person now lives with someone new—e.g., moved in with another person, other moved in
0 No **1** Yes

c. Person or relative feels that the person would be better off living elsewhere
0 No
1 Yes, other community residence
2 Yes, institution

15. TIME SINCE LAST HOSPITAL STAY
Code for most recent instance in LAST 90 DAYS
0 No hospitalization within 90 days
1 31 – 90 days ago
2 15 – 30 days ago
3 8 - 14 days ago
4 In the last 7 days
5 Now in hospital

SECTION B. Intake and Initial History

[Note. Complete at Admission/First Assessment only]

1. DATE CASE OPENED (this agency)
Year — Month — Day

2. ABORIGINAL IDENTITY [EXAMPLE — CANADA]
Person identifies self as First Nations, Métis, or Inuit
0 No **1** Yes
a. First Nations
b. Métis
c. Inuit

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3. PRIMARY LANGUAGE [EXAMPLE — CANADA]
eng English **fre** French
(See HCC Language Codes document for additional codes)

4. RESIDENTIAL HISTORY OVER LAST 5 YEARS [EXAMPLE — CANADA]
Code for all settings person lived in during 5 YEARS prior to date case opened (Item B1)

0 No **1** Yes

a. Residential care facility—e.g., long-term care home, nursing home
b. Board and care home, assisted living
c. Mental health residence—e.g., psychiatric group home
d. Psychiatric hospital / unit
e. Setting for persons with intellectual disability
f. Post-acute / rehabilitation setting (includes complex continuing care settings)

SECTION C. Cognition

1. COGNITIVE SKILLS FOR DAILY DECISION MAKING
Making decisions regarding tasks of daily life—e.g., when to get up or have meals, which clothes to wear or activities to do

0 Independent—Decisions consistent, reasonable, and safe
1 Modified independence—Some difficulty in new situations only
2 Minimally impaired—In specific recurring situations, decisions become poor or unsafe; cues / supervision necessary at those times
3 Moderately impaired—Decisions consistently poor or unsafe; cues / supervision required at all times
4 Severely impaired—Never or rarely makes decisions
5 No discernible consciousness, coma [Skip to Section G]

2. MEMORY / RECALL ABILITY
Code for recall of what was learned or known

0 Yes, memory OK **1** Memory problem

a. **Short-term memory OK**—Seems / appears to recall after 5 minutes
b. **Procedural memory OK**—Can perform all or almost all steps in a multistep sequence without cues
c. **Situational memory OK**—Both, recognizes caregivers' names / faces frequently encountered AND knows location of places regularly visited (bedroom, dining room, activity room, therapy room)

3. PERIODIC DISORDERED THINKING OR AWARENESS
(Note: Accurate assessment requires conversations with staff, family, or others who have direct knowledge of the person's behaviour over this time)

0 Behaviour not present
1 Behaviour present, consistent with usual functioning
2 Behaviour present, appears different from usual functioning (e.g., new onset or worsening; different from a few weeks ago)

a. **Easily distracted**—e.g., episodes of difficulty paying attention; gets sidetracked
b. **Episodes of disorganized speech**—e.g., speech is nonsensical, irrelevant, or rambling from subject to subject; loses train of thought
c. **Mental function varies over the course of the day**—e.g., sometimes better, sometimes worse

4. ACUTE CHANGE IN MENTAL STATUS FROM PERSON'S USUAL FUNCTIONING—*e.g., restlessness, lethargy, difficult to arouse, altered environmental perception*

0 No **1** Yes

5. CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO)

0 Improved **2** Declined
1 No change **8** Uncertain

SECTION D. Communication and Vision

1. MAKING SELF UNDERSTOOD (Expression)
Expressing information content—both verbal and nonverbal

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 AND prompting usually required
3 Sometimes understood—Ability is limited to making concrete requests
4 Rarely or never understood

2. ABILITY TO UNDERSTAND OTHERS (Comprehension)
Understanding verbal information content (however able, with hearing appliance normally used)

0 Understands—Clear comprehension
1 Usually understands—Misses some part / intent of message BUT comprehends most conversation
2 Often understands—Misses some part / intent of message BUT with repetition or explanation can often comprehend conversation
3 Sometimes understands—Responds adequately to simple, direct communication only
4 Rarely or never understands

3. HEARING
Ability to hear (with hearing appliance normally used)

0 Adequate—No difficulty in normal conversation, social interaction, listening to TV
1 Minimal difficulty—Difficulty in some environments (e.g., when person speaks softly or is more than 2 metres [6 feet] away)
2 Moderate difficulty—Problem hearing normal conversation; requires quiet setting to hear well
3 Severe difficulty—Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
4 No hearing

4. VISION
Ability to see in adequate light (with glasses or with other visual appliance normally used)

0 Adequate—Sees fine detail, including regular print in newspapers/books
1 Minimal difficulty—Sees large print, but not regular print in newspapers/books
2 Moderate difficulty—Limited vision; not able to see newspaper headlines, but can identify objects
3 Severe difficulty—Object identification in question, but eyes appear to follow objects; sees only light, colours, shapes
4 No vision

SECTION E. Mood and Behaviour

1. INDICATORS OF POSSIBLE DEPRESSED, ANXIOUS, OR SAD MOOD
Code for indicators observed in last 3 days, irrespective of the assumed cause (Note: Whenever possible, ask person)

0 Not present
1 Present but not exhibited in last 3 days
2 Exhibited on 1–2 of last 3 days
3 Exhibited daily in last 3 days

a. **Made negative statements**—e.g., "Nothing matters"; "Would rather be dead", "What's the use"; "Regret having lived so long"; "Let me die"
b. **Persistent anger with self or others**—e.g., easily annoyed, anger at care received
c. **Expressions, including nonverbal, of what appear to be unrealistic fears**—e.g., fear of being abandoned, being left alone, being with others; intense fear of specific objects or situations
d. **Repetitive health complaints**—e.g., persistently seeks medical attention, incessant concern with body functions
e. **Repetitive anxious complaints/concerns (non-health-related)**—e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationships
f. **Sad, pained, or worried facial expressions**—e.g., furrowed brow, constant frowning
g. **Crying, tearfulness**
h. **Recurrent statements that something terrible is about to happen**—e.g., believes he or she is about to die, have a heart attack

