

IRRS

interRAI Home Care

CIHI Coding Reference Guide

Updated July 2026

CIHI

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Introduction

The *CIHI Coding Reference Guide for the interRAI Home Care* was developed by the Canadian Institute for Health Information (CIHI). This guide highlights items from the interRAI Home Care (interRAI HC ©) (version 9.1.4 and 9.1.5) that may require clarification, thereby assisting assessors to complete the more challenging items of the assessment.

The *CIHI Coding Reference Guide for the interRAI Home Care* is updated through scheduled releases during the year. For the most up-to-date clinical coding directions between releases, users are encouraged to consult eQuery (refer to Additional resources below).

Purpose

The purpose of this document is to assist assessors in completing the interRAI HC assessment by highlighting some of its potentially challenging coding areas. It is intended to function as a companion guide for assessors completing the interRAI HC, to be used in conjunction with clinical judgment, expertise and relevant best practice guidelines.

Additional resources

The *interRAI HC User's Manual* remains the comprehensive resource to guide the understanding and documentation of assessment findings. In addition, resources are available to assessors to assist with accurate coding of the assessment:

Resources for long-term care and home care interRAI assessments: A centralized website where users can access a wide range of materials related to interRAI assessments. It provides convenient access to job aids, reference guides, training materials and useful links, supporting consistent assessment practices and helping users quickly find the information they need.

eQuery: eQuery is a web-based application that stakeholders can use when they have a question about assessment-related topics. Search a repository of previously submitted questions and answers, or submit new questions if you're unable to find answers to specific coding questions.

Job aids: Several job aids specific to the interRAI HC provide further information to assessors. These job aids can be accessed through eQuery.

CIHI tips by assessment section

Section A **Identification Information**

Item	CIHI tip
A2a — Sex at birth	A person's biological sex plays an important role in treating certain health conditions and is a potential protective or risk factor. It can be used to predict health-related issues and outcomes. Ask the person, "What was your sex at birth?". **The following coding options are new to the interRAI HC version 9.1.5:** • IX (intersex) refers to people who were born with sex characteristics (such as sexual anatomy, reproductive organs, hormonal patterns and/or chromosomal patterns) that do not fit typical binary notions of male or female bodies. • IND (indeterminate) is used when the sex characteristics are visually neither male nor female. Further assessment may be required for sex determination and should be updated by the assessor if a more definitive sex value can be documented. • ASKD (prefer not to answer) is used when the person was asked "What was your sex at birth?" and declined to answer. • ASKU (asked but unknown) is used when the person was asked "What was your sex at birth?" and was unable to provide an answer. For example, the person responded with "I don't know" or "I can't remember," and there is no reliable collateral history or clinical documentation available that refers to sex at birth. • UNK (unknown) is used when the person's sex was not known at the time of the assessment or is inadequately described. For example, the person is non-responsive or minimally responsive and is unable to participate in the assessment, and there is no reliable collateral history or clinical documentation available that refers to sex at birth.

Item	CIHI tip
A2b — Gender identity	Gender is the person's sense of being a man, woman, both, neither or anywhere along the gender spectrum. A person's gender identity may be the same as or different than their birth-assigned sex. Ask the person, "What is your gender identity?". If a person responds with a gender identity not listed in A2b (Gender identity), the assessor should use the open text box in A2c (Person self-identifies gender as) to record the person's verbatim response. **The following coding options are new to the interRAI HC version 9.1.5:** • M (man) is used for persons who self-identify as a man, regardless of sex assigned at birth (e.g., cisgender man, transgender man). A man's gender identity may or may not align with societal expectations about masculinity, appearance or roles. • W (woman) is used for persons who self-identify as a woman, regardless of sex assigned at birth (e.g., cisgender woman, transgender woman). A woman's gender identity may or may not align with societal expectations about femininity, appearance or roles. • X (nonbinary) is used for persons who report their gender identity as neither exclusively woman/girl/female nor man/boy/male or who do not identify with the binary gender construct. • ASKD (prefer not to answer) is used when the person was asked "What is your gender identity?" and declined to answer. • ASKU (asked but unknown) is used when the person was asked "What is your gender identity?" and responded with "I don't know" or was unable to provide a clear or meaningful response, even after clarification. • UNK (unknown) is used when the person's gender was not known at the time of the assessment or is inadequately described. For example, the person is non-responsive or minimally responsive and is unable to participate in the assessment, and there is no reliable collateral history or clinical documentation available that refers to the person's self-identified gender. • NA (not asked) is used in limited situations in which it may not be appropriate to ask a person's self-identity. This may include situations where the safety of the person and/or assessor is at risk. The table below provides examples of how selected gender identities may be mapped to the appropriate interRAI HC version 9.1.5 Gender identity code. (Note: This list is not exhaustive.)

<table>
<tr><th>Item</th><th colspan="2">CIHI tip</th></tr>
<tr><td rowspan="2">A2b — Gender identity (suite)</td><td>Gender identity
• Agender
• Cisman
• Ciswoman
• Fluid gender identity
• Transfeminine
• Transman
• Transwoman
• Transmasculine
• Two-Spirit
• Indigiqueer
• Unknown
• Asked but declined
• Asked but unknown
• Not asked
• No information</td><td>Coding in version 9.1.5
• Nonbinary
• Man
• Woman
• Nonbinary
• Nonbinary
• Man
• Woman
• Nonbinary
• Nonbinary
• Nonbinary
• Unknown
• Prefer not to answer
• Asked but unknown
• Not asked
• Unknown</td></tr>
<tr><td colspan="2">If an individual identifies with a gender not explicitly listed in the mapping table, the recommendation is to
• Code using the closest aligned coding where possible; if the identified gender identity is neither exclusively woman, girl or female nor man, boy or male and does not fall within the binary gender construct, code X (nonbinary).
• Capture the person's self-reported identity in A2c (Person self-identifies gender as) to ensure their identity is accurately and respectfully represented.</td></tr>
<tr><td>A2c — Person self-identifies gender as</td><td colspan="2">Use the open text box to record the person's verbatim response. Examples may include transgender, cisgender, gender diverse and two-spirit. If the person does not want to respond to the question in A2b (Gender identity), leave the text box blank.

