SECTION E. MOOD AND BEHAVIOR PATTERNS

1. TWO KEY INDICATORS

2. CHANGE IN MOOD

3. BEHAVIORAL SYMPTOMS

4. CHANGES IN BEHAVIORAL SYMPTOMS

SECTION F. SOCIAL FUNCTIONING

1. INVOLVEMENT

2. CHANGE IN SOCIAL ACTIVITIES

3. ISOLATION

SECTION G. INFORMAL SUPPORT SERVICES

1. TWO KEY INFORMAL HELPERS

SECTION H. PHYSICAL FUNCTIONING

1. IADL PERFORMANCE IN 7 DAYS

2. ADL PERFORMANCE IN 3 DAYS
2. ADL SELF-PERFORMANCE (cont)
   a. MOBILITY IN BED—Including moving to and from lying position, turning side to side, and positioning body while in bed.
   b. TRANSFER—Including moving to and between surfaces—to from bed, chair, wheelchair, standing position. [Note—Excludes to/from bath/toilet]
   c. LOCOMOTION IN HOME—[Note—If in wheelchair, self-sufficiency once in chair]
   d. LOCOMOTION OUTSIDE OF HOME—[Note—If in wheelchair, self-sufficiency once in chair]
   e. DRESSING UPPER BODY—How client dresses and undresses (street clothes, underwear) above the waist, includes prostheses, orthotics, fasteners, pull-ups, etc.
   f. DRESSING LOWER BODY—How client dresses and undresses (street clothes, underwear) from the waist down, includes prostheses, orthotics, belts, pants, skirts, shoes, and fasteners.
   g. EATING—Including taking in food by any method, including tube feedings.
   h. TOILET USE—Including using the toilet room or commode, bedpan, urinal, transferring on/off toilet, cleaning self after toilet use or incontinent episode, changing pad, managing any special devices required (ostomy or catheter), and adjusting clothes.
   i. PERSONAL HYGIENE—Including combing hair, brushing teeth, shaving, applying makeup, washing/drying feet and hands (EXCLUDE baths and showers).
   j. BATHING—How client takes full-body bath/shower or sponge bath (EXCLUDE washing of back and hair). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. Code for most dependent episode in LAST 7 DAYS

3. ADL DECLINE
   a. ADL status has become worse (i.e., now more impaired in self performance) as compared to status 90 days ago (or since last assessment if less than 90 days)
   b. No
   c. Yes

4. PRIMARY MODES OF LOCOMOTION
   a. No assistive device
   b. Walker/crutch
   c. Wheelchair
   d. Scooter (e.g., Amigo)
   e. Care
   f. ACTIVITY DID NOT OCCUR
   a. Indoors
   b. Outdoors

5. STAIR CLIMBING
   a. In the last 3 days, how client went up and down stairs (e.g., single or multiple steps, using handrail as needed)
   b. Up and down stairs without help
   c. Up and down stairs with help
   d. 2. No assistive devices used

6. STAMINA
   a. In a typical week, during the LAST 30 DAYS (or since last assessment)
   b. No days
   c. 1 day a week
   d. 2-6 days a week
   e. Every day
   f. ACTIVITY DID NOT OCCUR
   a. Hours of physical activities in the last 3 days (e.g., walking, cleaning house, exercise)
   b. 0. Two or more hours
   c. 1. Less than two hours

7. FUNCTIONAL POTENTIAL
   a. Client believes he/she capable of increased functional independence (ADL, IADL, mobility)
   b. Caregivers believe client capable of increased functional independence (ADL, IADL, mobility)
   c. Good prospects of recovery from current disease or conditions, improved health status expected
   d. NONE OF ABOVE

SECTION I. CONTINUENCE IN LAST 7 DAYS

1. BLADDER CONTINENCE
   a. In LAST 7 DAYS, control of urinary bladder function (with appliances such as catheters or incontinence program employed) [Note—if dribbles, volume insufficient to soak through underpants]
   b. CONTINENT—Complete control
   c. CONTINENT WITH CATHETER—Complete control with use of any type of catheter or urinary collection device that does not leak urine
   d. OCCASIONALLY INCONTINENT—Incontinent episodes once a week or less
   e. FREQUENTLY INCONTINENT—Incontinent episodes 2 or more times a week but not daily
   f. Incontinence as compared to status 90 DAYS AGO (or since last assessment if less than 90 days)
   g. 0. No
   h. 1. Yes