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i. **Withdrawal from activities of interest**—e.g., long-standing activities, being with family / friends
j. **Reduced social interactions**
k. **Expressions, including nonverbal, of a lack of pleasure in life (anhedonia)**—e.g., "I don't enjoy anything anymore"

2. SELF-REPORTED MOOD

0 Not in last 3 days
1 Not in last 3 days, but often feels that way
2 In 1–2 of last 3 days
3 Daily in the last 3 days
8 Person could not (would not) respond

Ask: "In the last 3 days, how often have you felt . . ."

a. **Little interest or pleasure in things you normally enjoy?**
b. **Anxious, restless, or uneasy?**
c. **Sad, depressed, or hopeless?**

3. BEHAVIOUR SYMPTOMS

Code for indicators observed, irrespective of the assumed cause

0 Not present
1 Present but not exhibited in last 3 days
2 Exhibited on 1–2 of last 3 days
3 Exhibited daily in last 3 days

a. **Wandering**—Moved with no rational purpose, seemingly oblivious to needs or safety
b. **Verbal abuse**—e.g., others were threatened, screamed at, cursed at
c. **Physical abuse**—e.g., others were hit, shoved, scratched, sexually abused
d. **Socially inappropriate or disruptive behaviour**—e.g., made disruptive sounds or noises, screamed out, smeared or threw food or feces, hoarded, rummaged through others' belongings
e. **Inappropriate public sexual behaviour or public disrobing**
f. **Resists care**—e.g., taking medications / injections, ADL assistance, eating

SECTION F. Psychosocial Well-Being

1. SOCIAL RELATIONSHIPS

[Note: Whenever possible, ask person]

0 Never
1 More than 30 days ago
2 8 – 30 days ago
3 4 – 7 days ago
4 In last 3 days
8 Unable to determine

a. Participation in social activities of long standing interest
b. Visit with a long-standing social relation or family member
c. Other interaction with long-standing social relation or family member—e.g., telephone, e-mail
d. Conflict or anger with family or friends
e. Fearful of a family member or close acquaintance
f. Neglected, abused, or mistreated

2. LONELY

Says or indicates that he / she feels lonely

0 No 1 Yes

3. CHANGE IN SOCIAL ACTIVITIES IN LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO)

Decline in level of participation in social, religious, occupational, or other preferred activities

IF THERE WAS A DECLINE, person distressed by this fact

0 No decline
1 Decline, not distressed
2 Decline, distressed

4. LENGTH OF TIME ALONE DURING THE DAY (MORNING AND AFTERNOON)

0 Less than 1 hour
1 1–2 hours
2 More than 2 hours but less than 8 hours
3 8 hours or more

5. MAJOR LIFE STRESSORS IN LAST 90 DAYS—*e.g., episode of severe personal illness; death or severe illness of close family member / friend; loss of home; major loss of income / assets; victim of a crime such as robbery or assault; loss of driving licence / car*

0 No 1 Yes

SECTION G. Functional Status

1. IADL SELF-PERFORMANCE AND CAPACITY

Code for PERFORMANCE in routine activities around the home or in the community during the LAST 3 DAYS

Code for CAPACITY based on presumed ability to carry out activity as independently as possible. This will require "speculation" by the assessor.

0 **Independent**—No help, set up, or supervision
1 **Set-up help only**
2 **Supervision**—Oversight / cueing
3 **Limited assistance**—Help on some occasions
4 **Extensive assistance**—Help throughout task, but performs 50% or more of task on own
5 **Maximal assistance**—Help throughout task, but performs less than 50% of task on own
6 **Total dependence**—Full performance by others during entire period
8 **Activity did not occur**—During entire period [DO NOT USE THIS CODE IN SCORING CAPACITY]

	Performance	Capacity
a. **Meal preparation**—How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)		
b. **Ordinary housework**—How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)		
c. **Managing finances**—How bills are paid, chequebook is balanced, household expenses are budgeted, credit card account is monitored		
d. **Managing medications**—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments)		
e. **Phone use**—How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed)		
f. **Stairs**—How full flight of stairs is managed (12–14 stairs)		
g. **Shopping**—How shopping is performed for food and household items (e.g., selecting items, paying money)—EXCLUDE TRANSPORTATION		
h. **Transportation**—How travels by public transportation (navigating system, paying fare) or driving self (including getting out of house, into and out of vehicles)		

2. ADL SELF-PERFORMANCE

Consider all episodes over 3-day period.

If all episodes are performed at the same level, score ADL at that level.

If any episodes at level 6, and others less dependent, score ADL as a 5.

Otherwise, focus on the three most dependent episodes [or all episodes if performed fewer than 3 times]. If most dependent episode is 1, score ADL as 1. If not, score ADL as least dependent of those episodes in range 2–5.

0 **Independent**—No physical assistance, set-up, or supervision in any episode
1 **Independent, set-up help only**—Article or device provided or placed within reach, no physical assistance or supervision in any episode
2 **Supervision**—Oversight / cueing
3 **Limited assistance**—Guided manoeuvring of limbs, physical guidance without taking weight
4 **Extensive assistance**—Weight bearing support (including lifting limbs) by 1 helper where person still performs 50% or more of subtasks
5 **Maximal assistance**—Weight-bearing support (including lifting limbs) by 2+ 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**

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

b. **Personal hygiene**—How manages personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing and drying face and hands — EXCLUDE BATHS AND SHOWERS

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

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

e. **Walking**—How walks between locations on same floor indoors

f. **Locomotion**—How moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair

g. **Transfer toilet**—How moves on and off toilet or commode

h. **Toilet use**—How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes — EXCLUDE TRANSFER ON AND OFF TOILET

i. **Bed mobility**—How moves to and from lying position, turns from side to side, and positions body while in bed

j. **Eating**—How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)

3. LOCOMOTION / WALKING

a. **Primary mode of locomotion indoors**
- 0 Walking, no assistive device
- 1 Walking, uses assistive device—e.g., cane, walker, crutch, pushing wheelchair
- 2 Wheelchair, scooter
- 3 Bed-bound

b. **Timed 4-metre (13-foot) walk**

Lay out a straight, unobstructed course. Have person stand in still position, feet just touching start line. Then say: "When I tell you begin to walk at a normal pace (with cane/walker if used). This is not a test of how fast you can walk. Stop when I tell you to stop. Is this clear?" Assessor may demonstrate test. Then say: "Begin to walk now." Start stopwatch (or can count seconds) when first foot falls. End count when foot falls beyond 4-metre mark. Then say: "You may stop now."