This item must not contain any names (full or partial) or the person's health care identification number or date of birth.</td></tr>
<tr><td>A7i — Canadian resident, self-pay</td><td colspan="2">If the person is responsible for paying for all or part of their clinical health services in the home from personal resources, code 1 (yes). This includes situations where the person provides a co-payment to top off home care services that are arranged and provided through the provincial/territorial home care program.

Accommodation fees that include clinical health services are captured in this item.

This item excludes medication dispensing fees.</td></tr>
</table>

Item	CIHI tip
A8 — Reason for Assessment	The first assessment or initial assessment is done when the person enters the home care system or when they are screened for eligibility for home care/home health services. This assessment should be completed within 7 days after the person has been deemed eligible. Evidence indicates that a person receiving long-term home care services may go through clinically meaningful changes within 6 months. To capture changes, it is recommended that routine assessments be scheduled every 6 months, and no more than every 12 months, to ensure the care plan is appropriate and current. Assessors should prioritize both the initial and routine assessments according to the person's needs. If an interRAI Contact Assessment (interRAI CA) was completed prior to the interRAI HC, the Assessment Urgency Algorithm derived from the interRAI CA can be used to determine the relative urgency of completing an initial assessment. Code 4 (significant change in status reassessment) is defined as a change that is not self-limited, that affects the person's health status and that requires review or revision of the care plan to ensure that appropriate care is given. A major change can be an improvement or deterioration in the person's status. Assessments coded as 7 (other) are not submitted to the Integrated interRAI Reporting System (IRRS).
A9 — Assessment Reference Date	The Assessment Reference Date establishes a common period of observation as a reference point for each completed assessment. All information gathered about the person pertains to the 3-day observation period prior to and including the Assessment Reference Date. Home care assessments are usually completed during a single visit. If an assessment carries over to a second visit, information for the remaining assessment items must be for the time period established by the original Assessment Reference Date.
A10 — Location of Assessment	When the interRAI HC assessment is completed in a hospital, residential care facility or other setting that is not the person's own home (A10a = 2, 3 or 4), selected assessment items are optional to code and submit to the Integrated interRAI Reporting System Home Care (IRRS HC). If a person is being assessed in a setting that is not the person's own home (e.g., medical office, community clinic), you may choose to code 1 (private home) to generate the full assessment and all its associated clinical outputs.
A14 — Living Arrangement	The code 1 (alone) in A14a — Lives pertains to a person who is living in a private home or apartment with no other individuals and is not in a congregate setting. If they need help, there is no one to assist. If the person is living in a congregate setting (e.g., assisted living, board and care, residential care facility, retirement residence/home), code 8 (with nonrelatives). If the person lives with their spouse in a congregate setting, code 3 (with spouse/partner and others). In a congregate living setting, if the person needs help there is a call bell, phone number, person or agency to call for support. If the person lives alone in a self-contained apartment (e.g., "in-law suite") in a relative's house, code 1 (alone), as it is assumed that the unit has a separate entrance, with a kitchen and no shared spaces.

Item	CIHI tip
A15 — Time Since Last Hospital Stay	This item refers specifically to admitted hospital stays where the person was an inpatient. It does not include visits to the emergency department that did not result in an admission. If the person has not been admitted to a hospital in the past 90 days, code 0 (no hospitalization within 90 days).

Section B Intake and Initial History

Item	CIHI tip
B — Intake and Initial History	Although this information is not likely to change during the person's involvement with the service, it can be updated if required.
B1 — Date Case Opened	This is the date the person was originally admitted to home care. It is not the date of implementation or transition to the new interRAI HC standard, nor the date the interRAI HC assessment was completed (referred to as the Assessment Reference Date).
B3 — Primary Language	This is the person's preferred language for day-to-day communication. For a person who is severely cognitively impaired or has limited language skills, code for the language they are exposed to in their place of residence.
B4 — Residential History Over Last 5 Years	Document all institutional or group settings in which the person lived for the 5 years prior to the Date Case Opened (B1). This includes admissions to psychiatric hospitals/units (B4d) and admissions to post-acute/rehabilitation settings (B4f). Code stays of any duration. In exceptional circumstances only, code items as 0 (no) if there are no available sources, or if the person or an informant is unable to confirm residential history prior to the person's original admission to home care.
B5 — Racialized Group	**Note: This item is available only in the interRAI HC version 9.1.5.** The intent of B5 (Racialized Group) is to document the person's self-identified racialized group(s). This item identifies inequalities that may be the result of racism, bias and discrimination, and supports improvements to quality of care. Give the person the choice to provide (or not provide) the information and ensure their decision does not impact their care. Multiple categories can be selected for a given person. • Code "another race category" if the person's identified race category is not available for selection. • Code "prefer not to answer" if the person was asked about their racialized group but declined to answer. • Code "asked but unknown" if the person was asked about their racialized group but was unable to provide an answer. For example, the person responded with "I don't know" and there is no reliable collateral history or clinical documentation available that refers to the person's racialized group. • Code "unknown" if the person's racialized group was not known at the time of assessment or is inadequately described. For example, the person is non-responsive or minimally responsive and is unable to participate in the assessment, and there is no reliable collateral history or clinical documentation available that refers to the person's racialized group.

Section C Cognition

Item	CIHI tip
C1 — Cognitive Skills for Daily Decision Making	Coma is a state of deep unarousable unconsciousness. A comatose person is in a state of deep and usually prolonged unconsciousness; they are unable to respond to external stimuli, such as pain. The comatose person does not open their eyes, does not speak and does not move their extremities on command. A persistent vegetative state may follow a coma and is characterized by wakefulness with no evidence of awareness.
C2a — Short-term memory OK	The person must be able to remember all 3 items after 5 minutes to code C2a as 0 (yes, memory OK). If the person can remember only 1 or 2 of the items, code 1 (memory problem).
C5 — Change in Decision Making as Compared to 90 Days Ago	Compare the decision-making ability of 90 days ago with the decision-making ability at the time of assessment. **Note:** If there was a change in the person's ability to make decisions at a given time during the past 90 days but their status at the time of assessment has returned to what it was 90 days ago, code 1 (no change).

