Resident Assessment Instrument (RAI)
RAI-MDS 2.0 User's Manual

Canadian Version

February 2012

interRAI

Canadian Institute for Health Information

Institut canadien d'information sur la santé

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Acknowledgements

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The Canadian version of the RAI-MDS 2.0 was initially adapted by John P. Hirdes, Ph.D. and Nancy Curtin-Telegdi M.A. interRAI is represented in Canada by the Canadian Collaborating Centre-interRAI, The Homewood Research Institute, Guelph, Ontario. It has been further modified for Canadian use with permission from interRAI under a license agreement with the Canadian Institute for Health Information.

For information or comments on the RAI-MDS 2.0 contact ccrs@cihi.ca or visit www.interRAI.org.

Neither interRAI, the publisher, nor the authors intend that this manual should be used in lieu of comprehensive appropriate support or care. Every reasonable effort has been made to be sure that the information provided is accurate and up to date. However, the resident's physician or other authorized practitioner should validate information about drugs and therapies for appropriateness before prescribing.

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interRAI has developed assessment instruments for a range of populations in various areas of health care, including but not limited to home care, mental health, community mental health, persons with intellectual disability and palliative care.

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Chapter 1—Introduction

How to Use This Manual

This manual is designed to meet the needs of continuing care facility staff who are both skilled in the use of the RAI-MDS 2.0 and staff who are just beginning to work with it. The manual provides comprehensive information for a broad range of partners and stakeholders who have key roles in the accurate coding and reporting of RAI-MDS 2.0 activities.

For those who have had experience with the RAI-MDS 2.0, this manual will serve as an up-to-date reference for use with the Canadian version. While individual RAI-MDS 2.0 items may change over time, the process of completing a clinical RAI-MDS 2.0 assessment does not.

If you are new to the RAI-MDS 2.0 and its process, you will find this manual an invaluable companion. In essence, this manual promotes a step-by-step system of assessing a resident's needs and functional status based on standardized definitions of items in the RAI-MDS 2.0. It then helps you think through possible reasons for and risk factors that contribute to a resident's clinical status using the Clinical Assessment Protocols (CAPs) or Resident Assessment Protocols (RAPs). This informative material offers the interdisciplinary team realistic approaches to resident care that are based on specific, individual characteristics.

The following fundamental concepts associated with the RAI-MDS 2.0 are interwoven as themes throughout this manual:

- The resident is an individual with strengths, as well as functional limitations and health problems.
- Possible causes for each problem area and guidance for further assessment and resolution are presented in the CAPs/RAPs.
- An interdisciplinary approach to resident care is vital—both in assessment and in developing the resident's care plan.
- Good clinical practice requires solid, sound assessment.

Overview of the Manual

- Chapter 1 provides an introduction to the RAI-MDS 2.0, an overview of its components, and suggestions for using the RAI-MDS 2.0 and integrating it into clinical practice.
- Chapter 2 provides detailed coding guidelines for each item in the RAI-MDS 2.0.
- Chapter 3 contains copies of the Canadian version of the RAI-MDS 2.0 Assessment Forms.

Overview of the RAI-MDS 2.0

Providing care to residents of facilities is complex and challenging work. It utilizes clinical competence, observational skills, and assessment expertise from all disciplines to develop individualized care plans. The RAI-MDS 2.0 helps facility staff to gather definitive information on a resident's strengths and needs which must be addressed in an individualized care plan. It also assists facility staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident's status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident's unique path toward achieving or maintaining his or her highest practicable level of well-being.

The RAI-MDS 2.0 helps facility staff to look at residents holistically—as individuals for whom quality of life and quality of care are mutually significant and necessary. Interdisciplinary use of the RAI-MDS 2.0 promotes this very emphasis on quality of care and quality of life. Facilities have found that involving disciplines such as dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy, and recreation therapy in the RAI-MDS 2.0 process has fostered a more holistic approach to resident care and strengthened team communication.

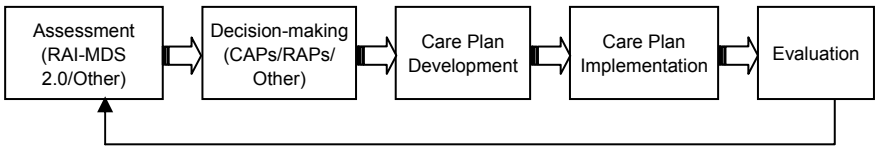
Persons generally enter a facility due to functional status problems caused by physical deterioration, cognitive decline, or other related factors. The ability to manage independently has been limited to the extent that assistance or medical treatment is needed for residents to function or to live safely from day to day. All necessary resources and disciplines must be used to ensure that residents achieve the highest level of functioning possible (Quality of Care) and maintain their sense of individuality (Quality of Life). This is true for long stay residents, as well as residents in a rehabilitative program anticipating return to a less restrictive environment.

Clinicians are generally taught a problem identification process as part of their professional education. For example, the nursing profession's problem identification model is called the nursing process, which consists of assessment, planning, implementation and evaluation. The RAI-MDS 2.0 simply provides a structured, standardized approach for applying a problem identification process in facilities. The RAI-MDS 2.0 should not, nor was it ever meant to be an additional burden for facility staff.

All good problem identification models have similar steps:

- **Assessment**—Taking stock of all observations, information and knowledge about a resident; understanding the resident's limitations and strengths; finding out who the resident is.
- **Decision-making**—Determining the severity, functional impact, and scope of a resident's problems; understanding the causes and relationships between a resident's problems; discovering the "whats" and "whys" of a resident's problems.
- **Care Planning**—Establishing a course of action that moves a resident toward a specific goal utilizing individual resident strengths and interdisciplinary expertise; crafting the "how" of resident care.
- **Implementation**—Putting that course of action (specific interventions on the care plan) into motion by staff knowledgeable about the resident care goals and approaches; carrying out the "how" and "when" of resident care.
- **Evaluation**—Critically reviewing care plan goals, interventions and implementation in terms of achieved resident outcomes and assessing the need to modify the care plan (i.e. change interventions) to adjust to changes in the resident's status, either improvement or decline.

This is how the problem identification process would look as a pathway. This manual will feature this pathway throughout and will highlight the point in the pathway that each chapter discusses.



If you look at the RAI-MDS 2.0 system as solution oriented and dynamic, it becomes a richly practical means of helping facility staff to gather and analyze information in order to improve a resident's quality of care and quality of life. In an already overburdened structure, the RAI-MDS 2.0 offers a clear path toward utilizing all members of the interdisciplinary team in a proactive process. There is absolutely no reason to insert the RAI-MDS 2.0 process as an added task or view it as another "layer" of labour.

The key to understanding the RAI-MDS 2.0 process, and successfully using it, is believing that its structure is designed to enhance resident care and promote the quality of a resident's life. This occurs not only because it follows an interdisciplinary problem-solving model but also because staff, across all shifts, are involved in its "hands on" approach. The result is a process that flows smoothly from one component to the next and allows for good communication and uncomplicated tracking of resident care. In short, it works!

Over the course of the years since the RAI-MDS 2.0 has been implemented, facilities who have applied the RAI-MDS 2.0 in the manner we have discussed have discovered that it works in the following ways:

Residents respond to individualized care. While we will discuss other positive responses to the RAI-MDS 2.0 below, there is none more persuasive or more powerful than good resident outcomes both in terms of a resident's quality of care and quality of life. Facility after facility has found that when the care plan reflects careful consideration of individual problems and causes, linked with appropriate resident specific approaches to care, residents have experienced goal achievement and either the level of functioning has improved or deteriorated at a slower rate. Facilities report that as individualized attention increases, resident satisfaction with quality of life is also increased.