Enter time in seconds, up to 30 seconds
- 30 30 or more seconds to walk 4 metres
- 77 Stopped before test complete
- 88 Refused to do the test
- 99 Not tested—e.g., does not walk on own

c. **Distance walked**—Farthest distance walked at one time without sitting down in the LAST 3 DAYS (with support as needed)
- 0 Did not walk
- 1 Less than 5 metres (under 15 feet)
- 2 5–49 metres (15–149 feet)
- 3 50–99 metres (150–299 feet)
- 4 100+ metres (300+ feet)
- 5 1+ kilometres (1/2 mile or more)

d. **Distance wheeled self**—Farthest distance wheeled self at one time in the LAST 3 DAYS (includes independent use of motorized wheelchair)
- 0 Wheeled by others
- 1 Used motorized wheelchair / scooter
- 2 Wheeled self less than 5 metres (under 15 feet)
- 3 Wheeled self 5–49 metres (15–149 feet)
- 4 Wheeled self 50–99 metres (150–299 feet)
- 5 Wheeled self 100+ metres (300+ feet)
- 8 Did not use wheelchair

4. ACTIVITY LEVEL

a. **Total hours of exercise or physical activity in LAST 3 DAYS**—e.g., walking
- 0 None
- 1 Less than 1 hour
- 2 1–2 hours
- 3 3–4 hours
- 4 More than 4 hours

b. **In the LAST 3 DAYS, number of days went out of the house or building in which he / she resides** (no matter how short the period)
- 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

5. PHYSICAL FUNCTION IMPROVEMENT POTENTIAL

0 No 1 Yes

a. Person believes he / she is capable of improved performance in physical function

b. Care professional believes person is capable of improved performance in physical function

6. CHANGE IN ADL STATUS AS COMPARED TO 90 DAYS AGO, OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO
- 0 Improved
- 1 No change
- 2 Declined
- 8 Uncertain

7. DRIVING

a. Drove car (vehicle) in the LAST 90 DAYS

0 No 1 Yes

b. If drove in LAST 90 DAYS, assessor is aware that someone has suggested that person limits OR stops driving

0 No, or does not drive 1 Yes

SECTION H. Continence

1. BLADDER CONTINENCE
- 0 **Continent**—Complete control, DOES NOT USE any type of catheter or other urinary collection device
- 1 **Control with any catheter or ostomy** over last 3 days
- 2 **Infrequently incontinent**—Not incontinent over last 3 days, but does have incontinent episodes
- 3 **Occasionally incontinent**—Less than daily
- 4 **Frequently incontinent**—Daily, but some control present
- 5 **Incontinent**—No control present
- 8 **Did not occur**—No urine output from bladder in last 3 days

2. URINARY COLLECTION DEVICE [Exclude pads / briefs]
- 0 None
- 1 Condom catheter
- 2 Indwelling catheter
- 3 Cystostomy, nephrostomy, ureterostomy

3. BOWEL CONTINENCE
- 0 **Continent**—Complete control; DOES NOT USE any type of ostomy device
- 1 **Control with ostomy**—Control with ostomy device over last 3 days
- 2 **Infrequently incontinent**—Not incontinent over last 3 days, but does have incontinent episodes
- 3 **Occasionally incontinent**—Less than daily
- 4 **Frequently incontinent**—Daily, but some control present
- 5 **Incontinent**—No control present
- 8 **Did not occur**—No bowel movement in the last 3 days

4. PADS OR BRIEFS WORN

0 No 1 Yes

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SECTION I. Disease Diagnoses

Disease code

0 Not present
1 Primary diagnosis / diagnoses for current stay
2 Diagnosis present, receiving active treatment
3 Diagnosis present, monitored but no active treatment

1. DISEASE DIAGNOSES

Musculoskeletal

a. Hip fracture during last 30 days (or since last assessment if less than 30 days)
b. Other fracture during last 30 days (or since last assessment if less than 30 days)

Neurological

c. Alzheimer's disease
d. Dementia other than Alzheimer's disease
e. Hemiplegia
f. Multiple sclerosis
g. Paraplegia
h. Parkinson's disease
i. Quadriplegia
j. Stroke / CVA

Cardiac or Pulmonary

k. Coronary heart disease
l. Chronic obstructive pulmonary disease
m. Congestive heart failure

Psychiatric

n. Anxiety
o. Bipolar disorder
p. Depression
q. Schizophrenia

Infections

r. Pneumonia
s. Urinary tract infection in last 30 days

Other

t. Cancer
u. Diabetes mellitus

2. OTHER DISEASE DIAGNOSES

	Diagnosis	Disease Code	ICD-10-CA code
a.			
b.			
c.			
d.			
e.			
f.			

[Note: See disease diagnoses information at the end of this file]
[Note: Add additional lines as necessary for other disease diagnoses]

SECTION J. Health Conditions

1. FALLS

0 No falls
1 One fall
2 Two or more falls

a. Falls last 30 days
b. Falls 31-90 days ago
c. Falls 91-180 days ago

2. PROBLEM FREQUENCY

Code for presence in last 3 days

0 Not present
1 Present but not exhibited in last 3 days
2 Exhibited on 1 of last 3 days
3 Exhibited on 2 of last 3 days
4 Exhibited daily in last 3 days

Balance

a. Difficult or unable to move self to standing position unassisted
b. Difficult or unable to turn self around and face the opposite direction when standing
c. Dizziness
d. Unsteady gait

Cardiac or Pulmonary

e. Chest pain
f. Difficulty clearing airway secretions

Psychiatric

g. Abnormal thought process—e.g., loosening of associations, blocking, flight of ideas, tangentiality, circumstantiality
h. Delusions—Fixed false beliefs
i. Hallucinations—False sensory perceptions