Section D Communication and Vision

Item	CIHI tip
D1 — Making Self Understood	This item includes the person's ability to express or communicate requests, needs, opinions, urgent problems and social conversation, whether in speech, writing, sign language or a combination of these (including the use of a word board or keyboard). This item is not intended to address differences in language understanding (e.g., a Russian speaker in an English-language facility) or difficulties with speech (e.g., slurring words that may make expression unclear).
D2 — Ability to Understand Others	This item involves the person's ability to understand others in any manner. It includes the use of a hearing appliance, if needed. This item does not test whether the problem is in understanding a particular language, such as when the individual's first language is different from that normally used by others.
D3 — Hearing	If the person regularly uses a hearing aid or other assistive listening device and indicates that they hear adequately, code 0 (adequate).
D4 — Vision	If the person regularly uses visual appliances (e.g., glasses) and indicates that they see adequately, code 0 (adequate).

Section E **Mood and Behaviour**

Item	CIHI tip
E1 — Indicators of Possible Depressed, Anxious or Sad Mood	This item is not restricted to persons who have suicidal thoughts or verbalizations. Persistent expressions or feelings of sadness or depression, regardless of the severity, should be captured in this item. Do not include transient minor fluctuations in mood state (e.g., expressions of sadness after watching a movie).
E1 — Indicators of Possible Depressed, Anxious or Sad Mood and E3 — Behaviour Symptoms	Code 1 (present but not exhibited in last 3 days) is intended to capture health problems or symptoms that were not exhibited during the 3-day observation period but that are significant for the person, their caregiver, facility staff and/or from a care planning perspective. Use clinical judgment as to whether the item in question should be captured as relevant to the person at the time of assessment. The issue has to have been present recently enough as a clinical issue that it is still relevant for management or that the person/family feels it is necessary to manage. If a problem or symptom was last exhibited 1 year ago or more, code 0 (not present).
E1b — Persistent anger with self or others	Persistent anger may be exhibited by verbal statements and nonverbal expressions of anger.
E1i — Withdrawal from activities of interest	This item captures a substantial reduction in the person's level of participation in activities or involvement with their long-standing relations, regardless of assumed cause. This includes withdrawal due to short-term, recoverable medical issues (e.g., fractured hip, flu).
E1j — Reduced social interactions	If the person has always preferred to be on their own or usually has no social contacts with others, code 0 (not present). This item captures a reduction in the person's usual interactions only.
E2 — Self-Reported Mood	This item should be treated strictly as a self-report measure. Do not code based on your own inferences nor on ratings given by family, friends or other informants. If the person is unable or refuses to answer, code 8 (person could not (would not) respond).
E3a — Wandering	There is a difference between wandering, exit-seeking behaviour and elopement attempts. For example, persons who have a rational purpose in their exit-seeking behaviour and/or elopement attempts **do not** necessarily meet the definition of wandering.
E3c — Physical abuse	If the person strikes out with the intent to make physical contact with the targeted individual but does not make physical contact (e.g., because the targeted individual moves out of the line of contact), this is considered physical abuse.
E3d — Socially inappropriate/ disruptive behaviour symptoms	Socially inappropriate or disruptive behaviours may include pacing, if it is disruptive or distressing to others.
E3f — Resists care	Resisting care does not include a situation where a person has made an informed decision to refuse treatment.

Section F Psychosocial Well-Being

Item	CIHI tip
F1d — Conflict or anger with family or friends	This item refers to the person's actual expression of conflict or anger, verbally or in writing, even if family/friends don't report conflict.
F1e — Fearful of a family member or close acquaintance	Applies to the person's informal caregivers only. It is not necessary to establish the reason for the fear, only to determine whether it is present.
F4 — Length of Time Alone During the Day (Morning and Afternoon)	This item captures face-to-face interactions only. It excludes telephone calls, video calls and the company of pets. Capture the amount of time the person is literally alone, without any other person in the home. There is no specified time frame to capture "the day" other than morning and afternoon. A person's day in the context of this item may generally be from the hours of 9:00 a.m. to 6:00 p.m. The boundary between afternoon and evening has no standard definition.

Section G Functional Status

Item	CIHI tip
G1a — Meal preparation	Administration of tube feedings and total parenteral nutrition (TPN) is not considered in G1a. The person's ability to manage their tube feeding/TPN is assessed in G2j — Eating. Includes planning meals, assembling ingredients or meal components (e.g., raw or pre-packaged foods), preparing food (washing, cutting, peeling, etc.), using kitchen appliances (stove, oven, microwave, fridge, freezer, kettle, etc.), opening food packages, cans or boxes, and setting out utensils and dishes. Excludes shopping for items, eating, TPN and meals consisting of only takeout. Do not consider the nutritional value of the meal.
G1b — Ordinary housework	Includes loading and unloading dishwasher; washing, drying and putting away dishes; making bed, including changing sheets; dusting, sweeping or wiping the floor with a light mop, light vacuuming; doing laundry, hanging clothes to dry; tidying up kitchen, bathroom, bedroom, etc.; and managing garbage. Excludes spring cleaning and other seasonal housekeeping activities, scrubbing floors, moving furniture and exterior cleaning (e.g., yard maintenance, washing windows). Do not consider the quality of the housework.
G1c — Managing finances	Includes paying bills (e.g., cash, cheque, online, etransfer, smartphone app, at bank or ATM); budgeting household expenses, including small allowances (e.g., pocket money not contributing to major expense); and monitoring credit card and balancing accounts. Excludes complex financial transactions (e.g., preparing tax returns) and assistance needed with transportation to/from the bank/ATM.

