ERRATA APPROVED

interRAI Long-Term Care Facilities (LTCF) 9.1

These changes have been approved by the interRAI Instrument and Systems Development Committee (ISD)

List released: August 30, 2012 and June 10, 2014

Edition	interRAI Standard Edition
Version # and Publication Dates	LTCF 9.1 November 2009 LTCF 9.1.1 June 2010 updates to form LTCF 9.1.2 September 2010

Yellow highlight indicates SUBSTANTIVE EDITORIAL change or correction that was approved.

Red text indicates words to insert; red text with strikethrough (~~example~~) indicates words to delete.

FORM

Page	**Item #**	**Change Suggested/Requested**		
1	B5	"Admitted from and Usual Residence [Example -- USA]"		
2	C5	CHANGE IN DECISION MAKING AS COMPARED TO 90 DAYS AGO (OR SINCE LAST ASSESSMENT IF LESS THAN 90 DAYS AGO)		
3	F3c	Correct typo: ~~frustation~~ frustration *[May apply to other localized English LTCF editions as well.]*		
4	H1	1 ~~Control~~ Managed with any catheter or ostomy over last 3 days		
5	J2	RECENT FALLS [Skip if last assessed more than 30 days ago or if this is first assessment**; only code falls that have occurred since the last assessment**.] 0 No 1 Yes [blank] Not applicable (first assessment, or more than 30 days since last assessment)		

5	J6d	Breakthrough pain—~~Times in LAST 3 DAYS when person experienced sudden, acute flare-ups of pain~~ Person experienced sudden, acute flare-ups of pain in LAST 3 DAYS 0 No 1 Yes		
6	J3	J3 Problem Frequency has extra response box near heading - remove it		
7	K3	Score 4 "**-AND-thickened liquids**" should be bold		

MANUAL

Page	Item #	Change Suggested/Requested		
i	ISD list	move "Dinnus Frijters, PhD" after "Brant E. Fries, PhD "		
	Localized items	Drop this note from items flagged as [Country Specific] ~~**NOTE: If not in the USA, please consult your addendum.**~~		
10	A8	Reason for Assessment Intent "To document the ~~key~~ reason for completing the assessment. ~~This item may also be known as the "record type," as it defines the data elements required for electronic versions of the assessment.~~ Each assessment requires completion of the interRAI LTCF Assessment Form and development or revision of a comprehensive care plan."		
20	B8	Coding "~~Check~~ Code for all institutional or group settings..."		
25	C1 example box	Delete example box ~~"Examples of Cognitive Skills for Daily Decision Making"~~		
29	C5	Change title in example box delete title: "Examples of How to Code Change in ~~Cognitive Status~~ Decision Making"		

32	D2	Ability to Understand Others (Comprehension) Coding: insert text: "4. Rarely or never understands — The person demonstrates very limited ability to understand communication, or the assessor cannot determine whether the person comprehends messages, based on his or her verbal and nonverbal responses. Includes situations where the person can hear sounds but does not understand messages."		
45	F2 Example box	Example of How to Code Sense of Involvement "This happened ~~for several days during the past week~~ several days ago."		
49	G1	Activities of Daily Living (ADL) Self-Performance Intent change "...how much verbal or physical help was required by ~~staff members~~ others"		
50	G1	Setup Help: Move the final sentence in that paragraph: "For the "Personal hygiene" item, setup help might mean providing a washbasin or grooming articles." to be first item in the list beneath "*Examples of setup help*"		
51	G1	Coding section bullet beginning with "If any episodes were ~~at level score~~ scored as..."		
52	G1 box	example box " Guidelines for Assessing ADL Self-Performance" 2nd bullet: "Do not record your assessment of the ~~resident's~~ person's capacity for involvement in self-care — that is, what you believe the ~~resident~~ person might be able to do for himself or herself based on demonstrated skills or physical attributes."		
52	G1 box	example box " Guidelines for Assessing ADL Self-Performance" 4th bullet: "Engage direct care staff from all shifts who have cared for the ~~resident~~ person over the last 3 days in discussions regarding the ~~resident's~~ person's ADL functional performance."		
57	G5 box	example box "Examples of How to Code Changes in ADL Status" second example, first sentence: change beginning of sentence from: "~~Since fracturing her hip 3 weeks ago~~ Since her assessment directly following a hip fracture 3 weeks ago, Mrs. Z receives..."		