Neurological

j. Aphasia

GI Status

k. Acid reflux—Regurgitation of acid from stomach to throat
l. Constipation—No bowel movement in 3 days or difficult passage of hard stool
m. Diarrhea
n. Vomiting

Sleep Problems

o. Difficulty falling asleep or staying asleep; waking up too early; restlessness; nonrestful sleep
p. Too much sleep—Excessive amount of sleep that interferes with person's normal functioning

Other

q. Aspiration
r. Fever
s. GI or GU bleeding
t. Hygiene—Unusually poor hygiene, unkempt, dishevelled
u. Peripheral edema

3. DYSPNEA (Shortness of breath)

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

4. FATIGUE

Inability to complete normal daily activities—e.g., ADLs, IADLs

0 **None**
1 **Minimal**—Diminished energy but completes normal day-to-day activities
2 **Moderate**—Due to diminished energy, UNABLE TO FINISH normal day-to-day activities
3 **Severe**—Due to diminished energy, UNABLE TO START SOME normal day-to-day activities
4 **Unable to commence any normal day-to-day activities**—Due to diminished energy

5. PAIN SYMPTOMS

[Note: Always ask the person about pain frequency, intensity, and control. Observe person and ask others who are in contact with the person.]

g. **Frequency with which person complains or shows evidence of pain** (including grimacing, teeth clenching, moaning, withdrawal when touched, or other nonverbal signs suggesting pain)

0 No pain
1 Present but not exhibited in last 3 days
2 Exhibited on 1–2 of last 3 days
3 Exhibited daily in last 3 days

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b. **Intensity of highest level of pain present**
- 0 No pain
- 1 Mild
- 2 Moderate
- 3 Severe
- 4 Times when pain is horrible or excruciating

c. **Consistency of pain**
- 0 No pain
- 1 Single episode during last 3 days
- 2 Intermittent
- 3 Constant

d. **Breakthrough pain**—Times in LAST 3 DAYS when person experienced sudden, acute flare-ups of pain
- 0 No
- 1 Yes

e. **Pain control**—Adequacy of current therapeutic regimen to control pain (from person's point of view)
- 0 No issue of pain
- 1 Pain intensity acceptable to person; no treatment regimen or change in regimen required
- 2 Controlled adequately by therapeutic regimen
- 3 Controlled when therapeutic regimen followed, but not always followed as ordered
- 4 Therapeutic regimen followed, but pain control not adequate
- 5 No therapeutic regimen being followed for pain; pain not adequately controlled

6. INSTABILITY OF CONDITIONS
- 0 No
- 1 Yes

a. Conditions / diseases make cognitive, ADL, mood, or behaviour patterns unstable (fluctuating, precarious, or deteriorating)

b. Experiencing an acute episode, or a flare-up of a recurrent or chronic problem

c. End-stage disease, 6 or fewer months to live

7. SELF-REPORTED HEALTH
Ask: "In general, how would you rate your health?"
- 0 Excellent
- 1 Good
- 2 Fair
- 3 Poor
- 8 Could not (would not) respond

8. TOBACCO AND ALCOHOL

a. Smokes tobacco daily
- 0 No
- 1 Not in last 3 days, but is usually a daily smoker
- 2 Yes

b. Alcohol—Highest number of drinks in any "single sitting" in LAST 14 DAYS
- 0 None
- 1 1
- 2 2–4
- 3 5 or more

SECTION K. Oral and Nutritional Status

1. HEIGHT AND WEIGHT [EXAMPLE — CANADA]
Record (a.) height in centimetres and (b.) weight in kilograms. Base weight on most recent measure in LAST 30 DAYS.

a. HT (cm) [ ] b. WT (kg) [ ]

2. NUTRITIONAL ISSUES
- 0 No
- 1 Yes

[Note: Items K2e and K2f are additional interRAI items specific to the Canadian interRAI HC]

a. Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS

b. Dehydrated or BUN / Cre ratio > 20 [Ratio, country specific]

c. Fluid intake less than 1,000 ml per day (less than four 8 oz cups / day)

d. Fluid output exceeds input

e. Decrease in amount of food or fluid usually consumed

f. Ate one or fewer meals on AT LEAST 2 of LAST 3 DAYS

3. MODE OF NUTRITIONAL INTAKE
- 0 **Normal**—Swallows all types of foods
- 1 **Modified independent**—e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
- 2 **Requires diet modification to swallow solid food**—e.g., mechanical diet (e.g., puree, minced, etc.) or only able to ingest specific foods
- 3 **Requires modification to swallow liquids**—e.g., thickened liquids
- 4 **Can swallow only pureed solids—AND—thickened liquids**
- 5 **Combined oral and parenteral or tube feeding**
- 6 **Nasogastric tube feeding only**
- 7 **Abdominal feeding tube**—e.g., PEG tube
- 8 **Parenteral feeding only**—Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)
- 9 **Activity did not occur**—During entire period

4. DENTAL OR ORAL
- 0 No
- 1 Yes

a. Wears a denture (removable prosthesis)

b. Has broken, fragmented, loose, or otherwise non-intact natural teeth

c. Reports having dry mouth

d. Reports difficulty chewing

SECTION L. Skin Condition

1. MOST SEVERE PRESSURE ULCER
- 0 No pressure ulcer
- 1 Any area of persistent skin redness
- 2 Partial loss of skin layers
- 3 Deep craters in the skin
- 4 Breaks in skin exposing muscle or bone
- 5 Not codeable, e.g., necrotic eschar predominant

2. PRIOR PRESSURE ULCER
- 0 No
- 1 Yes

3. PRESENCE OF SKIN ULCER OTHER THAN PRESSURE ULCER—*e.g., venous ulcer, arterial ulcer, mixed venous-arterial ulcer, diabetic foot ulcer*
- 0 No
- 1 Yes

4. MAJOR SKIN PROBLEMS—*e.g., lesions, 2nd- or 3rd-degree burns, healing surgical wounds*
- 0 No
- 1 Yes

5. SKIN TEARS OR CUTS—*Other than surgery*
- 0 No
- 1 Yes

6. OTHER SKIN CONDITIONS OR CHANGES IN SKIN CONDITION—*e.g., bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema*
- 0 No
- 1 Yes