Item	CIHI tip
G1d — Managing medications	If medications are prepared in blister packs and the person manages the medications independently without any difficulty, code 0 (independent) for the following: • G1dC — Managing medications — Capacity • G1dP — Managing medications — Self-performance Includes knowing how to use a blister pack, dosette or pill box/caddy prepared by another; filling the dosette or pill box/caddy; taking medications as prescribed (e.g., taking correct dosage, opening bottles, applying ointments, giving injections); remembering to take medications; applying creams and managing eyedrops, eardrops, etc.; and filling prescriptions/medications and ordering refills.
G1e — Phone use	Includes making a call, answering a call and accessing appropriate numbers. Excludes texting as part of phone use.
G1f — Stairs	The definition for this item includes ascending and descending the stairs, with rests within the flight if needed. It excludes half or partial flights and managing stairs only with a ramp/lift/elevator. If the person is carried up/down a full flight of stairs, or if they use a chair lift, code 8 (activity did not occur) for self-performance and 6 (total dependence) for capacity. If the person crawls or uses their buttocks to climb or descend stairs independently, code 0 (independent).
G1g — Shopping	This item captures the person's self-performance and capacity for in-store purchases only. Includes physically selecting articles in the store from the shelf and paying for items at the checkout. Excludes online or telephone shopping delivered to the home, transportation to/from the store, putting groceries away and making lists. Transportation to the store is not captured in this item.
G1h — Transportation	This item captures the person's self-performance and capacity using any mode of transportation between locations. Includes navigating public transportation, calling and arranging for a taxi or Uber/other e-hailing services, paying fares, getting in and out of a vehicle, driving themself and using a bicycle (motorized or not) or electric scooter. Excludes transportation by informal caregivers, putting on a seatbelt, placing mobility aids or equipment into the vehicle and using a wheelchair (self-propelled or electric).
G2 — ADL Self-Performance	Codes of 4 (extensive assistance), 5 (maximal assistance) and 6 (total dependence) must include weight-bearing support. A code of 5 (maximal assistance) includes weight-bearing support (including lifting limbs) by 2 or more helpers, or weight-bearing support by 1 helper for more than 50% of subtasks.

Item	CIHI tip
G2a — Bathing	If the person uses a bathing method other than a full tub bath or shower, the assessor should consider whether the bath achieved a similar degree of cleanliness as a tub bath or shower. If the same amount of cleanliness was met, then the assistance provided for the other method can be included. Includes turning the water on and off, adjusting the water temperature, lathering and rinsing the body, drying with a towel, and transferring in and out of the tub. Excludes washing the back and hair.
G2c — Dressing upper body and G2d — Dressing lower body	Includes locating, selecting, obtaining and grasping clothing, as well as putting on and removing clothing and using snaps and zippers.
G2f — Locomotion	Locomotion captures any method used to move between locations on the same floor (e.g., walking, wheelchair, crawling).
G2g — Transfer toilet	Includes standing, sitting, lifting and turning during transfers on and off the toilet or commode. Unsafe transfers completed by the person are still captured as independent unless the person is provided with assistance during the unsafe transfer.
G2h — Toilet use	Includes using the toilet, commode or urinal, managing an ostomy or catheter, removing, opening and adjusting clothing, cleaning oneself, and tearing and using toilet paper. Excludes getting to and from the bathroom, transferring on and off the toilet, and emptying a commode, bedpan or urinal. If a person is having their toileting needs met by others when bedbound and not using a toilet, and is not participating in the task, code 6 (total dependence). A code of 8 (activity did not occur) applies only in the case of a person who is on dialysis with no urine output and has had no bowel movements either.
G2i — Bed mobility	Bed mobility excludes lifting the legs in and out of bed to and from a sitting position.
G2j — Eating	Includes opening containers, pouring, unwrapping food, cutting, scooping, spearing food, using utensils or fingers when needed, and preparing tube feeds or total parenteral nutrition (TPN). Excludes swallowing and chewing food. This item captures the person's self-performance in intake of nourishment.
G3a — Primary mode of locomotion indoors	If the person crawls, bum scoots or walks on their knees, code 0 (walking, no assistive device). If the person uses a cane, walking sticks, walking poles, walker, rollator (wheeled walker) or crutch(es), or pushes a wheelchair, code 1 (walking, uses assistive device). If the person sits on a rollator (wheeled walker) and propels with feet, code 2 (wheelchair, scooter). If all locomotion and transportation is completed with a stretcher, code 3 (bed-bound).
G3b — Timed 4-metre (13-foot) walk	This item excludes any hands-on support when walking but does include the use of ambulation devices such as a cane or walker.
G3c — Distance walked	The intent of this item is to capture the person's independence in walking around the home or in the community. "Support as needed" refers both to assistive devices and to non-weight-bearing support from a caregiver (e.g., supervision, guided manoeuvring) that may be needed for the person to walk.

Item	CIHI tip
G3d — Distance wheeled self	If the person was wheeled by others, code 0 (wheeled by others). If the person did not wheel themselves but used a motorized wheelchair or scooter, code 1 (used motorized wheelchair/scooter). If the person wheeled themselves, code in the range of 2 (wheeled self less than 5 metres) to 5 (wheeled self 100+ metres) based on the distance they wheeled themselves. Codes 2 to 5 would also be correct if both manual and motorized wheelchairs were used in the same observation period.
G7 — Driving	This item pertains to licensed vehicles only. It excludes bicycles and mobility scooters. While these are technically vehicles, the intent of this item is to determine whether the person can drive their car or other licensed vehicle safely and thus remain independent around the community.

Section H **Continence**

Item	CIHI tip
H1 — Bladder Continence and H3 — Bowel Continence	A catheter or ostomy that has leaked would be coded in the range of 2 (infrequently incontinent) to 5 (incontinent), depending on how frequently leakage occurred. If the person is receiving intermittent catheterization and did not have any leakage in between catheterizations during the observation period, code 1 (managed with any catheter or ostomy over last 3 days).
H2 — Urinary Collection Device	Female external catheters are captured with code 1 (condom catheter). Intermittent catheterization devices are captured with code 2 (indwelling catheter).
H4 — Pads or Briefs Worn	Do not include the routine use of pads on beds (or chairs) when the person is never or rarely incontinent.

Section I **Disease Diagnoses**

Item	CIHI tip
I1 — Diseases	Code 3 (diagnosis present, monitored but no active treatment) includes any diagnosis with intermittent symptoms that are not managed by medication (e.g., migraines, cataracts). If a disease or infection occurred during a specified lookback period (e.g., UTI in last 30 days), the disease should be coded as present, even if it resolved during the time of assessment.
I1s — Urinary tract infection in last 30 days	This item is not necessarily coded if the person is receiving prophylactic antibiotics for chronic urinary tract infections (UTIs). Code I1s only if a positive infection is reported in a laboratory result within this time.
I2 — Other Disease Diagnoses	This item should be used **both** to capture diagnoses not listed in I1 — Diseases **and** to record a more specific diagnosis that has already been coded in I1. For example, if diabetes is coded in I1 and the assessor also wants to specify the type, this would be captured as an ICD-10-CA code in I2. Reasonable decision-making on the part of the assessor is expected to determine which diseases should be captured more specifically in I2.

