Health PEI
One Island Health System

Canadian Health Outcomes for Better Information and Care (C-HOBIC)

C-HOBIC Assessment – Questions and Scoring

Symptom Management (At Home)

Pain:

1. Ask the patient if they have experienced pain (frequency) **in the last 24 Hours prior to admission.**

0. No pain

1. Present but not exhibited in last 24) hours (effective pain management for the past 24 hrs)

2. Exhibited in last 24 hours

Pain Intensity

2. Ask the patient to rate their pain on a scale of 1-10 (intensity) **in the last 24 hours**.

1 – 10

Symptom Management (At Home)

Fatigue:

Ask the patient if they have felt fatigued or tired **in the last 24 hours prior to admission**.

If the patient has experienced fatigue **in the last 24 hours**, determine the degree to which the fatigue interferes with the person's ability to complete or initiate normal day-to-day activities (e.g., ADLs).

0. None

1. Minimal — Diminished energy but completes normal day-to-day activities

2. Moderate — Due to diminished energy, UNABLE TO FINISH normal day-to-day activities

3. Severe — Due to diminished energy, UNABLE TO START SOME normal day-to-day activities

4. Unable to commence any normal day-to-day activities — Due to diminished energy

Symptom Management (At Home)

Dyspnea:

Ask the patient if they have experienced shortness of breath in the last 24 hours.
If the patient has been short of breath determine if it occurs with strenuous activity, normal day-to-day activity, or when resting.

0. Absence of symptom
1. Absent at rest, but present when performed moderate activities (e.g., climbing stairs, gardening)
2. Absent at rest, but present when performed normal day-to-day activities (e.g., making a bed, dressing lower body)
3. Present at rest

Symptom Management (At Home)

Nausea:

Ask the patient if they have experienced nausea **in the last 24 hours**.

If the patient has been having nausea, determine if the nausea has interfered with the patient's ability to eat or carry out activities.

0. No nausea

1. Mild nausea — occasionally experienced but does not interfere with eating and/or activities

2. Moderate nausea — interferes somewhat with eating and/or some activities

3. Severe nausea — interferes daily with eating and/or activities

4. Incapacitating — remains in bed part of each day due to nausea and interferes with eating and activities

Safety Outcomes (At Home)
Pressure Injuries: How to Score

Documentation of any pressure injuries currently present on the patient, to monitor healing or worsening during time in hospital. Score is based on the most severe pressure injury present at time of assessment

0. No pressure injury present

1. Any area of persistent skin redness — A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

2. Partial loss of skin layers — A partial-thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

3. Deep craters in the skin — A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

4. Breaks in skin exposing muscle or bone — A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

5. Not codeable — e.g., necrotic eschar predominant.

Safety Outcomes (At Home)

Measuring falls and pressure injuries, as a demonstration of the patient's current injuries or risk for future injuries

Falls: How to Score

0. Patient has had no fall in the last 90 days

1. Patient has had no fall in the last 30 days, but has fallen in the last 31-90 days

2. Patient has had one fall in the last 30 days

3. Patient has had two or more falls in the last 30 days

Note: The patient should be asked directly concerning their history of falls, but the nurse should also check with other care providers and family, if necessary

Bladder Continence: How to Score (At Home)

0. **Continent→** complete control (**not** via catheter/urinary collection device)
1. **Control with catheter or ostomy over last 24 hours**
2. **Infrequently incontinent→** Not incontinent over last 24 hours, but has periods of incontinence
3. **Frequently incontinent→** Had incontinent episode(s) over last 24 hours, but some control present
4. **Incontinent→** No control present
5. **Did not occur→** No urine output in last 24 hours

Functional Status/ADLs (At Home)

We are *m*easuring what the patient actually did and how much help was required within each functional status/ADL category in the last **24 hours** prior to starting the admission assessment

*Keep in mind this is what the patient has **actually** done, not what they think they could or should have done