7. FOOT PROBLEMS—*e.g., bunions, hammertoes, overlapping toes, structural problems, infections, ulcers*
- 0 No foot problems
- 1 Foot problems, no limitation in walking
- 2 Foot problems limit walking
- 3 Foot problems prevent walking
- 4 Foot problems, does not walk for other reasons

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SECTION M. Medications

1. LIST OF ALL MEDICATIONS

List all active prescriptions, and any nonprescribed (over-the-counter) medications taken in the LAST 3 DAYS

[Note: Use computerized records if possible; hand enter only when absolutely necessary]

For each drug, record:

a. **Name**

b. **Dose**—A positive number such as 0.5, 5, 150, 300.
[Note: Never write a zero by itself after a decimal point (X mg). Always use a zero before a decimal point (0.X mg).]

c. **Unit**—Code using the following list.

gtts	(drops)	**meq**	(milliequivalent)	**puffs**	(puffs)
g	(gram)	**mg**	(milligram)	**%**	(percent)
l	(litres)	**ml**	(millilitre)	**u**	(units)
mcg	(microgram)	**oz**	(ounce)	**oth**	(other)

d. **Route of administration**—Code using the following list:

PO	(by mouth/oral)	**REC**	(rectal)	**ET**	(enteral tube)
SL	(sublingual)	**TOP**	(topical)	**TD**	(transdermal)
IM	(intramuscular)	**ORINHL**	(inhalation, oral)	**OPTH**	(eye)
IV	(intravenous)	**NASINHL**	(inhalation, nasal)	**OTH**	(other)
SC	(subcutaneous)				

e. **Frequency**—Code the number of times per day, week, or month the medication is administered using the following list:

Q1H	(every hour)	**BID**	(2 times daily) (includes every 12 hrs)
Q2H	(every 2 hours)	**TID**	(3 times daily)
Q3H	(every 3 hours)	**QID**	(4 times daily)
Q4H	(every 4 hours)	**5D**	(5 times daily)
Q6H	(every 6 hours)	**Q2D**	(every other day)
Q8H	(every 8 hours)	**Q3D**	(every 3 days)
Daily		**Weekly**	
BED	(at bedtime)		
2W	(2 times weekly)	**6W**	(6 times weekly)
3W	(3 times weekly)	**1M**	(monthly)
4W	(4 times weekly)	**2M**	(twice every month)
5W	(5 times weekly)	**OTH**	(other)

f. **PRN**
0 No 1 Yes

g. **Computer-entered drug code**

	a. Name	b. Dose	c. Unit	d. Route	e. Freq.	f. PRN	g. Drug Code
1.							
2.							
3.							
4.							
5.							

[Note: Please refer to the end of the file for full list of Medications]

2. ALLERGY TO ANY DRUG ☐
0 No known drug allergies 1 Yes

3. ADHERENCE WITH PRESCRIBED MEDICATIONS ☐
0 Always adherent
1 Adherent 80% of time or more
2 Adherent less than 80% of time, including failure to purchase prescribed medications
8 No medications prescribed

4. TOTAL NUMBER OF MEDICATIONS ☐
Record the number of different medications (prescription and over-the-counter), including eye drops, taken regularly or on an occasional basis in last 3 days [note: also include medication taken on a maintenance basis]. Code number (enter 15 if 15 or higher)

5. TOTAL NUMBER OF HERBAL/NUTRITIONAL SUPPLEMENTS ☐
Record the number of different herbal and nutritional supplements taken regularly or on an occasional basis in the last 3 days. Code number (enter 15 if 15 or higher)

6. RECENTLY CHANGED MEDICATIONS ☐
Physician has prescribed a new medication or stopped an existing medication in the last 14 days
0 No 1 Yes

7. SELF-REPORTED NEED FOR MEDICATION REVIEW ☐
Ask: "Do you have concerns about your medications that you want to discuss with a health professional?
0 No
1 Yes
8 Could not (would not) respond

8. RECEIPT OF PSYCHOTROPIC MEDICATION
Psychotropic medication taken in the LAST 7 DAYS (or since last assessment). Also enter "1" if long-acting medication used less than weekly (e.g., in the last month)
0 No 1 Yes

a. Antipsychotic ☐
b. Anxiolytic ☐
c. Antidepressant ☐
d. Hypnotic ☐

9. MEDICATION BY DAILY INJECTION ☐
0 No 1 Yes

SECTION N. Treatments and Procedures

1. PREVENTION
0 No 1 Yes

a. Blood pressure measured in LAST YEAR ☐
b. Colonoscopy test in LAST 5 YEARS ☐
c. Dental exam in LAST YEAR ☐
d. Eye exam in LAST YEAR ☐
e. Hearing exam in LAST 2 YEARS ☐
f. Influenza vaccine in LAST YEAR ☐
g. Mammogram or breast exam in LAST 2 YEARS (for women) ☐
h. Pneumovax vaccine in LAST 5 YEARS or after age 65 ☐

2. TREATMENTS AND PROGRAMS RECEIVED OR SCHEDULED IN THE LAST 3 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 3 DAYS)
0 Not ordered AND did not occur
1 Ordered, not implemented
2 1–2 of last 3 days
3 Daily in last 3 days

Treatments
a. Chemotherapy ☐
b. Dialysis ☐
c. Infection control—e.g., isolation, quarantine ☐

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d. IV medication
e. Oxygen therapy
f. Radiation
g. Suctioning
h. Tracheostomy care
i. Transfusion
j. Ventilator or respirator
k. Wound care

Programs

l. Scheduled toileting program
m. Hospice / palliative care program
n. Turning / repositioning program

3. FORMAL CARE

Days (A) and Total minutes (B) of care in last 7 days

Extent of care / treatment in LAST 7 DAYS (or since last assessment or admission, if less than 7 days) involving:

	(A) # of Days	(B) Total Minutes in Last Week
a. Home health aide		
b. Home nurse		
c. Homemaking services		
d. Meals		
e. Physical therapy		
f. Occupational therapy		
g. Speech-language pathology and audiology services		
h. Psychological therapy (by any licensed mental health professional)		