2. BLADDER DEVICES
   Use of pads or briefs to protect against wetness
   Use of an indwelling urinary catheter
   NONE OF ABOVE

SECTION J. DISEASE DIAGNOSIS

Disease/infection that doctor has indicated is present and affects client’s status, requires treatment, or symptom management. Also include if disease is monitored by a home care professional or is the reason for a hospitalization in LAST 90 DAYS (or since last assessment if less than 90 days)

[Blank], Not present
1. Present—not subject to focused treatment or monitoring by home care professional
2. Present—monitored or treated by home care professional
[If no disease in list, check: None of Above]

SECTION K. HEALTH CONDITIONS AND PREVENTIVE HEALTH MEASURES

1. PREVENTIVE MEASURES
   a. Blood pressure measured
   b. Received influenza vaccination
   c. Test for blood in stool or screening endoscopy
   d. IF FEMALE—Received breast examination or mammography
   e. NONE OF ABOVE

2. PROBLEM CONDITIONS PRESENT ON 2 OR MORE DAYS
   a. Diarrhea
   b. Difficulty urinating or urinating 3 or more times at night
   c. Fever
   d. NONE OF ABOVE

3. PROBLEM CONDITIONS
   a. Chest pain/pressure at rest or on exertion
   b. No bowel movement in 3 days
   c. Dizziness or lightheadedness
   d. Edema
   e. Shortness of breath
   f. Delusions
   g. Hallucinations
   h. NONE OF ABOVE
**SECTION M. DENTAL STATUS (ORAL HEALTH)**

### 1. ORAL STATUS

- **(Check all that apply)**
  - Problem chewing (e.g., poor mastication, immobile jaw, surgical resection), decreased sensation/motor control, pain while eating
  - Mouth is "dry" when eating a meal
  - Problem brushing teeth or dentures

**NONE OF ABOVE**

### 2. ULCERS (Pressure/ Stasis)

- **Presence of an ulcer anywhere on the body. Ulcers include any area of persistent skin redness (Stage 1); partial loss of skin layers (Stage 2); deep craters in the skin (Stage 3); breaks in skin exposing muscle or bone (Stage 4).**

- **CODE 0 if no ulcer, otherwise record the highest ulcer stage (Stage 1-4).**

#### a. Pressure ulcer
- Any lesion caused by pressure, shear forces, or friction resulting in damage of underlying tissues

#### b. Stasis ulcer
- Open lesion caused by poor circulation in the lower extremities

### 3. OTHER SKIN PROBLEMS REQUIRING TREATMENT

**Check all that apply**

- **Surgical wound**
- Burns (second or third degree)

- **Open lesions other than ulcers, rashes, cuts (e.g., cancer)**

- **Skin tears or cuts**

- **NONE OF ABOVE**

### 4. HISTORY OF RESOLVED PRESSURE ULCERS

- **Check for formal care in LAST 7 DAYS**
  - **Antibiotics, systemic or topical**
  - **Dressings**
  - **Surgical wound care**
  - **Other wound/ulcer care (e.g., pressure relieving device, nutrition, turning, debridement)**

**NONE OF ABOVE**

### 5. WOUND/ULAR CARE

**NONE OF ABOVE**

### 6. DANGER OF FALL

#### a. Unsteady gait

#### b. Client limits going outdoors due to fear of falling (e.g., stopped using bus, goes out only with others)

### 7. LIFESTYLE (Drinking/Smoking)

#### a. In the LAST 90 DAYS (or since last assessment if less than 90 days), client felt the need or was told by others to cut down on drinking, or others were concerned with client's drinking

#### b. In the LAST 90 DAYS (or since last assessment if less than 90 days), client had to have a drink first thing in the morning to steady nerves (i.e., an "eye opener") or has been in trouble because of drinking

#### c. Smoked or chewed tobacco daily

### 8. HEALTH STATUS INDICATORS

- **(Check all that apply)**
  - Client feels he/she has poor health (when asked)
  - Has conditions or diseases that make cognition, ADL, mood, or behavior patterns unstable (fluctuations, precarious, or deteriorating)
  - Experiencing a flare-up of a recurrent or chronic problem

### 9. OTHER STATUS INDICATORS

- **(Check all that apply)**
  - Fearful of a family member or caregiver
  - Unusually poor hygiene
  - Unexplained injuries, broken bones, or burns
  - Neglected, abused, or mistreated
  - Physically restrained (e.g., limbs restrained, used bed rails, constrained to chair when sitting)