Staff communication has become more effective. When staff are involved in a resident's ongoing assessment and have input into the determination and development of a resident's care plan, the commitment to and the understanding of that care plan is enhanced. All levels of staff, including nursing assistants, have a stake in the process. Knowledge gained from careful examination of possible causes and solutions of resident problems (i.e. from using the CAPs/RAPs) challenges staff to hone the professional skills of their discipline as well as focus on the individuality of the resident and holistically consider how that individuality must be accommodated in the care plan.

Resident and family involvement in care has increased. There has been a dramatic increase in the frequency and nature of resident and family involvement in the care planning process. Input has been provided on individual resident strengths, problems, and preferences. Staff have a much better picture of the resident, and residents and families have a better understanding of the goals and processes of care.

Documentation has become clearer. When the approaches to achieving a specific goal are understood and distinct, the need for voluminous documentation diminishes. Likewise, when staff are communicating effectively among themselves with respect to resident care, repetitive documentation is not necessary and contradictory notes do not occur. In addition, new staff, consultants, or others who review records find that information documented about a resident is clearer and tracking care and outcomes is more easily accomplished.

It is the intent of this manual to offer clear guidance, through instruction and example, for the effective use of the RAI-MDS 2.0, and thereby help facilities achieve the benefits listed above.

The RAI-MDS 2.0 provides each resident with a standardized, comprehensive and reproducible assessment. It evaluates a resident's ability to perform daily life functions and identifies significant impairments in a resident's functional capacity. In essence, with an accurate RAI-MDS 2.0 completed periodically, caregivers have a genuine and consistently recorded "look" at the resident and can attend to that resident's needs with realistic goals in hand.

With the consistent application of item definitions, the RAI-MDS 2.0 ensures standardized communication both within the facility and between facilities (e.g. other facilities or hospitals). Basically, when everyone is speaking the same language, the opportunity for misunderstanding or error is diminished considerably.

The **RAI-MDS 2.0** consists of two versions of the assessment form, item-by-item instructions, a series of care planning protocols and other decision support algorithms.

The **RAI-MDS 2.0 assessment forms** are standardized, minimal assessment and screening tools designed for clinical use. It is not a questionnaire for analyzing the characteristics of a population, nor does it include all the information that might be necessary to construct a comprehensive plan of care. Supplemental information, relevant to the resident, should be assessed and incorporated as necessary. The assessment forms enable a health care provider to assess key domains of function, mental and physical health, social support, and service use. Particular RAI-MDS 2.0 items also identify residents who could benefit from further evaluation of specific problems or risks for functional decline. These items, known as "triggers," link the RAI-MDS 2.0 to a series of problem-oriented care planning protocols.

There are two sets of care planning protocols that can be used with the RAI-MDS 2.0: the newer Clinical Assessment Protocols (CAPs) and older Resident Assessment Protocols (RAPs). Both contain general guidelines for further assessment and individualized care and services. There are 19 CAPs in multiple domains (including clinical, mental health, psychosocial, and physical function) and 18 RAPs. On average, a person living in residential care triggers about 5 of the 19 CAPs and about 10 of the 18 RAPs.

In addition to the assessment forms there is a series of supplementary forms that collect information, such as admission and discharge information, that are required in order to submit RAI-MDS 2.0 data to the Continuing Care Reporting System (CCRS). Please see the **CCRS Specifications Manual** for further information on these supplementary forms and instructions on how and when to complete them.

Throughout this manual, the users will also find the utilization guidelines which are instructions concerning when and how to use the RAI-MDS 2.0.

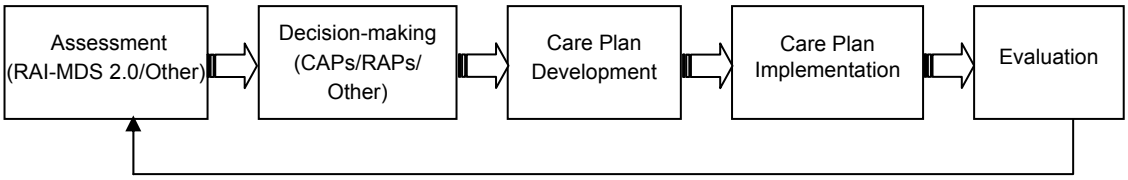
RAI-MDS 2.0 Decision Support Algorithms

The RAI-MDS 2.0 has embedded decision-support algorithms. These algorithms summarize information from the assessment and can be used to support both clinical and organizational decision making. All RAI-MDS 2.0 assessments should be done electronically to ensure that the assessors receive instantaneous results for the clinical algorithms and indicators embedded in the RAI-MDS 2.0. The outputs from these algorithms can be compared over time to monitor changes, and enable an assessor to see whether the resident is responding to the interventions put in place.

The algorithms that are designed to support clinical decision-making and care planning are:

- **Outcome Scales** are clinical scales that combine assessment items from the RAI-MDS 2.0 to summarize a specific clinical domain. Scales available in the RAI-MDS 2.0 include measures of cognitive performance, activities of daily living, behaviour, pain, depression and clinical complexity.
- **interRAI Clinical Assessment Protocols (CAPs**), released in March 2008, provide evidence-informed guidance for further assessment and intervention in key problem areas. When key items in the RAI-MDS 2.0 assessment indicate a risk of decline or failure to improve that may respond to intervention, the issue is flagged and a CAP is "triggered". The CAPs also include care planning guidelines, based on research and best practice, which provide the clinician with a structured approach to address these important care issues.
- **Resident Assessment Protocols (RAPs)** contain the original care planning triggers and guidelines designed for use with the RAI-MDS 2.0 that are still being used by some jurisdictions who have yet to transition to the 2008 version of the CAPs. The overall process and goals for the RAPs are similar to the latest (2008) CAPs, with algorithms designed to trigger the RAPs, and care planning guidelines to help address the identified issues. However, the triggers are different, triggering rates are higher, care guidelines do not reflect the more recent research and best practice, and they are not compatible with CAPs used in other sectors (for example, RAI-Home Care, interRAI Community Health Assessment).

Note, these algorithms are not designed to automate care planning nor to replace an assessor's professional clinical judgement regarding the appropriate care required for a resident. They are designed to provide standardized information to **support** the clinician in his or her decision-making process.



Use of CAPs/RAPs

The presence of an accurate RAI-MDS 2.0 assessment lays the ground work for all that will follow—problem identification, identification of problem causes and associated conditions, and specification of necessary care goals and related approaches to care.

Key points relative to use of CAPs/RAPs:

- Problems may be found in many areas, and the understanding of relevant causal factors and the appropriate referral for additional evaluation or care will be facilitated by the in-depth evaluation of problems using the CAPs/RAPs.
- The in-depth evaluation of problems will help to think through why a problem exists or why the resident is at risk, providing the necessary foundation on which to base next steps.
- This review may require an evaluation of a wide variety of triggered problems, many more than most agencies have traditionally reviewed. The focus is not just on simple maintenance services or planning the response to an immediate problem. While these are included, the system also helps clinicians assess for opportunities to rehabilitate function, prevent decline, and maintain resident strengths.
- In responding to urgent needs, care priorities can be identified; in looking at chronic problems, comprehensive well-being can be maintained.