4. HOSPITAL USE, EMERGENCY ROOM USE, PHYSICIAN VISIT

Code for number of times during the LAST 90 DAYS (or since last assessment if LESS THAN 90 DAYS AGO)

a. In-patient acute hospital with overnight stay
b. Emergency room visit (not counting overnight stay)
c. Physician visit (or authorized assistant or practitioner)

5. PHYSICALLY RESTRAINED—Limbs restrained, restrained to chair when sitting, chair prevents rising

0 No **1** Yes

SECTION O. Responsibility

1. DECISION-MAKER FOR PERSONAL CARE AND PROPERTY [EXAMPLE — CANADA]

1 Person **2** Other

a. Personal care
b. Property

SECTION P. Social Supports

1. TWO KEY INFORMAL HELPERS

Helper 1 / Helper 2

a. **Relationship to person**
- **1** Child or child-in-law
- **2** Spouse
- **3** Partner / Significant other
- **4** Parent / guardian
- **5** Sibling
- **6** Other relative
- **7** Friend
- **8** Neighbour
- **9** No informal helper

b. **Lives with person**
- **0** No
- **1** Yes, 6 months or less
- **2** Yes, more than 6 months
- **8** No informal helper

Areas of Informal Help during Last 3 Days
- **0** No
- **1** Yes
- **8** No informal helper

Helper 1 / Helper 2

c. **IADL help**
d. **ADL help**

2. INFORMAL HELPER STATUS

0 No **1** Yes

a. Informal helper(s) is unable to continue in caring activities—e.g., decline in health of helper makes it difficult to continue
b. Primary informal helper expresses feelings of distress, anger, or depression
c. Family or close friends report feeling overwhelmed by person's illness

3. HOURS OF INFORMAL CARE AND ACTIVE MONITORING DURING LAST 3 DAYS

For instrumental and personal activities of daily living in the LAST 3 DAYS, indicate the total number of hours of help received from all family, friends, and neighbours

4. STRONG AND SUPPORTIVE RELATIONSHIP WITH FAMILY

0 No **1** Yes

SECTION Q. Environmental Assessment

1. HOME ENVIRONMENT

Code for any of following that make home environment hazardous or uninhabitable (if temporarily in institution, base assessment on home visit)

0 No **1** Yes

a. **Disrepair of the home**—e.g., hazardous clutter, inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors, holes in floor, leaking pipes
b. **Squalid condition**—e.g., extremely dirty, infestation by rats or bugs
c. **Inadequate heating or cooling**—e.g., too hot in summer, too cold in winter
d. **Lack of personal safety**—e.g., fear of violence, safety problem in going to mailbox or visiting neighbours, heavy traffic in street
e. **Limited access to home or rooms in home**—e.g., difficulty entering or leaving home, unable to climb stairs, difficulty manoeuvring within rooms, no railings although needed

2. LIVES IN APARTMENT OR HOUSE RE-ENGINEERED ACCESSIBLE FOR PERSONS WITH DISABILITIES

0 No **1** Yes

3. OUTSIDE ENVIRONMENT

0 No **1** Yes

a. **Availability of emergency assistance**—e.g., telephone, alarm response system
b. **Accessibility to grocery store without assistance**
c. **Availability of home delivery of groceries**

4. FINANCES

Because of limited funds, during the last 30 days made trade-offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care

0 No **1** Yes

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SECTION R. Discharge Potential and Overall Status

1. **ONE OR MORE CARE GOALS MET IN THE LAST 90 DAYS (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO)** ☐
   0 No 1 Yes
2. **OVERALL SELF-SUFFICIENCY HAS CHANGED SIGNIFICANTLY AS COMPARED TO STATUS OF 90 DAYS AGO (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO)** ☐
   0 Improved [Skip to Section S]
   1 No change [Skip to Section S]
   2 Deteriorated

CODE FOLLOWING THREE ITEMS IF "DETERIORATED" IN LAST 90 DAYS — OTHERWISE SKIP TO SECTION S

3. **NUMBER OF 10 ADL AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION** ☐☐
4. **NUMBER OF 8 IADL PERFORMANCE AREAS IN WHICH PERSON WAS INDEPENDENT PRIOR TO DETERIORATION** ☐
5. **TIME OF ONSET OF THE PRECIPITATING EVENT OR PROBLEM RELATED TO DETERIORATION** ☐
   0 Within last 7 days
   1 8–14 days ago
   2 15–30 days ago
   3 31–60 days ago
   4 More than 60 days ago
   8 No clear precipitating event

SECTION S. Discharge

(Note: Complete Section S at Discharge only)

1. **LAST DAY OF STAY**
   ☐☐☐☐ — ☐☐ — ☐☐
   Year Month Day
2. **RESIDENTIAL / LIVING STATUS AFTER DISCHARGE [EXAMPLE — CANADA]** ☐☐
   1 Private home / apartment / rented room
   2 Board and care
   3 Assisted living or semi-independent living
   4 Mental health residence—e.g., psychiatric group home
   5 Group home for persons with physical disability
   6 Setting for persons with intellectual disability
   7 Psychiatric hospital / unit
   8 Homeless (with or without shelter)
   9 Residential care facility (e.g., long-term care home, nursing home)
   10 Rehabilitation hospital / unit
   11 Hospice facility / palliative care unit
   12 Acute care hospital / unit
   13 Correctional facility
   14 Continuing care hospital / unit
   15 Other
   16 Deceased

SECTION T. Assessment Information

SIGNATURE OF PERSON COORDINATING / COMPLETING THE ASSESSMENT

1. **Signature (sign on above line)**

2. **Date assessment signed as complete**
   ☐☐☐☐ — ☐☐ — ☐☐
   Year Month Day

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Name:

Health Card Number:

Date Printed:

Assessment Reference Date: / /

Case Record NO:

Signature of Assessor:

SECTION V. CLIENT ASSESSMENT PROTOCOL SUMMARY

CAPS	Description	Will be addressed in service plan / I+R	Previously addressed / no further intervention required	Client declines intervention	Deferred	False positive, no intervention required	False negative, will be addressed in service plan / I+R
FUNCTIONAL PERFORMANCE CAPS							
1. Physical Activities Promotion							
2. Instrumental Activities of Daily Living (IADL)							
3. Activities of Daily Living (ADL)							
4. Home Environment Optimization							
5. Institutional Risk							
COGNITION / MENTAL HEALTH CAPS							
6. Cognitive Loss							
7. Delirium							
8. Communication							
9. Mood							
10. Behaviour							
11. Abusive Relationship							
SOCIAL LIFE CAPS							
12. Informal Support							
13. Social Relationship							