59	H1	Bladder Continence Coding section, first paragraph: "~~Choose the response that best reflects the person's level of bladder continence in the last 3 days. Code for the pattern of the person's actual bladder continence with urinary device, if used. This pattern is the frequency with which the person was wet during the 3-day assessment period. Do not code the level of control the person might have received under optimal circumstances.~~ A six-level coding scale is used to describe continence patterns. Choose one response to code the person's level of urinary continence over the last 3 days."		
60	H1	1. ~~Complete control~~ Managed with any catheter or ostomy over last 3 days — ~~Control~~ Managed with ~~use of~~ any type of catheter or urinary collection device.		
63	I1e	Hemiplegia delete the sentence "~~There must be a diagnosis of hemiplegia in the person's record to code this item.~~"		
68	J2	If this is the first assessment, or if less than 30 days have passed since the last assessment, simply leave this item blank. If this is a follow-up assessment ~~30 or more days since the previous assessment, code for the most correct response.~~ with less than 30 days since the last assessment, **only code falls that have occurred since the last assessment**. 0. No ~~fall in last 30 days~~ 1. Yes~~, fall in last 30 days~~ [blank] Not applicable (first assessment, or more than 30 days since last assessment)		
73-74	J6	*J6 Pain Symptoms - Headers should be rewritten to avoid multiple lines. Specific recommendations align with same changes made to other editions of LTCF, HC and CHA, so they will all match. See errata spreadsheet comparing text of J6 across all titles. J6 in LTCF Standard Form is ok as is.*		
73	J6a	replace this header: J6a. ~~Frequency with which person complains or shows evidence of pain — including grimacing, teeth clenching, moaning, withdrawal when touched, or other nonverbal signs suggesting pain.~~ with this header and definition: J6a. Frequency with which person complains or shows evidence of pain Definition Measures how often the person experiences pain (reports or shows evidence of pain), including grimacing, teeth clenching, moaning, withdrawal when touched, or other nonverbal signs suggesting pain.		

73	J6b	replace this header: J6b. ~~Intensity of highest level of pain present — The level of pain reported by or observed in the person.~~ with this header and definition: J6b. Intensity of highest level of pain present Definition Measures the level of pain reported by or observed in the person. Code for the highest level of pain present.		
73	J6c	replace this header: J6c. ~~Consistency of pain — Measures the frequency (ebb and flow) of pain from the person's perspective.~~ with this header and definition: J6c. Consistency of pain Definition Measures the frequency (ebb and flow) of pain from the person's perspective.		
73	J6d	replace this header: J6d. ~~Breakthrough pain — The person experienced a sudden, acute flare-up of pain one or more times in the last 3 days. Breakthrough pain might appear as a dramatic increase in the level of pain above that addressed by ongoing analgesics, or the recurrence of pain associated with end-of-dose failure.~~ with this header and definition: J6d. Breakthrough pain Definition Person experienced sudden, acute flare-ups of pain in LAST 3 DAYS. Breakthrough pain might appear as a dramatic increase in the level of pain above that addressed by ongoing analgesics, or the recurrence of pain associated with end-of-dose failure.		
74	J6e	replace this header: J6e. ~~Pain control — The ability of the current therapeutic regimen to control the person's pain adequately (from the person's point of view). This item describes the adequacy or inadequacy of pain control measures instituted by clinical staff caring for the person (such as medications, massage, TENS, or other therapeutic regimen).~~ with this header and definition:		

		J6e. Pain control Definition The ability of the current therapeutic regimen to control the person's pain adequately (from the person's point of view). This item describes the adequacy or inadequacy of pain control measures instituted by clinical staff caring for the person (such as medications, massage, TENS, or other therapeutic regimen).		
79	K3	Mode of Nutritional Intake "Parenteral ~~(PEG)~~ feeding only — Includes all types of parenteral feedings such as ~~PEG feeding and~~ total parenteral nutrition (TPN)."		
79	K4	Parenteral or Enteral Intake, Intent: "To record the proportion of calories received ~~and the average fluid intake~~ through parenteral or tube feeding in the last 3 days."		
80	K4 Box	Example of Calculation for Proportion of Total Calories from IV or Tube Feeding restore missing text: **Step #4:** Code "**3**" for "26% or more of total calories through device."		
89	M2	Activity Preferences and Involvement Process: Last sentence: "~~check the item on the form~~ code the item "1", "3", or "4" as appropriate."		
91	N	Medications Intro section, about 2/3 of the way down the 1st paragraph: "~~individual's~~ person's"		
91	N1	List of All Medications Intent section, 2nd and 3rd sentences: "~~an individual~~ a person"		
92	N1	Coding section: remove present wording; " ~~The coding instructions for Item N1 are extensive. Review them carefully, from N1a through N1g. Study the examples. Complete the coding exercises at the end of this section.~~" *Process section:* ***move all of the second last paragraph*** *of the "process section" (the coding instructions … of this item) to the "coding section":* "The coding instructions for Item N1 are extensive. Review them carefully, from N1a through N1g; for each drug record, you will need to enter information in all the columns (N1a, N1b, and so forth). Complete the coding exercise at the end of all the explanations of this item."		

93	N1a	N1a Name (medication) in definition "~~geriatric~~ generic name"		
95	N1e	under the heading "**Coding**" The second last paragraph timeframes regarding frequency is unclear. It currently reads: "There is a different frequency code for tid ~~(3d)~~ (3 times daily) and q8 hours ~~(8h)~~ (every 8 hours). In this case the frequency code would be q8h (~~q~~ every 8 hours)."		
96	box	"Example of how to code Frequency and PRN" Point 3 should be two separate points as there are 2 separate medications. Change to: * Compazine suppository 5 mg STAT * Lanoxin 0.25 every other day. On...		
101	N2	Intent section "~~individual~~ person"		
105	O3	Therapy/Nursing Services in Last 7 Days Intro first paragraph: "Therapies that occurred after admission to the facility~~, that were ordered by a physician,~~ and that were performed by a qualified therapist (for example, one who meets state credentialing requirements or, in some instances, under such a person's direct supervision). Therapies listed in O3 require the referral of a physician if such a referral is legislated in the facility type or jurisdiction. Otherwise, a physician's order is not required to include the therapy time in the interRAI LTCF."		