Section J Health Conditions

Item	CIHI tip
J1 — Falls	An intercepted fall — where the person is caught before falling to a lower surface — is not considered a fall. To be considered a fall, the person must unintentionally end up on a lower level or the ground. This item includes falls that occur while the person is being assisted by others.
J2 — Problem Frequency	Code 1 (present but not exhibited in last 3 days) is intended to capture health problems or symptoms that were not exhibited during the 3-day observation period but that are significant for the person, their caregiver, facility staff and/or from a care planning perspective. Use clinical judgment as to whether the item in question should be captured as relevant to the person at the time of assessment. The issue has to have been present recently enough as a clinical issue that it is still relevant for management or that the person/family feels it is necessary to manage. If a problem or symptom was last exhibited 1 year ago or more, code 0 (not present).
J2a — Difficult or unable to move self to standing position unassisted	If the person used a hoist independently to get to a standing position in the last 3 days, code 0 (not present). If they required the assistance of another person to hoist to a standing position daily in the last 3 days, code 4 (exhibited daily in the last 3 days). A person who cannot stand and cannot be assessed for item J2a would be captured as 4 (exhibited daily in last 3 days).
J2d — Unsteady gait	A person who cannot weight bear and cannot be assessed for J2d would be captured as 0 (not present).
J3 — Dyspnea (Shortness of Breath)	If dyspnea was absent over the last 3 days but would have been present had the person undertaken activity, code according to the activity level that would normally have caused them to experience shortness of breath.
J4 — Fatigue	Use observation or discussion with the person or others to explore how the person's energy levels impact their daily schedule. Explore both physical and mental fatigue. Physical tiredness results in reduced energy, whereas mental or cognitive tiredness may result in reduced concentration and mental restlessness.
J5a — Frequency with which person complains or shows evidence of pain	If the person does not experience any pain because they are on a medication regimen that renders them pain free, code 0 (no pain). For a code of 1 (present but not exhibited in last 3 days), there is no defined time frame for this option. It would be up to the assessor to use their clinical judgment to determine whether the symptom is of ongoing clinical concern and/or significant to the person being assessed.
J6b — Experiencing an acute episode or a flare-up of a recurrent or chronic problem	Examples of conditions for which the person may experience a flare-up include multiple sclerosis (MS), chronic obstructive pulmonary disease (COPD) and rheumatoid arthritis.
J6c — End-stage disease, 6 or fewer months to live	Items under J6 (Instability of Conditions) determine whether the person's disease or health conditions present over the last 3 days are acute, unstable or deteriorating. Capture J6c as 1 (yes) only if the person has 6 months or less to live. Clinical judgment should be substantiated by a well-documented disease diagnosis and deteriorating clinical course.
J8a — Smokes tobacco daily	This item excludes vaping with nicotine, chewing tobacco and occasional smoking.

Section K **Oral and Nutritional Status**

Item	CIHI tip
K1 — Height and Weight	K1a (Height) and K1b (Weight) are both included in the calculation of body mass index (BMI), which contributes to the Undernutrition CAP. When this CAP is calculated, if the BMI is greater than or equal to 19 and less than 22 **and** the person is not coded as end-stage disease, the CAP will trigger at medium risk. If the BMI is greater than or equal to 5 and less than 19 **and** the person is not coded as end-stage disease, the CAP will trigger at high risk.
K1a — Height	In the absence of a calibrated measurement tool, use estimates from the person, family member or caregiver. In exceptional circumstances only, there are 2 additional codes for K1a that may be used: • If the person refuses to have their height measured, code 1 • If the person is palliative (and meets the criteria for end-stage disease) and cannot be measured, code 248
K1b — Weight	In the absence of a calibrated measurement tool, use estimates from the person, family member or caregiver. In exceptional circumstances only, there are 2 additional codes for K1b that may be used: • If the person refuses to be weighed, code 0.1 • If the person is palliative (and meets the criteria for end-stage disease) and cannot be weighed, code 999.9
K2a — Weight loss of 5% or more in LAST 30 DAYS, or 10% or more in LAST 180 DAYS	Weight loss is coded regardless of assumed cause (e.g., weight loss from diuresis). Weight loss can be intentional or unintentional.
K2b — Dehydrated or BUN/creatinine ratio >20	Using clinical judgment, record based upon clinical signs and symptoms of dehydration. These **include but are not limited to** • Severe vomiting or other fluid loss; • Lethargy, confusion or delirium; • Rapid pulse or significant increase in pulse; • Decrease in fluid intake; and • Dry skin and mouth.
K2c — Fluid intake less than 1,000 ml per day (or less than four 8 oz. cups per day)	This item includes all sources of fluids in the last 3 days (e.g., during the administration of supplements and medication passes).
K2d — Fluid output exceeds input	Fluid output refers to fluid loss from events such as vomiting, diarrhea or heat. Intake and output do not need to be actively measured but can be approximated with clinical judgment.

Item	CIHI tip
K3 — Mode of Nutritional Intake	If the person is swallowing all types of food without showing any signs of swallowing difficulty, code 0 (normal). If the person requires both diet modification to swallow solid food (e.g., minced solids) and modification to swallow liquids (e.g., thickened liquids), code 3 (requires modification to swallow liquids). It is assumed that if an individual has trouble with liquids, they will also have trouble swallowing food. In situations where the person elects not to follow the prescribed dietary modification intended to address swallowing, the coding should reflect what occurred over the last 3-day observation period. If the person has been consuming regular food, code 0 (normal). If there is evidence of difficulty with regular intake, code 1 (modified independent). Subcutaneous fluids are not included in parenteral feeding.

Section L **Skin Condition**

Item	CIHI tip
L1 — Most Severe Pressure Ulcer	This item only includes all pressure ulcers/injuries — that is, any lesions caused by unrelieved pressure, usually over bony prominences. **Exclude** venous ulcers, arterial ulcers, mixed venous–arterial ulcers, diabetic foot ulcers and stasis ulcers. Deep tissue pressure injuries are captured in L1, using the most appropriate coding option in the range of 1 (any area of persistent skin redness) to 5 (not codeable). Only deep tissue injuries as a result of pressure are coded in L1.
L2 — Prior Pressure Ulcer	The intent of L2 is to document a history of pressure ulcers/injuries, which is a risk factor for developing pressure ulcers/injuries in the future. There is no limit in the time frame or lookback period. This item documents pressure ulcers/injuries that are now healed. **Exclude** pressure ulcers/injuries that are actively being treated.
L3 — Presence of Skin Ulcer Other Than Pressure Ulcer	This item includes venous ulcers, arterial ulcers, mixed venous–arterial ulcers, diabetic foot ulcers and stasis ulcers. **Exclude** pressure ulcers/injuries from this item.
L6 — Other Skin Conditions or Changes in Skin Condition	Deep tissue injuries that present with changes in skin condition (e.g., bruises) are captured in L6.
L7 — Foot Problems	This item refers to structural problems at or below the ankle. A complete or partial foot amputation would be considered a structural problem and included in L7.