Name:

Health Card Number:

Date Printed:

Assessment Reference Date: / /

Case Record NO:

Signature of Assessor:

SECTION V. CLIENT ASSESSMENT PROTOCOL SUMMARY cont'd

CAPS	Description	Will be addressed in service plan / I+R	Previously addressed / no further intervention required	Client declines intervention	Deferred	False positive, no intervention required	False negative, will be addressed in service plan / I+R
CLINICAL ISSUES CAPS							
14. Falls							
15. Pain							
16. Pressure Ulcer							
17. Cardio-Respiratory Conditions							
18. Undernutrition							
19. Dehydration							
20. Feeding Tube							
21. Prevention							
22. Appropriate Medications							
23. Tobacco and Alcohol Use							
24. Urinary incontinence							
25. Bowel Conditions							

Name:

Health Card Number:

Date Printed:

Case Record NO:

Assessment Reference Date: / /

Signature of Assessor:

OUTCOMES

Outcome	Score
ADL Hierarchy	
ADL Long Form	/ Higher values indicating greater difficulty in performing activities
ADL Short Form	/ Higher values indicating greater difficulty in performing activities
ADL-IADL Functional Hierarchy Scale	
Age in Years	Years old
Aggressive Behaviour Scale (ABS)	
Body Mass Index (BMI)	Kg/m2
CHESS	
Cognitive Performance Scale 2 (CPS2)	
Communication Scale	
Deafblind Severity Index	
Depression Rating Scale (DRS)	/ Scores of 3 or greater indicate major and minor depressive disorders
DIVERT Scale	/ Higher scores indicate higher risk for unplanned emergency department (ED) use within 6 months of assessment
IADL Capacity Hierarchy Scale	
Method for Assigning Priority Levels (MAPLe)	
Pain Scale	
Pressure Ulcer Risk Scale (PURS)	
Resource Utilization Groups - III/Home Care (RUG-III/HC)	

Name:

Health Card Number:

Date Printed:

Case Record NO:

Assessment Reference Date: / /

Signature of Assessor:

Notes

Section B. Intake and Initial History

Preferred Language (if not English):

Translation provided by:

Name of Occupation:

☐ Present ☐ Former

Section D. Communication and Vision

☐ Communication device/system

☐ Glasses ☐ Hearing Aid(s)

Section E. Mood and Behaviour

Depression:

☐ Chronic problem

☐ Agencies or professionals involved

If yes, please list agencies:

☐ **Specialized assessment attached**

Current interventions:

Wandering:

Description:

Triggers:

Current interventions:

Exit Seeking:

Description:

Triggers:

Current interventions:

Verbal Abuse:

Description:

Triggers:

Current interventions:

Physical Abuse:

Description:

Triggers:

Current interventions:

Name:

Health Card Number:

Date Printed:

Assessment Reference Date: / /

Case Record NO:

Signature of Assessor:

Section E. Mood and Behaviour cont'd

Socially inappropriate/disruptive behavioural symptoms:

Description:

Triggers:

Current interventions:

Inappropriate public sexual behaviour or public disrobing:

Description:

Triggers:

Current interventions:

Resists Care:

Description:

Triggers:

Current interventions:

☐ **Mental health referrals**

Section F: Psychosocial Well-Being

Social Activities:

Spiritual Activities:

Hobbies:

Other:

Section G. Functional Status

Transfer aids used:

☐ Transfer board ☐ Transfer pole ☐ Pivot disc ☐ Trapeze

☐ 1-person assist ☐ 2-person assist ☐ 2-person lift ☐ Mechanical lift

Type of lift:

Other:

Problems with dressing upper and lower body:

Name:

Health Card Number:

Date Printed:

Assessment Reference Date: / /

Case Record NO:

Signature of Assessor:

Section G. Functional Status cont'd

Prosthesis:

- ☐ Left arm
- ☐ Right arm
- ☐ Left leg
- ☐ Right leg
- ☐ Special care requirements

If yes, please describe special care requirements :

- ☐ Client needs assistance with prosthesis

Section H. Continence

Type of catheterization or bladder device

- ☐ Intermittent
- ☐ Suprapubic
- ☐ Urethral catheter Size: _____
- ☐ Ileal conduit
- ☐ Special care requirements

If yes, please describe special care requirements:

_____

- ☐ Stress incontinence

Bowel continence:

Type of appliance: _____

Bowel routine: _____

Ostomy care

- ☐ Colostomy
- ☐ Ileostomy

Section I. Disease Diagnosis

Current infections/ infectious diseases: _____

Management approaches: _____

History of antibiotic resistance:

Name:

Health Card Number:

Date Printed:

Assessment Reference Date: / /

Case Record NO:

Signature of Assessor:

Section J. Health Conditions

Sites of pain:

Lifestyle-if smoker, ☐ requires supervision

Details:

Section K. Oral and Nutritional Status

Source of weight and height measurement:

Special Diet:

Treatments:

Section L. Skin Condition

Wound / ulcer care

Type of dressing :

Frequency of dressing:

Specialized skin care management approaches :

Section N. Treatments and Procedures

Special treatments, therapies, programs :

Type of oxygen required

☐ Compressed ☐ Concentrator ☐ Liquid

☐ Use of ventilator required

Dialysis

☐ Hemodialysis ☐ Peritoneal dialysis

Special treatments:

Type of physical restraints :

When used :

Frequency :

This is Exhibit "C"
to the Affidavit of KAREN MITCHELL,
Sworn before me this 19th
Day of July, 2018

Meagan Williams LSO#64283G

Connecting you with care

CCAC COSC

Community Care Access Centre

South West CCAC

Client Notes Report

For Client: Bertram, Beverly [redacted]

[redacted]

PAGES OMITTED FOR REASONS OF CONFIDENIALITY

[redacted]