Resource documents are available that explain the triggers and respective definitions for each CAP or RAP and provide guidelines for care planning:

- interRAI Clinical Assessment Protocols (CAPs)—For Use With Community and Long-Term Care Assessment Instruments (March 2008)
- RAI-MDS 2.0 Resident Assessment Protocols (RAPs)—the original protocols developed for use with the RAI-MDS 2.0.

The CAPs/RAPs provide a structured, problem-oriented framework for organizing RAI-MDS 2.0 information and additional clinically relevant information about a resident's health problems or functional status. What are the problems that require immediate attention? What risk factors are important? Are there issues that might cause you to proceed in an unconventional manner for the CAP/RAP in question? Clinical staff are responsible for answering questions such as these. The information from the RAI-MDS 2.0 assessment form and the decision support algorithms forms the basis for individualized care planning.

The resident's care plan must be evaluated and revised, if appropriate, each time a RAI-MDS 2.0 assessment is completed. Facilities may either make changes on the original care plan or develop a new care plan.

Additional information relevant to a resident's status, but not necessarily included on the RAI-MDS 2.0, may be documented in the resident's clinical record. This documentation should include progress notes or facility specific flow sheets.

Applicability of RAI-MDS 2.0 to Facility Residents

The RAI-MDS 2.0 may be applied to all residents of Canadian continuing care facilities including short-term stay or respite residents.

Given the nature of short-stay or respite admissions, staff members may not have access to all information required to complete some RAI-MDS 2.0 items prior to the resident's discharge (e.g. the physician may not be available, or the family may not be able to provide information on the resident's customary routine). In this case, a partially completed Full Assessment will still provide useful information to support care planning for the resident; however, the partial assessment will not be accepted by the CCRS managed by CIHI.

Types and Timing of RAI-MDS 2.0 Assessments

Although the RAI-MDS 2.0 assessments discussed in the following section must occur at specific times, a facility's obligation to meet each resident's needs through ongoing assessment is not neatly confined to these mandated time frames. Likewise, completion of the RAI-MDS 2.0 in the prescribed time frame does not necessarily fulfil a facility's obligation to perform a comprehensive assessment. Facilities are responsible for assessing areas that are relevant to individual residents regardless of whether these areas are included in the RAI-MDS 2.0.

The RAI-MDS 2.0 process requires completion of the RAI-MDS 2.0 assessment form and review of triggered CAPs/RAPs, followed by development or review of a comprehensive care plan. The comprehensive care plan must be developed/reviewed and documented within 7 days of the RAPs/CAPs review.

The following table summarizes the different types of assessments and other supplementary information developed for those jurisdictions submitting to CCRS.

RAI-MDS 2.0 Assessments

Type of Assessment	Timing of Assessment
Admission Full Assessment (AA8 Reason for Assessment = 01)	Must be completed by the 14th day of resident's stay.[i] Day of admission is counted as day "0". For example, if a resident is admitted on Oct 1, the assessment would be due by Oct 15. That is, the Assessment Reference Date (A3) must be no later than Oct 15.
Full Annual Assessment (AA8 Reason for Assessment = 02)	Must be completed within 366 days of the Assessment Reference Date (A3) of the last full assessment.
Significant Change in Status Full Assessment (AA8 Reason for Assessment = 03)	Must be completed by the 14th day following the determination that a significant change in the resident's status has occurred. For example, if it is determined that a significant change has occurred on Oct 16 (day 0), the assessment would be due by Oct 30. (Refer to the *Resident Assessment Instrument (RAI) RAI-MDS 2.0 User's Manual*, *Canadian Version, February 2012* for change criteria and examples, page 14).
Significant Correction of Prior Full Assessment(AA8 Reason for Assessment = 04)	Should be completed following the determination that a significant correction is required to a Full Assessment.
Quarterly Assessment (AA8 Reason for Assessment = 05)	Is completed every quarter between full assessments, within a maximum of 92 days following the last full or quarterly assessment. For example, if the last assessment was conducted on Oct 30, and if the next assessment due is a quarterly, then it would be due by Jan 30.
Significant Correction of Prior Quarterly Assessment (AA8 Reason for Assessment = 10)	Should be completed following the determination that a significant correction is required to a Quarterly Assessment.

i. For residents staying less than 14 days, the Admission Full Assessment is not mandatory, although it may be submitted if the entire assessment has been completed. For example, for a palliative resident who is in the facility for 3 days, only the Admission/Re-entry and Discharge records would be required for CCRS submission.

Supplementary Resident Information

Type of Record	Timing of Record
Admission/Re-Entry (AA7 Admission Type = 01)	Must be completed for all admissions even if resident is discharged or dies prior to 14th day. Submitted with Admission Full Assessment, if one is completed.
Discharge (AA9 Discharge Type = 06, 07 or 08)	Must be completed at the time when a resident is discharged from the facility.**(including death).**
Admission/Re-Entry (AA7 Admission Type = 09)	May be completed when a resident is discharged from a facility and returns to the same facility **AND** has not missed a scheduled assessment while outside the facility.
Update Record	May be completed at any time, if administrative data elements originally captured on the Admission Background Form (e.g. private pay, bed type or Unit-MIS functional centre account code) have changed.
Special Project Record	May be completed at any time to collect supplemental data (i.e. data not already collected through the RAI-MDS 2.0) that the continuing care facility would like to capture. CIHI will provide specific instructions regarding the collection and submission of information for special projects as they arise.

Full Assessments

Admission Full Assessments

The Admission Full Assessment for a new resident must be completed by the 14th calendar day following admission to the facility if this is the resident's first stay in the facility or if the resident returns to the facility after being discharged and the conditions for re-entry do not apply. The day of admission is counted as day "0" and the 14-day calculation includes weekends. For example, if a resident is admitted on October 1, the Assessment Reference Date (A3) must be no later than October 15.

If a resident dies or is discharged within 14 days of admission, then whatever portions of the RAI-MDS 2.0 that have been completed must be maintained in the resident's health record at the facility.[ii] A partially completed Full Assessment will be rejected by CCRS. In closing the record, the facility may wish to note why the RAI-MDS 2.0 was not completed. RAI-MDS 2.0 items that were not completed prior to the day of death or discharge are left blank.

The interdisciplinary team may start and complete the Admission Full Assessment at any time prior to the end of the 14th day. If desired by the facility, the RAI-MDS 2.0 could be completed on the day of admission. However, this requires the staff to rely on resident and family reporting of information and transfer documentation to a large degree as a source of information on the resident's status during the time periods used to code each RAI-MDS 2.0 item, as opposed to allowing a period for facility observation. Facilities may find early completion of the RAI-MDS 2.0 assessment and CAPs/RAPs particularly beneficial for residents with short lengths of stay, when the assessment and care planning process is often accelerated.

ii. The RAI is considered part of the resident's clinical record and is treated as such by the RAI Utilization Guidelines.

Example

Miss A. is admitted on Friday, September 1. Staff establish the Assessment Reference Date as September 8, which means that September 8 is the final day of the observation period for all RAI-MDS 2.0 items (count back 7 days to determine the period of observation for 7 day items, count back 14 days for 14 day items, and so on). As this is an initial assessment, staff must rely on the resident and family's verbal history and transfer documentation accompanying Miss. A. to complete items requiring longer than a 7 day period of observation. Staff complete the RAI-MDS 2.0 by September 12 (note that the Assessment Reference Date (A3) does not need to be the same as the Date Assessment Coordinator Signed as Complete (R2b). Staff take an additional 3 days to assess the resident using triggered RAPs and to complete all related documentation. Thus, the date field that accompanies the signature of the Assessment Coordinator for the RAP Assessment Process (VB2) indicates September 15.