**NONE OF ABOVE**

### SECTION L. NUTRITION/HYDRATION STATUS

#### 1. WEIGHT

- **(Code for weight items)**
  - 0. No
  - 1. Yes

- **a. Unintended weight loss of 5% or more in the LAST 30 DAYS (or 10% or more in the LAST 180 DAYS)**
- **b. Severe malnutrition ( cachexia)**
- **c. Morbid obesity**

#### 2. CONSUMPTION

- **(Code for consumption)**
  - 0. No
  - 1. Yes

- **a. In at least 2 of the last 3 days, ate one or fewer meals a day**
- **b. In last 3 days, noticeable decrease in the amount of food client usually eats or fluids usually consumes**
- **c. Insufficient fluid—did not consume all/ almost all fluids during last 3 days**
- **d. Enteral tube feeding**

#### 3. SWALLOWING

- **0. NORMAL—Safe and efficient swallowing of all diet consistencies**
  - **1. REQUIRES DIET MODIFICATION TO SWALLOW SOLID FOODS (mechanical diet or ability to ingest specific foods only)**
  - **2. REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS (puree, thickened liquids)**
  - **3. COMBINED ORAL AND TUBE FEEDING**
  - **4. NO ORAL INTAKE (NPO)**

### SECTION N. SKIN CONDITION

#### 1. SKIN PROBLEMS

- **Any troubling skin conditions or changes in skin condition (e.g., burns, bruises, rashes, itchiness, body lice, scabies)**

- **0. No**
- **1. Yes**

#### 2. ULCERS (Pressure/ Stasis)

- **Presence of an ulcer anywhere on the body. Ulcers include any area of persistent skin redness (Stage 1); partial loss of skin layers (Stage 2); deep craters in the skin (Stage 3); breaks in skin exposing muscle or bone (Stage 4).**

- **CODE 0 if no ulcer, otherwise record the highest ulcer stage (Stage 1-4).**

- **a. Pressure ulcer**—any lesion caused by pressure, shear forces, or friction resulting in damage of underlying tissues

- **b. Stasis ulcer**—open lesion caused by poor circulation in the lower extremities

### SECTION O. ENVIRONMENTAL ASSESSMENT

#### 1. HOME ENVIRONMENT

- **[Check any of following that make home environment hazardous or uninhabit- able (if none apply, check NONE OF ABOVE) temporarily in institution, base assessment on home visit]**

- **a. Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors)**
- **b. Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs)**
- **c. Kitchen (e.g., dangerous stove, inoperative refrigerator, infestation by rats or bugs)**
- **d. Heating and cooling (e.g., too hot in summer, too cold in winter, wood stove in a home with an asthma)**
- **e. Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)**
- **f. Access to rooms in house (e.g., unable to climb stairs)**

**NONE OF ABOVE**

#### 2. LIVING ARRANGE-MENT

- **a. As compared to 90 DAYS AGO (or since last assessment), client now lives with other person—or—moved in with another person, other moved in with client**

- **0. No**
- **1. Yes**

- **b. Client or primary caregiver feels that client would be better off in another living environment**

- **0. No**
- **1. Client only**
- **2. Caregiver only**
- **3. Client and caregiver**

**NONE OF ABOVE**

### SECTION P. SERVICE UTILIZATION (IN LAST 7 DAYS)

#### 1. FORMAL CARE

- **(Minutes rounded to even 10 minutes)**

- **Extent of care or care management in LAST 7 DAYS (or since last assessment if less than 7 days) involving**

**A** | **B** | **C**
--- | --- | ---
| a. Home health aides | | |
| b. Visiting nurses | | |
| c. Homemaking services | | |
| d. Meals | | |
| e. Volunteer services | | |
| f. Physical therapy | | |
| g. Occupational therapy | | |
| h. Speech therapy | | |
| i. Day care or day hospital | | |
| j. Social worker in home | | |
### SECTION Q. MEDICATIONS

**1. NUMBER OF MEDICATIONS**
Record the number of different medicines (prescriptions and over the counter), including eye drops, taken regularly or on an occasional basis in the **LAST 7 DAYS** (or since last assessment if less than 7 days).

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>None</td>
</tr>
<tr>
<td>1-9</td>
<td>More than one</td>
</tr>
</tbody>
</table>

**2. RECEIPT OF PSYCHOTROPIC MEDICATION**
Psychotropic medications taken in the **LAST 7 DAYS** (or since last assessment). Note: Review client's medications with the list that applies to the following categories.