Date/Time	Author
30-Aug-2016 08:46 AM	Knijnenburg, Julia (RN, Care Coordinator)
Category:	Care Coordination
Subject:	Care Team Communication
Notes:	D:New wound care referral received from N. Carey, staples d/c'd, PICC d/c'd, 1st toe was debrided. Request to have dressing changed daily x 1 week then q2days as per medical referral, wash foot and apply lotion to intact skin. A:Referral forwarded to nursing and ET providers via communication wizard. Task to CL. , Note Created:30-Aug-2016 8:51 AM EDT
Types:	Client Type: Client --- Referral Type: Home Care --- Service Type: Enterostomal Therapy,Nursing
Note Sharing:	Sharing Groups: All Contracted Service Providers
Change Log:	

Date/Time	Author
19-Aug-2016 09:33 AM	Walpole, Sarilea (RN, Care Coordinator)
Category:	Care Coordination
Subject:	Care Team Communication
Notes:	D: Client has returned to her baseline and is for discharge home today. A: RAI CA completed and client will require nursing for IV abx, PICC line maintenance and wound care. Client also had PSW 2 x per week prior to admission and this will be reordered. R: Client appreciates CCAC support E:, Note Created:19-Aug-2016 9:35 AM EDT
Types:	Client Type: Client,Service Update --- Referral Type: Home Care --- Service Type: Nursing,Personal Support/Homemaking
Note Sharing:	Sharing Groups: All Contracted Service Providers
Change Log:	

Date/Time	Author
08-Aug-2016 01:25 PM	Walpole, Sarilea (RN, Care Coordinator)
Category:	Care Coordination
Subject:	Care Team Communication
Notes:	D: Client repatriated to AH Aug 5/16 from LHSC with a diagnosis of post op L femoral graft. A: Client will continue to be followed and assessed for service needs when appropriate. R: E:, Note Created:08-Aug-2016 1:26 PM EDT
Types:	Client Type: Client,Service Update ---

	Referral Type: Home Care
Note Sharing:	Sharing Groups: All Contracted Service Providers
Change Log:	

Date/Time	Author
27-Jul-2016 10:41 AM	Pytka, Melwina (RN, Care Coordinator)
Category:	Care Coordination
Subject:	Initial Contact Face to Face
Notes:	D: Received referral for wound care for pt. Pt admitted to Vic Hosp July 19th. Pt scheduled for OR Aug 3rd. Wound care referral was mislabeled and intended for another pt. Will disregard referral. Will discuss pt with SW to assess SW needs within hospital as per previous notes. A: R: E: HCC will continue to follow in hospital. , Note Created:27-Jul-2016 10:43 AM EDT
Types:	Client Type: Client --- Referral Type: Home Care
Note Sharing:	Sharing Groups:
Change Log:	

Date/Time	Author
20-Jul-2016 08:41 AM	Walpole, Sarilea (RN, Care Coordinator)
Category:	Care Coordination
Subject:	Care Team Communication
Notes:	D: Error from previous note. Client was transferred to LHSC vascular surgery July 19/16 A: R: E:, Note Created:20-Jul-2016 8:42 AM EDT
Types:	Client Type: Client,Service Update --- Referral Type: Home Care
Note Sharing:	Sharing Groups: All Contracted Service Providers
Change Log:	

Date/Time	Author
20-Jul-2016 08:38 AM	Walpole, Sarilea (RN, Care Coordinator)
Category:	Care Coordination
Subject:	Care Team Communication
Notes:	D: Client discharged home from hospital Tues. July 19/16 in the evening. Client not reassessed for service needs prior to discharge. A: Will get community to follow up with client. R: E:, Note Created:20-Jul-2016 8:39 AM EDT
Types:	Client Type: Client,Service Update --- Referral Type: Home Care
Note Sharing:	Sharing Groups: All Contracted Service Providers
Change Log:	

Date/Time	Author
08-Jul-2016 11:43 AM	Mitchell, Karen (RN, Care Coordinator)

Category:	Care Coordination
Subject:	Care Team Communication
Notes:	D:TC from Wendy Lantz SW from Pace requesting to continue to support and see clt while in the hospital [redacted] A:CC will forward request to CC at the AH to follow up if required while clt an inpatient. R: E:, Note Created:08-Jul-2016 11:46 AM EDT
Types:	
Note Sharing:	Sharing Groups: All Contracted Service Providers
Change Log:	

Date/Time	Author
08-Jul-2016 10:04 AM	Book, Jennifer (RN, Care Coordinator)

Category:	Care Coordination
Subject:	Initial Contact Face to Face
Notes:	D: AH Note: Client admitted to hospital July 7/16 with sepsis stemming from a diabetic foot ulcer. Client was admitted to SCU. She is currently receiving IV antibiotics, IV medication to stabilizer her BP, which on admission was 84/43, wound care and nutritional counseling for her noncompliance with her diabetic diet. [redacted] R:Client willing to answer writers questions. She wants help and is willing to accept any additional services that may be required on discharge. E:, Note Created:08-Jul-2016 10:24 AM EDT
Types:	Client Type: Care Plan,Client Referral Type: Home Care
Note Sharing:	Sharing Groups:
Change Log:	

Date/Time	Author
07-Jul-2016 05:52 PM	Devereaux, Eleanor (Patient Care Assistant)

Category:	Administrative
Subject:	E-Notification
Notes:	D: Patient admitted to Ingersol Hosp. July 7 05:50 p.m. Sepsis/infected diabetic foot A: SP/ CC/PCA advised. HCC notified via SWIT, Note Created:07-Jul-2016 5:54 PM EDT
Types:	Client Type: Client Referral Type: Home Care
Note Sharing:	Sharing Groups: All Contracted Service Providers
Change Log:	

Date/Time	Author

07-Jul-2016 01:48 PM	Cole, Leenah
Category:	Administrative
Subject:	E-Notification
Notes:	D: Patient presented to Alex hospital emergency department on July 7 Presenting Problem decreased loc Hospital admission status unknown at present time A: Service providers notified via HPG Hospital team will monitor for admission to hospital, Note Created:07-Jul-2016 1:48 PM EDT
Types:	Client Type: Client --- Referral Type: Home Care
Note Sharing:	Sharing Groups:
Change Log:	

[redacted]

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