Section M **Medications**

Item	CIHI tip
M1 — List of All Medications (Optional) and M4 — Total Number of Medications	The total count of the number of different prescribed and over-the-counter medications that were taken in the last 3 days, which includes • Prescribed medications that have been discontinued but were taken in the last 3 days • All PRN and STAT doses that were taken in the last 3 days • Topicals, creams, ointments, eye drops, artificial tears and patches • Long-acting medications given outside of the 3-day period (e.g., antipsychotic medications, chemotherapeutic agents, injectable vitamin B12) • All medications added to IV and CADD pumps, such as ampicillin, morphine, iron and potassium chloride • Therapeutic doses of heparin • Any vitamins, whether prescribed or over the counter (e.g., vitamin B12, vitamin D) and given by any route, including injectable vitamins (e.g., vitamin B1, vitamin B6, vitamin B12, vitamin C); exclude multivitamin/mineral (MVM) supplements • Fleet enemas, suppositories, laxatives (e.g., senokot), mineral oil and bowel preps such as GoLYTELY and Citro-Mag • Vaccinations and allergy serums only if they are provided within the 3-day observation period • Compounded medications composed of 2 or more chemical/active ingredients or medications (they are counted as 1 medication) • All forms of legal cannabis and related cannabinoid products. Exclude illicit or illegal synthetic cannabinoids (e.g., bath salts) • In some instances, there is a DIN on the cannabis product (e.g., the Sativex DIN is 02266121); If there is no DIN, use the default code 55555555
M5 — Total Number of Herbal/Nutritional Supplements	A total count of the number of different natural health products, including herbal and nutritional supplements, that were taken in the last 3 days, which includes • Minerals, herbs, meal supplements, sports nutrition products and natural food supplements • Multivitamin/mineral (MVM) supplements • Herbal products such as echinacea, elderberry, fenugreek, ginger, ginkgo biloba, grapeseed, melatonin, milk thistle, oregano oil, rhodiola, St. John's wort, turmeric and valerian root • Nutritional or meal supplements and digestive aids such as Ensure, Boost, Sustacal, RESOURCE 2.0, biotin, chromium, coenzyme Q-10, glucosamine, L-arginine, lycopene, omega-3 fatty acids and probiotics • Sports nutrition products such as protein powders and amino acid supplements • TPN solutions, including additives (such as trace elements) • Natural food supplements such as apple cider vinegar capsules, cranberry capsules and fish oil capsules

Item	CIHI tip
M8 — Receipt of Psychotropic Medication	Medications are coded according to their pharmacological classification, not their use. For example, if a psychotropic medication is classified as an antipsychotic/ neuroleptic but is used for depression, it would still be classified as an antipsychotic/ neuroleptic medication. Cannabis products are classified as analgesics; they are therefore not captured in M8.
M11 — Medicinal Use of Cannabis	Use or consumption of cannabis and related cannabinoid products can be identified for medicinal use in M11. This includes when cannabis was prescribed by a health professional and purchased over the counter. If purchased without a prescription, code based on the person's self-reported medicinal reasons for using cannabis.

Section N **Treatments and Procedures**

Item	CIHI tip
N1h — Pneumovax vaccine in LAST 5 YEARS or after age 65	This item is not limited to the Pneumovax vaccine. It captures all pneumococcal vaccines approved in Canada administered to the person in the last 5 years.
N2a — Chemotherapy	The intent of N2a is to identify persons who are receiving chemotherapy to treat cancer only. This includes adjuvant therapies (e.g., tamoxifen) and other hormonal therapies (e.g., Herceptin). N2a excludes chemotherapy agents used to treat any other disease (e.g., Megace as an appetite stimulant, methotrexate to treat rheumatoid arthritis).
N2c — Infection control	The intent of N2c is to capture infection control measures — such as isolation or quarantine — that significantly limit freedom of movement within the home and require substantial resources. Relevant infections include, but are not limited to, those such as influenza or norovirus, which typically involve single-room isolation and the use of full personal protective equipment (e.g., gowns, masks, face shields). If the person in a congregate setting is not isolated in their room and is free to move throughout the home, then item N2c (Infection control) would not apply.
N2d — IV medication	IV medications administered solely during a surgical procedure and in the immediate post-operative period (e.g., in a recovery room) are not captured in N2d. Medications administered by subcutaneous infusion, epidural, intrathecal, CADD pump and/or baclofen pump are included and captured in N2d.
N2e — Oxygen therapy	A person receiving a nebulizer would not meet the criteria for N2e. Oxygen administration during a nebulizer treatment is not considered oxygen therapy. If received in the observation period, medications administered as part of nebulizer therapy/treatment can be captured in sections M1 — List of All Medications and M4 — Total Number of Medications. The use of CPAP and BiPAP is not captured in this item.