If a resident is discharged to hospital and returns within the 14 day assessment period and most of the initial assessment was completed prior to the discharge, then the facility may wish to continue with the original assessment, provided the resident did not have a significant change in status. Otherwise a new fully completed Admission/Re-Entry record and an Admission Full Assessment must be completed. The partially completed previous assessment should be stored on the resident's record with a notation that the assessment was reinitiated because the resident was hospitalized.

Good clinical practice dictates that some RAI-MDS 2.0 items be assessed within the first hours after admission although not necessarily documented at that time (e.g. nutritional status and needs). Other RAI-MDS 2.0 items can best be observed with the passage of time (e.g. resident or staff interaction patterns). The needs of the resident will dictate the order and manner in which the interdisciplinary team proceeds throughout the assessment. For example, if a new resident is admitted short of breath and hypotensive, it is imperative to conduct an assessment of the resident's acute cardiorespiratory needs. Likewise, a new resident who is angry with his or her family for admitting him or her to the facility, and is actively grieving over losses, will benefit from an early assessment of Customary Routine, Psychosocial Well-Being, and Depression, Anxiety, and Sad Mood RAI-MDS 2.0 items.

Full Annual Assessments

Full Annual Assessments must be completed within 366 days of the Assessment Reference Date (A3) of the last Full Assessment. The Full Annual Assessment may be initiated at any point prior to the one-year follow-up date. If a Full Assessment is conducted again in the interim because a significant change in status has occurred, the clock "restarts," with the next full assessment due within 366 days of the Significant Change in Status Full Assessment. (Routinely scheduled RAI-MDS 2.0 assessments may be scheduled early if a facility wants to stagger due dates for assessments.

Significant Change in Status Full Assessments

Facilities have an ongoing responsibility to assess resident status and intervene to assist the resident to meet his or her highest practicable level of physical, mental, and psychosocial well-being. If interdisciplinary team members identify a significant change (either improvement or decline) in a resident's condition, they should share this information with the resident's physician, who then may consult about the permanency of change. The facility's medical director may also be consulted when differences of opinion about a resident's status occur among team members.

Document the initial identification of a significant change in terms of the resident's clinical status in the progress notes. Complete a Significant Change in Status Full Assessment as soon as needed to provide appropriate care to the individual, but in no case, later than 14 days of determining a significant change has occurred. Completing this assessment would reset the schedule of assessments.

A "significant change" is defined as a major change in the resident's status that:

- Is not self-limiting;
- Impacts on more than one area of the resident's health status; and
- Requires interdisciplinary review and/or revision of the care plan.

A condition is defined as "self-limiting" when the condition will normally resolve itself without further intervention or by staff implementing standard disease-related clinical interventions. For example, normally a 5% unplanned weight loss would trigger a Full Assessment related to a "Significant Change in Status" (see Guidelines For Determining Change In Resident Status below). However, if a resident had the flu and experienced nausea and diarrhea for a week, a 5% weight loss may be an expected outcome. In this situation, staff should monitor the resident's status and attempt various interventions to rectify the immediate weight loss. If the resident did not become dehydrated and started to regain weight after the symptoms subsided, a Significant Change in Status Full Assessment would not be required. The amount of time that would be appropriate for a facility to monitor a resident depends on the clinical situation and severity of symptoms experienced by the resident. Generally, if the condition has not resolved within approximately 2 weeks, staff should begin a comprehensive RAI-MDS 2.0 assessment. This time frame is not meant to be prescriptive, but rather should be driven by clinical judgment and the resident's needs.

Other conditions may not be permanent but would have such an impact on the resident's overall status that they would require a Full Assessment and care plan revision. For example, a hip fracture may be viewed as a transient condition but it would generally have a major impact on the resident's functional status in more than one area (e.g. ambulation, toileting, elimination patterns, activity patterns). Changes in the resident's condition that would affect the resident's functional capacity and day-to-day routine should be investigated in a holistic manner through Significant Change in Status Full Assessment. Therefore, concepts associated with significant change are "major" or "appears to be permanent" but a change does not need to be both major and permanent.

A Significant Change in Status Full Assessment is appropriate if there is a consistent pattern of changes, with either two or more areas of decline, or two or more areas of improvement. This may include two changes within a particular domain (e.g. two areas of ADL decline or improvement). Any determination about whether a resident has experienced a significant change in status is a clinical decision.

Guidelines for Determining Significant Change in Resident Status

(Please note this is not an exhaustive list.)

Decline in two or more of the following:

- Resident's decision-making changes from 0 or 1 to 2 or 3 for item B4;
- Emergence of sad or anxious mood pattern as a problem that is not easily altered (item E2);
- Increase in the number of areas where Behavioural Symptoms are coded as "not easily altered" (i.e. an increase in the number of code "1"s for item E4B;
- Any decline in an ADL physical functioning area where a resident is newly coded as 3 (Extensive assistance), 4 (Total dependence) or 8 (Activity did not occur) for item G1A;
- Resident's continence pattern changes from 0 or 1 to 2, 3 or 4 (items H1a or H1b), or there was placement of an indwelling catheter (item H3d);
- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days) for item K3a;
- Emergence of a pressure ulcer at Stage II or higher, when no ulcers were previously present at Stage II or higher (item M2a);
- Resident begins to use trunk restraint or a chair that prevents rising when it was not used before (items P4c and P4e);
- Overall deterioration of resident's condition; resident receives more support (e.g. in ADLs or decision-making); item Q2 is coded as 2; and
- Emergence of a condition or disease in which a resident is judged to be unstable (item J5a).

Example

Mr. T. no longer responds to verbal requests to alter his screaming behaviour. It now occurs daily and has neither lessened on its own nor responded to treatment. He is also starting to resist his daily care, pushing staff away from him as they attempt to assist with his ADLs. This is a significant change and a Full Assessment is required since there has been a deterioration in the behavioural symptoms to the point where it is occurring daily and new approaches are needed to alter the behaviour. Mr. T.'s behavioural symptoms could have many causes, and reassessment using Significant Change in Status Full Assessment will provide an opportunity for staff to consider illness, medication reactions, environmental stress, and other possible sources of Mr. T.'s disruptive behaviour.

Improvement in two or more of the following:

- Any improvement in an ADL physical functioning area where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8 (items G1A);
- Decrease in the number of areas where Behavioural Symptoms or Mood Persistence are coded as "not easily altered" (items E2 and E4);
- Resident's decision-making changes from 2 or 3 to 0 or 1 (item B4);
- Resident's continence pattern changes from 2, 3, or 4 to 0 or 1 (items H1a or H1b);
- Overall improvement of resident's condition; resident receives fewer supports (item Q2 coded as 1).

Example

Mrs. G. has been in the facility for 5 weeks, following an 8-week acute hospitalization. On admission she was very frail, had trouble thinking, was confused and had many behavioural complications. The course of treatment led to steady improvement and she is now stable. She is no longer confused or agitated. All concerned—the resident, her family, and staff—agree that she has made remarkable progress. A reassessment using Significant Change in Status Full Assessment is required at this time. The resident is not the person she was at admission; her initial problems have resolved. Reassessment will permit the interdisciplinary team to review her needs and plan a new course of care for the future.

While a facility may choose to perform more frequent Full Assessments than required for submission to the CCRS, assessments are not required for minor or temporary variations in resident status. However, staff must note these transient changes in the resident's status in the resident's clinical record and implement necessary clinical interventions, even though a reassessment using Significant Change in Status Full Assessment is not required. In these cases the resident's condition is expected to return to baseline within a short period of time, such as 1–2 weeks.

