IRRS

interRAI Long-Term Care Facilities
CIHI Coding Reference Guide

2025

Canadian Institute for Health Information
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Introduction

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

Purpose

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

Additional resources

The *interRAI LTCF 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:

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 LTCF 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
A8 — Reason for Assessment	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. The first assessment coded as 1 for A8 — Reason for Assessment is required by day 4 of the person's stay. Jurisdictions may set a different assessment reference date to complete this assessment, but it should not exceed 7 days after the admission date.

Section B Intake and Initial History

Item	CIHI tip
B7 — Living Arrangement Prior to Admission	When a jurisdiction transitions to the interRAI LTCF assessment, every resident will require a first assessment even if they have been in the facility for years (i.e., including residents who have been assessed in the past using the RAI-MDS 2.0 assessment). For B7, use the information that was captured when the person was first admitted to the facility. In exceptional circumstances only, if there is no information or informant available to determine the person's living arrangement prior to their original admission to the facility, code 7 (with other relatives) may be used. Code 1 (alone) does not include a person who lived in a residential or retirement home with or without services prior to admission. Instead, use code 8 (with nonrelative[s]).

Section C Cognition

Item	CIHI tip
C1 — Cognitive Skills for Daily Decision Making	A code of 5 (no discernible consciousness, 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).

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	For coding 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.
E1i — Withdrawal from activities of interest	If the person cannot participate in activities of interest due to illness but has not lost interest in being involved in activities with family and friends, code 0 (not present).
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-reported 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).
E3 — Behaviour Symptoms	For coding 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.
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.

Section F Psychosocial Well-Being

Item	CIHI tip
F1 — Social Relationships	If the person previously participated in social activities of long-standing interest but has not participated in the last 2 years, code 1 (more than 30 days ago). If the person has never participated in such activities, code 0 (never) for the following items: • F1a — Participation in social activities of long-standing interest • F1b — Visit with a long-standing social relation or family member • F1c — Other interaction with long-standing social relation or family member
F4 — Major Life Stressors in Last 90 Days	If the person has cognitive impairment, code 1 (yes) only if they are able to provide enough information to indicate that the experience has disrupted or threatened to disrupt their daily routine. If the person is unable to communicate (nonverbal communication included) how the stressful event has affected them, code 0 (no). The assessor is responsible for determining how this item should be coded if the person has advanced cognitive impairment.

Section G Functional Status

Item	CIHI tip
G1 — Activities of Daily Living (ADL) Self-Performance	Do not code 6 (total dependence) unless the person was totally dependent for **all** episodes during the 3-day observation period. If they participated or made any effort with anyone (e.g., physiotherapist, occupational therapist, family, any staff member) during the observation period, they would not be considered totally dependent. A code of 5 (maximal assistance) includes weight-bearing support (including limbs) by 2 or more helpers, or weight-bearing support by 1 helper for more than 50% of subtasks. A code of 4, 5 or 6 must include weight-bearing support.
G1a — Bathing	If the person has a full-body bed bath or sponge bath, the assessor should consider whether the bath achieved a similar degree of cleanliness as a tub bath or shower. If the full-body bed bath or sponge bath did meet those criteria, it can be included.
G1b — Personal hygiene	Care associated with a prosthetic eye can be captured in G1b.
G1c — Dressing upper body	Dressing includes self-care performance in dressing and undressing in night clothes as well as street clothes.
G1d — Dressing lower body	Dressing includes self-care performance in dressing and undressing in night clothes as well as street clothes.
G1e — Walking	Walking from the bedroom to an ensuite/bathroom counts in G1e. This item is intended to capture any walking done by the person, regardless of distance or how brief it was.
G1g — Transfer toilet	This item does not include getting to and from the bathroom.
G1h — Toilet use	This item does not include getting to and from the bathroom or transferring on and off the toilet. Emptying a commode, bedpan or urinal is not considered a subtask in G1h.
G1i — Bed mobility	G1i would apply if a recliner was used in lieu of a bed. The movement of legs in and/or out of bed during transfer is not included in G1i.
G1j — Eating	Swallowing and chewing food are not considered subtasks in G1j. This item captures the person's self-performance in intake of nourishment. For example, how does the person pour, unwrap, cut, scoop and spear their food? How does the person use utensils or their fingers when necessary? Does the person prepare their tube feed or total parenteral nutrition (TPN)?
G2a — Primary Mode of Locomotion Indoors	If the person is in bed or in a recliner for 22 hours or more per day, code 3 (bed-bound). This definition also includes residents who are primarily bedfast but have bathroom privileges.

Section H Continence

Item	CIHI tip
H1 — Bladder Continence and H3 — Bowel Continence	A catheter or ostomy that has leaked in the last 3 days would be coded in the range of 2 (infrequently incontinent) to 5 (incontinent), depending on how frequently leakage occurred.
H2 — Urinary Collection Device	This item excludes intermittent catheterization devices.

Section I Disease Diagnosis

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).
I1e — Hemiplegia	Hemiparesis on its own is not captured in I1e.
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 can 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.
J2 — Problem Frequency	For coding 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.
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).

Item	CIHI tip
J2d — Unsteady gait	A person who cannot weight bear and cannot be assessed for J2d would be captured as 0 (not present).
J2h — Delusions	Delusions are captured in J2h regardless of the cause. If the person does not experience any delusions during the observation period due to the effectiveness of antipsychotic medication, delusions are not captured on the assessment.
J2i — Hallucinations	Hallucinations are captured in J2i regardless of the cause. If the person does not experience any hallucinations during the observation period due to the effectiveness of antipsychotic medication, hallucinations are not captured on the assessment.
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 coding 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.
J8a — Smokes tobacco daily	This item excludes vaping with nicotine, chewing tobacco and occasional smoking.