Item	CIHI tip
N2j — Ventilator or respirator	The use of a ventilator or respirator must be overseen by a qualified professional such as a respiratory therapist. It can also include ongoing use of a ventilator or respirator as long as the treatment was set up and is periodically monitored by a qualified professional. The use of CPAP and BiPAP is not captured in this item. N2j is intended to capture the needs of persons who are ventilator/respirator dependent, specifically persons with an endotracheal tube or tracheostomy tube in place (i.e., invasive ventilation).
N2k — Wound care	Assessors may capture care provided by an informal caregiver (or self-care) only when the treatment plan is recommended by a formal caregiver and ongoing supervision and reassessment of the wound continues to be part of the care plan. Care provided to a PEG tube site or ostomy site may be captured here. If the site is from a recent surgical procedure, capture it in L4 — Major Skin Problems.
N2l — Scheduled toileting program	A scheduled toileting program aims to improve the person's bladder and/or bowel continence. The following are not considered a scheduled toileting program: • Provision of incontinence care • Changing of pads and/or linens on a regular schedule • Intermittent catheterization • Disimpactment

Item	CIHI tip
N3 — Formal Care	This item excludes care that is provided without charge. Because the names used to describe home- and community-based services often differ by jurisdiction, the assessor should seek clarification from agency leadership about how to code care that is excluded from this list. If a friend/neighbour or family member is providing care, to be considered "formal" the service must meet the professional qualifications necessary for providing the activity/service: • There must be evidence that the person has a therapeutic need for the service. • There must be a formal understanding between the care provider and the person regarding the nature and duration of the services that will be provided. • The person providing the service must meet the professional qualifications necessary for providing the activity or service, consistent with industry requirements in the residing jurisdiction. • The care provider must be paid at competitive rates. If a care provider is providing more than one type of formal care, code only the time provided for each type of formal care. For example, if a home support worker provides 1 hour of care that includes 30 minutes of ADL support and 30 minutes of IADL support, code 30 minutes for N3a (Home health aide) and 30 minutes for N3c (Homemaking services). If services are provided by multiple formal caregivers, divide the time between the disciplines. For example, if an occupational therapist and a physiotherapist both visit the person for 1 hour, code each as 30 minutes. Services provided by therapy assistants may be included if the assistant is under the direct supervision of a qualified and registered therapist. Personal support services, nursing visits and homemaking services provided by assisted-living staff to a client in an assisted-living environment or a retirement residence can be captured in N3a — Home health aide, N3b — Home nurse and N3c — Homemaking services. Volunteer hours are not captured in this item.
N3b — Home nurse	Telemedicine or telehealth nursing can be captured in N3b provided there is substantial clinical monitoring and care management. A call to telehealth for health advice or health-related information would not be captured. Check-in telephone calls are not included.
N3d — Meals	Only days are captured for this item, **not** minutes. If the person has prepared meals delivered (e.g., Uber, Meals on Wheels), count only the number of days the meals were received. In congregate living settings, capture only prepared meals delivered to the person's room, not meals served in the main dining room.

Item	CIHI tip
N3h — Psychological therapy	Capture only time spent providing psychological therapy by licensed mental health professionals (i.e., psychiatrist, psychologist, psychiatric nurse, psychiatric social worker). Exclude time spent counselling family members/significant others of the person. If a chaplain has credentials in counselling through a recognized organization such as the Canadian Association for Spiritual Care, pastoral counselling can be included as a form of psychotherapy if provided directly to the person.
N4a — In-patient acute hospital with overnight stay	This item records how many times the person was admitted (as an in-patient) to the hospital in the last 90 days. This item does not include overnight stays in in a hospital emergency room (ER), admissions for day surgery or other outpatient services.
N4b — Emergency room visit	This item records how many times a person visited a hospital emergency room (ER) for treatment or evaluation in the last 90 days. This excludes any ER visits that resulted in a hospital admission. If a person is in the ER and then subsequently is admitted as an inpatient, this would only be captured in N4a (In-patient acute hospital with overnight stay). This item excludes any visits that were scheduled or pre-arranged in the ER or visits to urgent care centres.
N4c — Physician visit	This item includes a visit to the medical provider's office or clinic by the person, or a medical provider's visit to the person's home. Virtual and phone visits can be counted under this item as long as they pertain to a clinical event and involve medical direction/management. The following providers can be included in this item: doctors of osteopathic medicine, podiatrist, optometrist, nurse practitioner, physician assistant, dentist, dental surgeon, any physician specialist (e.g., cardiologist, ophthalmologist) and naturopathic physician/doctor of naturopathic medicine. Exclude the following providers: chiropodist, orthotist/pedorthist, chiropractor, optician, denturist, psychologist, pharmacist and clinical nurse specialist.
N5 — Physically Restrained	A physical restraint is defined as any manual method, or any physical or mechanical device, material or equipment, that is attached or adjacent to the person's body; that the person cannot remove easily; and that does or has the potential to restrict the person's freedom of movement or normal access to their body. **Exception:** If the person has no voluntary movement (i.e., is comatose or is quadriplegic), code 0 (not used). Bedrails are not counted as a restraint in N5.

Section O Responsibility

Item	CIHI tip
Not applicable	Currently, there are no coding tips for this section.

Section P Social Supports

Item	CIHI tip
Not applicable	Currently, there are no coding tips for this section.

Section Q Environmental Assessment

Item	CIHI tip
Q3a — Availability of emergency assistance	Code for the availability of emergency assistance, not the capacity to use the emergency assistance (e.g., due to cognitive impairment).
Q4 — Finances	If the person has insufficient funds to purchase necessities, code 1 (yes) regardless of how they use their available resources.

Section R Discharge Potential and Overall Status

Item	CIHI tip
R6 — Client Group	Guidelines for assigning a Client Group: • A person is assigned to a Client Group based on their assessed needs, including their current health status (health condition, personal resources, living conditions), rather than on the services available or provided. • The assigned Client Group should reflect the health status and primary goals of care set for the person at the time of assessment. • The End-of-life Client Group takes precedence over all other categories. • A person may belong to only 1 Client Group at a time. Please refer to the appendix for the Client Group decision tree.