Guidelines for When a Change in Resident Status is not Significant

(Please note this is not an exhaustive list.)

- Discrete and easily reversible cause(s) documented in the resident's record and for which the interdisciplinary team can initiate corrective action (e.g. an anticipated side effect of introducing a psychoactive medication while attempting to establish a clinically effective dose level). Tapering and monitoring of dosage would not require a Significant Change in Status Full Assessment.
- Short-term acute illness such as a mild fever secondary to a cold from which the interdisciplinary team expects the resident to fully recover.

- Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (e.g. depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate a Significant Change in Status Full Assessment).
- Instances in which the resident continues to make steady progress under the current course of care. A reassessment using Significant Change in Status Full Assessment is required only when the condition has stabilized.
- Instances in which the resident has stabilized but is expected to be discharged in the immediate future. The facility has engaged in discharge planning with the resident and family, and a Full Assessment is not necessary to facilitate discharge planning.
- In an end-stage disease status, a Significant Change in Status Assessment is optional, depending on a clinical determination of whether the resident would benefit from it. The facility is still responsible for providing necessary care and services to assist the resident to achieve his or her highest practicable well-being. However, provided that the facility identifies and responds to problems and needs associated with the terminal condition, a Significant Change in Status Assessment is not necessarily indicated.

Examples

- Mr. M. has been in this facility for two and a half years. He has been a favourite of staff and other residents and his daughter has been an active volunteer on the unit. Mr. M. is now in the end stage of his course of chronic dementia—diagnosed as probable Alzheimer's. He experiences recurrent pneumonias and swallowing difficulties, his prognosis is guarded, and family are fully aware of his status. He is on a special dementia unit, staff have detailed palliative care protocols for all such end stage residents, and there has been active involvement of his daughter in the care planning process. As changes have occurred, staff have responded in a timely, appropriate manner. In this case, Mr. M.'s care is of a high quality. Even though his physical state has declined, there is no need for staff to complete a new RAI-MDS 2.0 assessment for this bedbound, highly dependent terminal resident.
- Mrs. K. came into the facility with identifiable problems and has steadily responded to treatment. Her condition has improved over time and plateaued. She will be discharged within 5 days. The initial RAI-MDS 2.0 helped to set goals and start care interventions. Care was modified as necessary to ensure continued improvement. The interdisciplinary team's treatment response reversed the causes of the resident's condition. A Significant Change in Status assessment need not be completed in view of the imminent discharge. Remember, facilities have 14 days to complete a Significant Change in Status assessment once the resident's condition has stabilized, and if Mrs. K. is discharged within this period, a new assessment is not required. If the resident's discharge plans change or if she is not discharged, a Significant Change in Status assessment is required by the end of the allotted 14-day period.

Examples (cont'd)

- Mrs. P. has also responded to care. Unlike Mrs. K., however, she continues to improve. Her discharge date has not been specified. She is benefiting from her care and full restoration of her functional abilities seems possible. In this case, treatment is focused appropriately, progress is being made, staff are on top of the situation, and there is nothing to be gained by requiring an RAI-MDS 2.0 assessment at this time. However, if her condition was to stabilize and her discharge was not imminent, a reassessment using a Significant Change in Status Full Assessment would be in order.
- Mr. M. has been in this facility for two and a half years. He has been a favourite of staff and other residents and his daughter has been an active volunteer on the unit. Mr. M. is now in the end stage of his course of chronic dementia—diagnosed as probable Alzheimer's. He experiences recurrent pneumonias and swallowing difficulties, his prognosis is guarded, and family are fully aware of his status. He is on a special dementia unit, staff have detailed palliative care protocols for all such end stage residents, and there has been active involvement of his daughter in the care planning process. As changes have occurred, staff have responded in a timely, appropriate manner. In this case, Mr. M.'s care is of a high quality. Even though his physical state has declined, there is no need for staff to complete a new RAI-MDS 2.0 assessment for this bedbound, highly dependent terminal resident.
- Mrs. K. came into the facility with identifiable problems and has steadily responded to treatment. Her condition has improved over time and plateaued. She will be discharged within 5 days. The initial RAI-MDS 2.0 helped to set goals and start care interventions. Care was modified as necessary to ensure continued improvement. The interdisciplinary team's treatment response reversed the causes of the resident's condition. A Significant Change in Status assessment need not be completed in view of the imminent discharge. Remember, facilities have 14 days to complete a Significant Change in Status assessment once the resident's condition has stabilized, and if Mrs. K. is discharged within this period, a new assessment is not required. If the resident's discharge plans change or if she is not discharged, a Significant Change in Status assessment is required by the end of the allotted 14-day period.
- Mrs. P. has also responded to care. Unlike Mrs. K., however, she continues to improve. Her discharge date has not been specified. She is benefiting from her care and full restoration of her functional abilities seems possible. In this case, treatment is focused appropriately, progress is being made, staff are on top of the situation, and there is nothing to be gained by requiring an RAI-MDS 2.0 assessment at this time. However, if her condition was to stabilize and her discharge was not imminent, a reassessment using a Significant Change in Status Full Assessment would be in order.

Significant Correction of Prior Full Assessment

Please refer to the section "Completing the RAI-MDS 2.0 Form—Coding and Corrections of Errors" (page 26).

Quarterly Assessments

The Quarterly Assessment is used to track the resident's status between full assessments, and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. The Quarterly Assessment must be completed on a quarterly basis between full assessments and within 92 days following the last Full or Quarterly assessment. Although a review of key items is required in each 92-day period, facilities may vary or stagger their schedules (e.g. a facility may choose to review all residents in February, May, August and November, while another facility may choose to stagger their quarterly assessments for residents by reviewing some in January, others in February and the remainder in March, with the first group reviewed again in April).

Examples

- Mrs. P. had her Admission Full Assessment on Oct 30.Her next quarterly assessment would be due by Jan 30.
- Mr. D. had his last quarterly assessment on March 31 and his next assessment is a quarterly assessment, which is due by June 30. Although there is only 91 days between the two assessments, the maximum of 92 days would have meant the next assessment would have fallen on July 1, which would result in Mr. D. having no assessment in the April to June fiscal quarter. As Mr. D must have an assessment each quarter, the assessment is due on the last day of the April to June quarter.

Based on the Quarterly Assessment, the resident's care plan is revised if necessary. The Quarterly Assessment form, found in Chapter 3, lists those items from the Full Assessment form that must be completed every quarter.

Significant Correction of Prior Quarterly Assessment

Please refer to the section "Completing the RAI-MDS 2.0 Form—Coding and Corrections of Errors" (page 26).

Supplementary Resident Information

Admission

The Admission/Re-Entry record must be fully completed for each resident upon admission (AA7 = 01 for Admission). The Admission Full Assessment, when completed, should be submitted with the Admission/Re-Entry record.

This information is also required when a resident re-enters the facility following discharge and the conditions for re-entry are not met.

Discharge

The Discharge record is required whenever a resident dies or is discharged from the facility. This is the only record that must be completed at the time of any discharge or death.

If the resident died or was discharged within 14 days of admission **and** the entire Admission Full Assessment was completed before the resident died or was discharged, the submission to CIHI should include: Admission/Re-Entry, Admission Full Assessment and Discharge records.