Section K Oral and Nutritional Status

Item	CIHI tip
K1a — Height	If the person refuses to have their height measured, code 001. If the person is palliative and cannot be measured, code 248.
K1b — Weight	If the person refuses to be weighed, code 0001. If the person is palliative and cannot be weighed, code 9999.
K2 — Nutritional Issues	If the person has a feeding tube and is NPO (nil per os) or is on a prescribed fluid restriction (due to a pre-existing condition), code the following as 0 (no): • K2b — Dehydrated or BUN/creatinine ratio >20 • K2c — Fluid intake less than 1,000 ml per day (or less than four 8 oz cups per day) • K2d — Fluid output exceeds input • K2e — Decrease in amount of food or fluid usually consumed • K2f — Ate one or fewer meals on at least 2 of last 3 days

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). A code of 1 (modified independent) should be considered if the person shows signs of swallowing difficulty (e.g., taking liquids in small sips, taking small bites of food, taking a long time to chew solids). This may require observation or discussion with the person or others. Subcutaneous fluids and dextrose are not included in parenteral feeding. If a 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.

Section L Skin Condition

Item	CIHI tip
L1 — Most Severe Pressure Ulcer	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.
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	A complete or partial foot amputation would be considered a structural problem and included in L7.

Section M Activity Pursuits

Item	CIHI tip
M2m — Spiritual or religious activities	Includes solitary prayer.

Section N Medications

Item	CIHI tip
N1 — List of All Medications (Optional) and N3 — Total Number of Medications	Long-acting medications given outside of the 3-day observation period are included in N1 and N3 (e.g., Haldol LA, chemotherapeutic agents). Vaccinations are included only if they are provided within the 3-day observation period. Legal cannabis products in any form are counted in N1 and N3. Exclude illicit or illegal synthetic cannabinoids (e.g., bath salts).
N4 — Total Number of Herbal/Nutritional Supplements	Minerals, vitamins, herbs, meal supplements, sports nutrition products and natural food supplements are included in N4. All oral and injectable vitamins prescribed, non-prescribed and over the counter are included in N4. Cannabis products are not captured in N4. Additives (vitamins, lipids, etc.) that are part of total parenteral nutrition (TPN) are not coded in N4.
N7 — Receipt of Psychotropic Medication	Medications are coded according to their pharmacological classification, not their use. If the resident uses long-lasting drugs that are taken less often than weekly, code 1 (one day).

Section O Treatments and Procedures

Item	CIHI tip
O1h — 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.
O2a — Chemotherapy	The intent of O2a 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). O2a excludes chemotherapy agents used to treat any other disease (e.g., Megace as an appetite stimulant, methotrexate to treat rheumatoid arthritis).
O2d — IV medication	IV medications administered prior to admission or solely during a surgical procedure and in the immediate post-operative period (e.g., in a recovery room) are not captured in O2d. Medications administered by subcutaneous infusion, epidural, intrathecal, CADD pump and/or baclofen pump are included and captured in O2d.
O2e — Oxygen therapy	Nebulizer treatment with oxygen is not captured as oxygen therapy.
O2j — Ventilator or respirator	The use of CPAP and BiPAP is not captured in this item. O2j 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).

Item	CIHI tip
O2l — 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
O3 — Therapy/ Nursing Service in Last 7 Days	All recorded time must be time spent directly with the person; documentation time and initial assessment are excluded. A family member's or volunteer's time assisting a therapist or an assistant in the context of therapy and/or nursing services provided to the person is not captured. Time spent teaching family or caregivers how to complete certain tasks or interventions for the person in the context of discharge or leave of absence can be included as long as the person is present.
O3d — Respiratory therapy	Time spent directly setting up and periodically monitoring a person on CPAP or BiPAP can be captured in O3d provided this is done by a respiratory therapist or trained nurse. The duration of the treatment itself is not captured. If the person receives a Ventolin nebulizer treatment, the time spent by a respiratory therapist or trained nurse setting up the equipment, administering the treatment and monitoring the person can be included. If the therapist or trained nurse sets up the treatment, leaves the person and returns to remove the equipment, only the set-up time is included.
O3f — Psychological therapy	Exclude time spent by a social worker counselling family members/significant others of the person (e.g., who may be cognitively impaired). Count only time spent providing counselling directly to 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.
O4a — In-patient acute hospital with overnight stay	This item does not include admissions for day surgery or other outpatient services.
O4b — Emergency room visit	Exclude any emergency department visits that resulted in a hospital admission or visits that were scheduled or pre-arranged.
O5 — Physician Visits	The following providers can be included in this item: osteopath, podiatrist, optometrist, ophthalmologist, nurse practitioner, physician assistant, dentist, dental surgeon, any consultant (e.g., cardiologist) and naturopathic physician/doctor of naturopathic medicine. Exclude the following providers: chiropodist, orthotist/pedorthist, chiropractor, optician, denturist, psychologist and clinical nurse specialist.
O6 — Physician Orders	If provincial/territorial legislation gives pharmacists the authority to prescribe medications, and the pharmacist has been approved by their respective regulatory and licensing body, the orders for new prescription medication that they write may be captured.
O7b — Trunk restraint	A tray table applied to a chair (i.e., wheelchair) that a person is unable to easily remove is included in item O7b.
O7c — Chair prevents rising	A tray table that is an integrated part of the chair (i.e., geriatric chair with table that slides into position and locks) that the person is unable to remove and prevents them from rising is included in item O7c.

Section P Responsibility and Directives

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

Section Q Discharge Potential

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

Section R Discharge

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

Section S Assessment Information

Item	CIHI tip
S1 — 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.

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