Section S Discharge

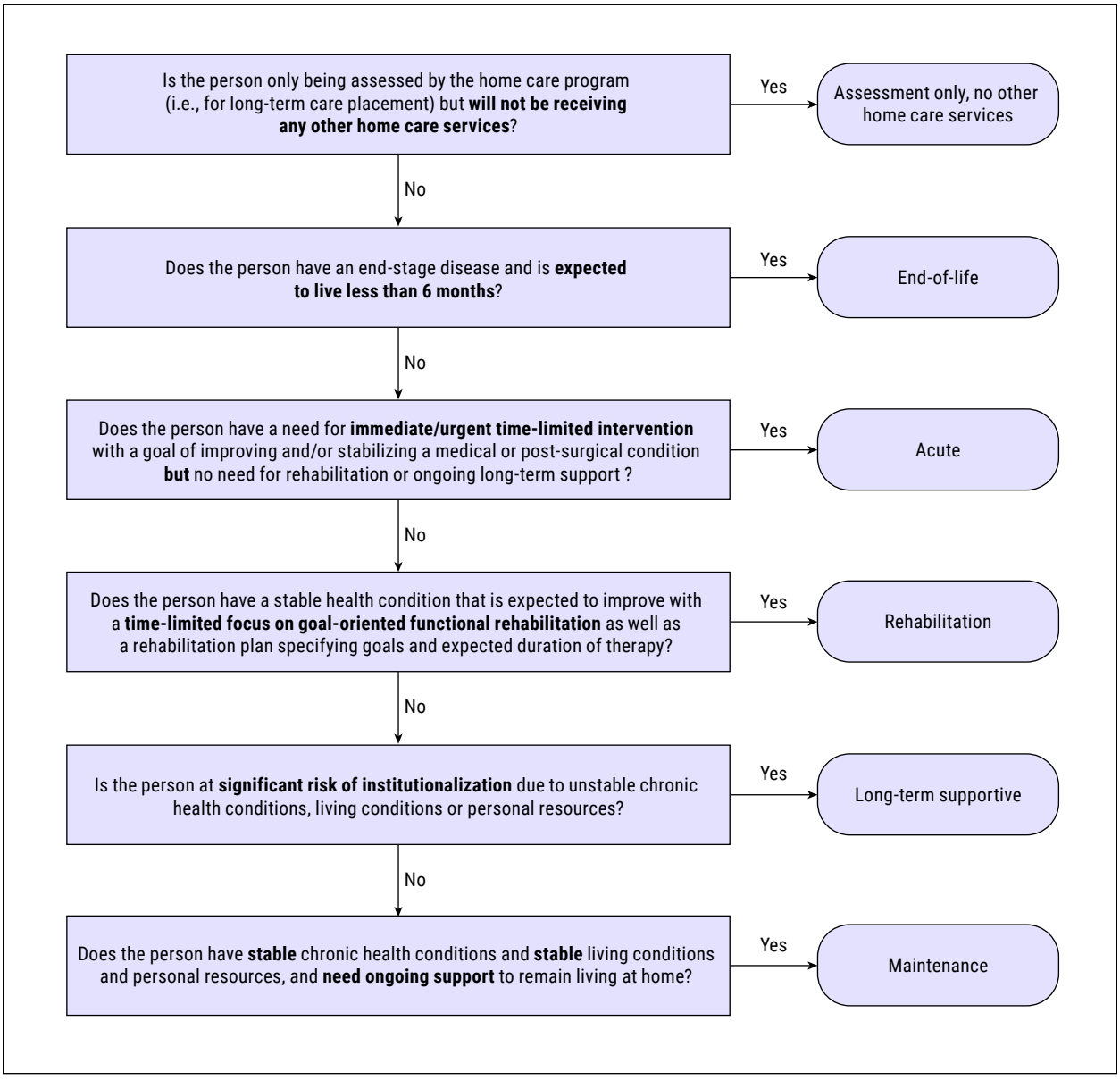
Item	CIHI tip
Not applicable	Currently, there are no coding tips for this section.

Section T Assessment Information

Item	CIHI tip
T1 — Signature of Person Coordinating/ Completing the Assessment	interRAI has no official requirements regarding the professional designation or educational requirements of the assessor/assessment coordinator. However, it is important to consider additional training that the individual may require to support development of the assessment skills necessary to complete the clinician-led tool. CIHI recommends that an assessment be completed and/or that the role of assessment coordinator be assumed by a regulated health care professional who would have otherwise carried out an equivalent process (assessment, problem identification/verification, collaborative goal setting, intervention and evaluation) based on their education/experience, and who has the appropriate training on the assessment tool. Each province/territory can determine its professional/educational requirements for completing an interRAI assessment.

Appendix

Figure **Client Group decision tree**



Text alternative for image

The decision process to assign a Client Group is as follows. First, determine whether the person will be receiving an assessment only, and no other home care services. If yes, then assign the Assessment only Client Group. If no, then determine whether death is anticipated within 6 months. If yes, then assign the End-of-life Client Group. If no, then determine whether the person has a primary need for immediate or urgent time-limited intervention, with a goal to improve and or stabilize a medical or a post-surgical condition but does not need rehabilitation or ongoing support to remain in the community. If this is the case, then assign the Acute Client Group. If it is not the case, then determine whether the person has a stable health condition that is expected to improve with a time-limited focus on goal-oriented, functional rehabilitation. If yes, then assign the Rehabilitation Client Group. If no, then determine whether there is a significant risk for institutionalization due to unstable chronic health conditions, living conditions or personal resources. If yes, then assign the Long-term supportive care Client Group. If no, then assign the Maintenance Client Group.

Summary of changes

The following table outlines changes made to this document following the previous release in March 2026.

Item	Status*
A2b — Gender identity	Updated
A2c — Person self-identifies gender as	New
A10 — Location of Assessment	New
A15 — Time Since Last Hospital Stay	New
B1 — Date Case Opened	New
B3 — Primary Language	Updated
B4 — Residential History Over Last 5 Years	Updated
G1a — Meal preparation	Updated
G1b — Ordinary housework	Updated
G1c — Managing finances	Updated
G1d — Managing medications	Updated
G1e — Phone use	Updated
G1f — Stairs	Updated
G1g — Shopping	Updated
G1h — Transportation	Updated
G2a — Bathing	Updated
G2c — Dressing upper body and G2d — Dressing lower body	New
G2g — Transfer toilet	Updated
G2h — Toilet use	Updated
G2j — Eating	Updated
I1 — Diseases	Updated
I1e — Hemiplegia	Removed
K2 — Nutritional Issues	Removed
L7 — Foot Problems	Updated
M1 — List of All Medications (Optional) and M4 — Total Number of Medications	Updated
M5 — Total Number of Herbal/Nutritional Supplements	Updated
N2c — Infection control	Updated
N2d — IV medication	Updated
N4a — In-patient acute hospital with overnight stay	Updated

Item	Status*
N4b — Emergency room visit	Updated
N4c — Physician visit	Updated
R6 — Client Group	Updated

Notes

* Status definitions are as follows:

- New: Indicates a new entry in the coding reference guide.
- Updated: Indicates an update to a previously existing entry in the coding reference guide.
- Removed: Indicates the removal of a previously existing entry in the coding reference guide.

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