Re-Entry

A resident can be readmitted following a previous discharge by completing the re-entry items in the Admission/Re-Entry record (AA7 = 09 for Re-entry), if the following conditions are met:

- An assessment from the original schedule of assessments has not been missed when the resident was outside the facility;
- There is a previous Discharge record for the same Unique Registration Identifier (URI); and
- The element R3a for the Discharge record was not coded as “11” for Deceased.

If the above conditions are met, this is the only record required at the time of re-entry to the facility.

The following is the only condition when other forms must accompany a re-entry:

- A significant change in the resident’s status has occurred according to the significant change guidelines (see page 15). In this case, a Significant Change in Status Full Assessment must be submitted with the Re-Entry Form. Again, it is very important that the Reason For Assessment (Element AA8) on each record is accurately coded.

Update Record

Several administrative items (e.g. private pay status, bed type or MIS functional centre) may change during the resident’s stay. The Update Record provides a mechanism to submit the updated information to CIHI.

Special Projects

The Special Project Record is designed to collect supplemental data required to meet the needs of CIHI, the provinces/territories, regional health authorities or heath care facilities.

CIHI will provide specific instructions regarding the collection and submission of information for special projects as they arise.

Completion of the RAI-MDS 2.0 Assessment

Participants in the Assessment Process

The RAI-MDS 2.0 assessment must be conducted or coordinated with the appropriate participation of health professionals. Although not required, completion of the RAI-MDS 2.0 is best accomplished by an interdisciplinary team that includes facility staff with varied clinical backgrounds. Such a team brings their combined experience and knowledge together for a better understanding of the strengths, needs and preferences of each resident to ensure the best possible quality of care and quality of life. In general, participation by all relevant interdisciplinary team members will encourage more active and appropriate assessment and care planning processes.

Facilities have flexibility in determining who should participate in the assessment process as long as it is accurately conducted. A facility may assign responsibility for completing the RAI-MDS 2.0 to a number of qualified staff members. In most cases, participants in the assessment process are regulated health professionals, such as nurses, social workers, therapists. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment. If there are several members of the interdisciplinary team participating in the assessment process, one team member must be assigned as the Assessment Coordinator who will take overall responsibility for the assessment, coordinate the input from the other team members, and will sign and certify the completion of the assessment. If only one person is responsible for the assessment, he or she will automatically be the Assessment Coordinator.

The attending physician is also an important participant in the RAI-MDS 2.0 process. The facility needs the physician's evaluation and orders for the resident's immediate care as well as for a variety of treatments and laboratory tests. Furthermore, the attending physician may provide valuable input on sections of the RAI-MDS 2.0 and CAPs/RAPs and is a member of the mandated interdisciplinary team that prepares the resident's comprehensive care plan.

While some aspects of the assessment process are dictated by regulation, much flexibility remains for facilities to determine how to integrate the RAI-MDS 2.0 into their day-to-day operations. For example, facilities should develop their own policies and procedures to accomplish the following:

- Train facility staff on the circumstances that require a comprehensive assessment and the staff that should be involved.
- Assign responsibility for completing sections of the RAI-MDS 2.0 to staff who have clinical knowledge about the resident, such as staff nurses, attending physicians, social workers, physical, occupational, speech, or recreation therapists, dieticians and pharmacists.
- Assure that residents and their families are actively involved in the information sharing and decision-making processes.

- Assure that the insights of all non-regulated persons who regularly provide direct care to the resident (e.g. nursing assistants, activity aides, volunteers) are included in the assessment process.
- Assure that key clinical personnel on all shifts (including nursing assistants) are knowledgeable about the information found in the resident's most current assessment and report changes in the resident's status that may affect the need to perform a Significant Change in Status Full Assessment.
- Instruct staff on how to integrate RAI-MDS 2.0 information with existing facility resident assessment and care planning practices.

Certification of Accuracy and Completeness

To certify accuracy, each interdisciplinary team member who completes a portion of the RAI-MDS 2.0 assessment signs, dates, and indicates the portion of the assessment he or she completed. The Assessment Coordinator is required to sign to certify that the RAI-MDS 2.0 is complete. The Assessment Coordinator must not sign and attest to completion of the assessment until all other individual team members participating in the assessment have finished their portions of the RAI-MDS 2.0. If only one person does all of the RAI-MDS 2.0, then he or she alone would sign and be responsible for certifying accuracy and completeness.

In facilities using the RAPs, the Assessment Coordinator must also sign the RAP Summary form to signify completion of the RAI-MDS 2.0. For the Admission Full Assessment, the Assessment Coordinator must sign and date the RAP Summary form within 14 days of the resident's admission to the facility. There is no requirement that each individual team member completing a RAP sign and date the RAP Summary form to certify its accuracy. It is assumed that other team members' documentation for a RAP will be signed wherever it appears in the clinical record. However, if desired, individual team members may indicate which RAP(s) they completed, list their credentials, and the date it was completed by signing the form wherever there is room to do so in a legible manner. In facilities using the CAPs, the Assessment Coordinator must ensure that the triggered CAPs are reviewed within 7 days of the Assessment Reference Date, followed by the development or review of the comprehensive care plan. For both RAPs and CAPs, the care plan information must be developed and implemented within 7 days of completion of the CAPs/RAPs review process.

It is never permissible to certify RAI-MDS 2.0 forms for another individual on the interdisciplinary team or to backdate the assessment. If an individual who completed a portion of the RAI-MDS 2.0 is not available to sign it, then another team member should review the information and sign the form. Facilities should establish a policy regarding accountability for the RAI-MDS 2.0 when these situations occur.

Reproduction of the RAI-MDS 2.0 in the Resident's Record and Maintenance of the RAI-MDS 2.0

The RAI-MDS 2.0 is considered to be part of the resident's health record. Therefore, facilities are required to follow all jurisdictional legislation, policies and guidelines and their own facility business processes regarding the retention, privacy, confidentiality and security of RAI-MSD 2.0/CCRS information in the resident's active clinical record, whether paper or electronic. **This includes all Assessment Forms, RAP Summary forms and other tracking and supplementary CCRS forms, as required.**

Sources of Information for Completion of the RAI-MDS 2.0

The process for performing an accurate and comprehensive assessment requires that information about residents be gathered from multiple sources. It is the role of the individual interdisciplinary team members completing the assessment to validate the information obtained from the resident, resident's family, or other health care team members through observation, interviewing, reviewing lab results, and so forth to ensure accuracy. Similarly, information in the resident's record is validated by interacting with the resident and direct care staff.

The following sources of information must be used in completing the RAI-MDS 2.0. Although not required, the review sequence for the assessment process generally follows the order below:

- **Review of the resident's record.** Depending on whether the assessment is an admission or follow-up assessment, the review could include: readmission, admission or transfer notes; current plan of care; recent physician notes or orders; documentation of services currently provided; results of recent diagnostic or other test procedures; monthly nursing summary notes and medical consultations for the previous 60 day period; and a record of medications administered for the prior 90 day period.
- Communication with and observation of the resident.
- **Communication with direct-care staff** (e.g. nursing assistants, activity aides) from all shifts.
- **Communication with regulated professionals** (from all disciplines) who have recently observed, evaluated, or treated the resident. Communication can be based on discussion or licensed staff can be asked to document their impressions of the resident.
- Communication with the resident's physician.
- **Communication with the resident's family.** Not all residents will have family. For some residents, family members may be unavailable or the resident may request that you not contact them. Where the family is not involved, someone else may be very close to the resident, and the resident may wish that this person be contacted.