<table>
<thead>
<tr>
<th>Category</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotic/neuroleptic</td>
<td>A</td>
</tr>
<tr>
<td>Antidepressant</td>
<td>C</td>
</tr>
<tr>
<td>Anxiolytic</td>
<td>B</td>
</tr>
<tr>
<td>Hypnotic</td>
<td>D</td>
</tr>
</tbody>
</table>

**3. MEDICAL OVERSIGHT**
Physician reviewed client's medications as a whole in **LAST 180 DAYS** (or since last assessment). Discussed with at least one physician (or no medication taken). 1. No single physician reviewed all medications

**4. COMPLIANCE/ADHERENCE WITH MEDICATIONS**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Always compliant</td>
</tr>
<tr>
<td>1</td>
<td>Compliant 80% of time or more</td>
</tr>
<tr>
<td>2</td>
<td>Compliant less than 80% of time, including failure to purchase prescribed medications</td>
</tr>
<tr>
<td>3</td>
<td>NO MEDICATIONS PRESCRIBED</td>
</tr>
</tbody>
</table>

---

**SECTION Q. MEDICATIONS**

**1. NUMBER OF MEDICATIONS**

- **a.** Name and Dose: Record the name of the medication and dose ordered.
- **b.** Form: Code the route of administration using the following list:
  - **PRN:** As necessary
  - **QOD:** Every other day
  - **QH:** Every hour
  - **QOD:** Every other day
  - **5W:** Five times daily
  - **QOD:** Every other day
  - **QOD:** Every other day
  - **QOD:** Every other day
  - **QOD:** Every other day
  - **QOD:** Every other day
  - **QOD:** Every other day
  - **QOD:** Every other day
  - **QOD:** Every other day
  - **QOD:** Every other day

- **c.** Number taken: Record the amount of medication administered each time the medication is given.
- **d.** Freq: Code the number of times per day, week, or month the medication is administered using the following list:
  - **PRN:** As necessary
  - **QOD:** Every other day
  - **QOD:** Every other day
  - **QOD:** Every other day
  - **QOD:** Every other day
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  - **QOD:** Every other day
  - **QOD:** Every other day

**2. RECEIPT OF PSYCHOTROPIC MEDICATION**

- **a.** Antipsychotic/neuroleptic
- **b.** Antidepressant
- **c.** Anxiolytic
- **d.** Hypnotic

**3. MEDICAL OVERSIGHT**

- **a.** Discussed with at least one physician (or no medication taken)
- **b.** No single physician reviewed medications

**4. COMPLIANCE/ADHERENCE WITH MEDICATIONS**

- **a.** Always compliant
- **b.** Compliant 80% of time or more
- **c.** Compliant less than 80% of time, including failure to purchase prescribed medications
- **d.** No medications prescribed

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**SECTION Q. MEDICATIONS**

**1. NUMBER OF MEDICATIONS**

- **a.** Name and Dose: Record the name of the medication and dose ordered.
- **b.** Form: Code the route of administration using the following list:
  - **PRN:** As necessary
  - **QOD:** Every other day
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- **c.** Number taken: Record the amount of medication administered each time the medication is given.
- **d.** Freq: Code the number of times per day, week, or month the medication is administered using the following list:
  - **PRN:** As necessary
  - **QOD:** Every other day
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**2. RECEIPT OF PSYCHOTROPIC MEDICATION**

- **a.** Antipsychotic/neuroleptic
- **b.** Antidepressant
- **c.** Anxiolytic
- **d.** Hypnotic

**3. MEDICAL OVERSIGHT**

- **a.** Discussed with at least one physician (or no medication taken)
- **b.** No single physician reviewed medications

**4. COMPLIANCE/ADHERENCE WITH MEDICATIONS**

- **a.** Always compliant
- **b.** Compliant 80% of time or more
- **c.** Compliant less than 80% of time, including failure to purchase prescribed medications
- **d.** No medications prescribed

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### SECTION R. ASSESSMENT INFORMATION

**1. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:**

- **a.** Name of Physician
- **b.** Name of Respiratory Therapist
- **c.** Name of Nurse
- **d.** Date Assessment

**2. OTHER SIGNATURES**

- **Name and Dose**
- **Form**
- **Number**
- **Freq**

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### Country Specific

- **3. Number of times**
- **4. Number of times per week**
- **5. Number of times per month**

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MDS-HC-Pa5