ADL

1. **Bathing→** How the patient takes a full-body bath/shower/sponge bath (exclude washing of back and hair). Include how the patient transfers in and out of the tub/shower.
2. **Personal hygiene→** How the patient manages personal hygiene, including combing hair, brushing teeth, shaving, washing face and hands (exclude bathing).
3. **Walking→** How the patient ambulates between locations on the same floor indoors.
4. **Transfer toilet→** How the patient moves on and off the toilet/commode.
5. **Toilet use→** How the patient uses the toilet/commode/bedpan and cleanses self after use or after episodes of incontinence (include care of ostomy/catheter/pads)
6. **Bed Mobility→** How the patient moves to and from a lying position, turns side to side, and positions body while in bed
7. **Eating→** How the patient eats and drinks, include all intake methods (tube feeding, total parenteral nutrition)
8. **Bladder continence→** Control of urinary bladder function (i.e. toileting schedule, urinary appliances, dripping or leaking of urine). This does not include the patient's ability to toilet themself (i.e. a patient could need maximum assistance on and off the toilet and still be continent)

SCORE

0. Independent→ No assistance, set-up help, or supervision required at any time

1. Set-up help only→ Article, device or preparation provided within reach, but no episode with supervision or physical assistance with activity

2. Supervision→ Oversight/cueing 3+ times during activity OR oversight/cueing 1+ time and physical assistance 1-2 times (Standby assist)

3. Limited assistance→ Guided maneuvering of limbs provided 3+ times OR combination of guided maneuvering and more help 1-2 times

4. Extensive assistance→ Weight-bearing support 3+ times by 1 helper where patient still performed 50% or more of tasks (1 person assist)

5. Maximal assistance→ Weight-bearing support 3+ times by 2+ helpers OR weight-bearing support for more than 50% of tasks (2 person assist)

6. Total dependence→ Full performance by other(s) during entire period (Total lift)

8. Activity did not occur→ During entire period

Therapeutic Self-Care: Examples hand out

Nurse Question	Patient Response	Score
1. "Do you know what medications you have to take?"	"Here is the bag/container of medications" "*I only know them by color*" "Yes, this is Metoprolol"	0 1 2
2. "Do you know what you are taking the medications for?"	"The doctor gave them to me" "For my heart (or other body part)" "Yes, this medication is for my high blood pressure"	0 1 2
3. "Are you taking your medications as prescribed?"	"My son helps me with my medications" "Whenever I think of it or want to" "I have a routine" (consistent with recommended routine)	0-1 1 2
4. "Were you able to notice changes in your health/symptoms?"	"When my ankles swell, I know that it is a sign of my heart failure"	2
5. "Are you able to carry out treatments to manage your symptoms or changes in your body (massage, breathing exercises)?"	"When I feel dizzy or tired I eat something because I know that my sugars are low" "When I get short of breath I sit down for a few seconds then get back to work"	2 1

Therapeutic Self-Care: (At Home)
How to Score

Taking Medications	Symptoms	ADLs	Support
0. Lack of knowledge **1. Aware of medications but do not know exact names** **2. Adequate knowledge**	**0: Not at all** **1: Somewhat** **2: Very much** **7: Not applicable** **8: Unable to assess**	**0: Not at all** **1: Somewhat** **2: Very much** **7: Not applicable** **8: Unable to assess**	**0: Not at all** **1: Somewhat** **2: Very much** **7: Not applicable** **8: Unable to assess**
<u>Questions:</u> 1. "Do you know what medications you have to take?" 2. "Do you know what you are taking the medications for?" 3. "Are you taking your medications as prescribed?"	<u>Questions:</u> 4. "Were you able to notice changes in your health/symptoms?" 5. "Are you able to carry out treatments to manage your symptoms or changes in your body (massage, breathing exercises)?"	<u>Questions:</u> 6. "Were you able to do everyday things (eating, shopping, driving)?" 7. "Did you have someone to call to help you with everyday things?"	<u>Questions:</u> 8. "Did you know who to call in case of a medical emergency?"