Review of the Resident's Record

The resident's record provides a starting point in the assessment process to review information about the resident in written staff notes across all shifts over multiple days. Starting with the resident's record, however, does not indicate that it is the most critical source of information, but only a convenient source.

At admission, record review includes an examination of notes written in the first 2 weeks (assuming the full 14 day period is used to complete the assessment), documentation that came with the resident at admission, facility intake forms (e.g. social service notes), and any readmission test results including copies of the RAI-MDS 2.0 and CAPs/RAPs from another facility if the resident was transferred. Obviously, transcribing the previous facility's RAI-MDS 2.0 is inappropriate.

Subsequent reassessments should focus on recorded information from earlier RAI-MDS 2.0 Full Assessments and Quarterly Assessments, written information from the previous 92-day period, and notes made during the prior 30-day period.

The following are important considerations when reviewing the resident's record:

- Review the information documented in the record, keeping in mind the required RAI-MDS 2.0 definitions. Make sure that assumptions based on the record are compatible with RAI-MDS 2.0 definitions (e.g. resident self-performance is evaluated with appliances if used, such as locomotion with a walker; similarly, according to the RAI-MDS 2.0, a resident, who stays "dry" with a catheter may be considered continent).
- Make sure that the information taken from the record covers the same observation period as that specified by the RAI-MDS 2.0 items. The RAI-MDS 2.0 refers to specific time frames for each item; for example, ADL status is based on resident performance over a 7-day period. To ensure uniformity, the RAI-MDS 2.0 has an Assessment Reference Date (A3) that establishes a common reference end-point for all items. Consequently, it is necessary to pay careful attention to the notes regarding time frames for each section of the RAI-MDS 2.0 and also to the item-by-item instructions in Chapter 2.
- Be aware of discrepancies and view the record information as preliminary only. Clarify and validate all such information during the assessment process. Be alert to information in the record that is not consistent with verbal information or physical assessment findings. Discuss discrepancies with other interdisciplinary team members (e.g. nurses, social workers, therapists). The extent to which the record can be relied upon for information will depend on the comprehensiveness of the record system. Note what information the record usually contains (e.g. current service notes, care plans, flow sheets, medication sheets), where different types of information are maintained in the clinical record, and more importantly, what information is missing.

- Where information in the record is sufficiently detailed and conforms to RAI-MDS 2.0 descriptions and time periods, complete the RAI-MDS 2.0 items. A few RAI-MDS 2.0 items can be completed in full from information found in the record. Comprehensive and accurate assessment of most items, however, requires information from other sources (i.e. the resident, the resident's family, and facility staff). Where information is incomplete or contradictory, make a note of the issues in question. This note can help plan contacts with the resident, facility staff and resident's family. There is no requirement that such a note be maintained as part of the resident's permanent record; it is a work tool only.
- As you observe, talk with, and discuss the resident with other staff members, verify the accuracy of what you learned from reviewing the record.

Communication With and Observation of the Resident

The resident is a primary source of information and may be the only source of information for many items (e.g. customary routine, activity preferences, vision, hearing, identification with past roles, and, in some instances, problem conditions). Many RAI-MDS 2.0 items will not be documented elsewhere in the clinical record, and the completed RAI-MDS 2.0 may ultimately be the single source of documentation about these issues.

Become familiar with the RAI-MDS 2.0 items to make communication and observation of the resident an ongoing everyday activity in the facility. For example, a registered nurse can observe and interact with a resident when medications are given, during meals, or when the resident comes to ask a question. Interaction with the resident may be a crucial factor in confirming staff judgments of resident problems. Weigh what the resident says, and what is observed about the resident against other information obtained from the resident record and facility staff.

To be most efficient, organize a framework for how to interview and observe the resident. Allow flexibility to accommodate the resident. Carefully listen and observe the resident to get guidance as to how to pursue the necessary information gathering. Try to interact with the resident, even if the resident may have difficulty responding. The degree and character of the difficulty in responding, as well as nonverbal responses (e.g. fearfulness) provide important information. Sensitive staff judgment is necessary in gathering information. (See the end of this chapter for further information on "Interviewing Techniques".)

Communication With Direct Care Staff

Direct care staff (e.g. nursing assistants, personal support workers, activity aides) have daily, intimate contact with residents and are often the most reliable source of information about the resident. Direct care staff talk with and listen to the resident. They observe and assist the resident's performance of ADLs and involvement in activities. They observe the resident's physical, cognitive and psychosocial status daily during all shifts, seven days a week. Key considerations when communicating with direct care staff include:

- Be sure to speak with a person who has first-hand knowledge of the resident. Plan for sufficient time to talk with direct care staff person(s).

- Start by asking about the resident's performance on ADLs and activities. What can the resident do without assistance? What do staff members do for the resident? What might the resident be able to do that he or she is not doing now? Continue by asking about communication and memory skills, body control, activity preferences, and the presence of mood or other behavioural symptoms.
- Talk with direct care staff across all shifts, if possible. The information from other shifts may be obtained in other ways as well (e.g. from change-of-shift reports if direct care staff comments are included).

Communication With Regulated Professionals

Licensed practical nurses (LPNs), registered nurses (RNs), social workers, occupational therapists, physical therapists, speech therapists, pharmacists, recreation therapists and other professionals who have observed, evaluated, or treated the resident should be interviewed about their knowledge of resident capabilities, performance patterns and problems. Their special expertise will enhance the accuracy and comprehensiveness of the resident assessment.

Communication With the Resident's Physician

The physician's role is central to the overall management and outcome of resident care. The RAI-MDS 2.0 assessment process should include a review of the physician's examination of the resident, plan of care, hospital discharge plan, goals of care, and medication and treatment orders.

At the Quarterly Assessments and Annual Assessments, review the most recent physician orders and notes. Also, review the RAI-MDS 2.0 with the resident's attending physician to share and validate pertinent information. If there is difficulty obtaining information or input for the assessment from the attending physician (or transferring institution), the facility's medical director should be asked to intervene.

Communication With the Resident's Family

The resident's family (or person closest to the resident) can be a valuable source of information about the resident's health history, history of strengths and problems in various functional areas, and customary routine prior to first facility admission. Using this source obviously depends on the presence of family members, their willingness to participate, and the resident's preferences. In most instances, family will not be the sole source of information but will supplement information from other sources. The RAI-MDS 2.0 assessment process provides an excellent opportunity for caregivers to develop trusting, working relationships with the resident and family.

Utilizing appropriate information gathered from all of the areas discussed above, the individual completing the assessment is required to make a best judgment about each item in each section of the RAI-MDS 2.0 form. The RAI-MDS 2.0 is part of the medical record and should always be typed or prepared in ink.

Completing the RAI-MDS 2.0 Form—Coding and Corrections of Errors

RAI-MDS 2.0 Coding Conventions

The following specifies the coding conventions to be used when completing the RAI-MDS 2.0 form:

- **Each section of the RAI-MDS 2.0 contains one or more items labelled sequentially.** For instance, the third item in Section B (Memory/Recall Ability) is labelled "B3"; the second item in Section E (Mood Persistence) is labelled "E2".
- **Use the following coding conventions to enter information on the RAI-MDS 2.0 form.** Note: if the assessment is completed electronically, the functionality of the software may differ slightly from what is listed**.**
  - Use a check mark for white boxes with lower case letters, if specified condition is met; otherwise these boxes remain blank (e.g. N4a-m General Activity Preferences).
  - Use a numeric response (a number or pre-assigned value) for blank white boxes (e.g. H1a Bowel Continence).
  - Darkly shaded areas remain blank; they are on the form to set off boxes visually.
- **The convention of entering "0":** In assigning values for items that have an ordered set of responses (e.g. from independent to dependent), zero ("0") is used universally to indicate the lack of a problem or that the resident is self-sufficient. For example, a resident whose ADL codes are almost all coded "0" is a self-sufficient resident; the resident whose ADLs have no "0" codes indicates a resident that receives help from others.
- USE PRINTED CAPITAL LETTERS to respond to items that require an open-ended response. Print legibly.
- **Dates**—Where recording month, day, and year, enter two digits for the month and the day, but four digits for the year. For example, the third day of January in the year 2010 is recorded as:

2	0	1	0
Year			

0	1
Month	

0	3
Day	

- **NONE OF ABOVE** is a response item to several items (e.g. I2n Infections). Check this item where none of the responses apply; it should not be used to signify lack of information about the item.
- **"Skip" Patterns**—There are a few instances where scoring on one item will govern how scoring is completed for one or more additional items. The instructions direct the assessor to "skip" over the next item (or several items) and go on to another (e.g. B1, Comatose, directs the assessor to "skip" to Section G if B1 is answered "1"—"Yes". The intervening items from B2–F3 would not be scored. If B1 was recorded as "0"—"No", then the assessor would continue with item B2). A useful technique for visually checking the proper use of the "skip" pattern instructions is to circle the "skip" instructions before going to the next appropriate item. In electronic versions of the assessment, the skipping of any sections that are not applicable may happen automatically.

- **The "8" code is** for use in Section G, Physical Functioning and Structural Problems only. The use of this code is limited to situations where the ADL activity was not performed and therefore an objective assessment of the resident's performance is not possible. When the "8" code is entered for self-performance, it should also be entered for support.

Correction of Errors

Facilities may not "change" a previously completed RAI-MDS 2.0 form as the resident's status changes during the course of the facility stay. Minor changes in the resident's status should be noted in the resident's record (e.g. in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is a part of the facility's responsibility to provide necessary care and services. Completion of a new RAI-MDS 2.0 to reflect changes in the resident's status is not required unless the resident has had a significant change in status (See page 14 for information on Significant Change in Status Full Assessments).

The following procedures apply to the correction of errors in either paper or electronic RAI-MDS 2.0 systems:

Facilities should "close" the RAI-MDS 2.0 within regulatory time frames (i.e. within 14 days after admission, etc.). This is done by having the Assessment Coordinator sign and date the RAI-MDS 2.0 Section R. Amendments may be made to any items during the next 7-day period, provided that the same Assessment Reference Date is used (A3) and there is a record of the date and time of change and the person making the change. Note: in many electronic versions of the assessment, the software "locks" the assessment and does not allow any changes after this 7-day period.

If the assessment is completed on paper:

- Revisions can be made to the paper copy by drawing a line through the previous response without obliterating it, entering the correct response, and initialling and dating the corrected entry. This procedure is similar to how any other entry in the medical record is corrected.
- The assessment data also needs to be captured in electronic format to be submitted to CIHI.

After completing the assessment, the facility has the next 7 days to encode the RAI-MDS 2.0 data in a computerized file, and to ensure that all RAI-MDS 2.0 items pass CIHI edits.

- **Encoding process**: The facility is responsible for verifying that all responses in the computer file match the responses on the paper form. Any discrepancies must be corrected in the computer file during this 7 day period.

- **Editing process:** The facility is responsible for running encoded RAI-MDS 2.0 data against CIHI specific edits (which all software vendors are responsible for building into RAI-MDS 2.0 computer systems). For each RAI-MDS 2.0 item, the response must be within the required range and also be consistent with other item responses. During this 7-day period, the facility may "correct" item responses in order to meet edits. An assessment is considered complete only if 100% of the required edits are passed. For "corrected" items, the facility must use the same "period of observation" as that used for the original item completion (i.e. the same Assessment Reference Date—A3). Any corrections must be accurately reflected in both the electronic and paper copies of the RAI-MDS 2.0 (i.e. the paper version of the RAI-MDS 2.0 must also be corrected, as described above).

RAI-MDS 2.0 assessments that are completed electronically must all pass all CIHI edits. In many cases, these edit checks are performed by the software during the assessment process itself and do not require a separate editing process. As with the paper versions, the facility has 7 days after the completion of assessment to ensure that the assessment passes all the required edits. Whether completed originally on paper or electronically individual RAI-MDS 2.0 records must pass 100% of the edits for the record to be accepted in the CIHI system.

After the 7 day encoding/editing period, the record cannot be changed by the facility. After this time, and in particular after the RAI-MDS 2.0 record has been submitted to CIHI, the facility may come to realize that items in this "locked" assessment (paper or electronic versions) are in error. The facility may come to such knowledge on its own or it may have been notified by CIHI that the assessment record failed edits. In any event, the record is "locked" and cannot be changed. The facility then has the following options:

- Complete a Significant Change in Status Full Assessment if a significant change has actually occurred in the resident's clinical status according to the significant change guidelines in this manual (page 14).
- Complete a Significant Correction of Prior Full or Quarterly Assessment, whichever applicable, if a significant change in status has not occurred clinically but erroneous data in a prior Full or Quarterly Assessment warrants a correction.

CAPs/RAPs

After completing the RAI-MDS 2.0 assessment form, the assessor(s) then proceed to further identify and evaluate the resident's strengths, problems, and needs through use of the care planning protocols and through further investigation of any resident-specific issues not addressed in the RAI-MDS 2.0.

The CAPs/RAPs should provide facility staff with information to better understand the underlying cause of a problem. Often staff may be aware that a problem, warranting care planning, exists before reviewing the CAP/RAP Guidelines for a triggered condition. The Guidelines should help staff to identify the factors that have caused the resident's problem and provide direction as to what additional information is needed about the resident's problem.

For facilities using the RAPs, after reviewing triggered RAPs, the RAP Summary form is used to document decisions about care planning and to specify where key information from the assessment for triggered RAP conditions is noted in the record.

Linkage of RAI-MDS 2.0 to the Care Plan

For an Admission Full Assessment, the resident enters the facility with a set of physician-based treatment orders. Facility staff typically review these orders. Questions may be raised, modifications discussed, and change orders issued. Ultimately, of course, it is the attending physician who is responsible for the orders at admission, around which significant segments of the care plan are constructed.

On the first day, facility staff also begin to assess the resident and to identify problems. Both activities provide the core of the RAI-MDS 2.0 and CAP/RAP process, as staff look at issues of safety, nourishment, medications, ADL needs, continence, psychosocial status and so forth. Facility staff determine whether there are problems that require immediate intervention (e.g. providing supplemental nourishment to reverse weight loss or attending to a resident's sense of loss at entering the facility). For each problem, facility staff will focus on causal factors and implement an initial plan of care based on their understanding of factors affecting the resident.

The RAI-MDS 2.0 and CAPs/RAPs provide the clinician with additional information to assist in this preliminary care planning process. The RAI-MDS 2.0 ensures that staff have timely access to a wide range of assessment data. The CAPs/RAPs provide criteria that trigger review of possible problem conditions to ensure that staff identify problems in a consistent and systematic manner. Use of the CAP/RAP Guidelines helps ensure that the full range of relevant causal factors is considered.

If the admission RAI-MDS 2.0 is not completed until the last date possible (i.e. at the end of calendar day 14 of the residency period), interventions will already have been implemented to address priority problems. Many of the appropriate CAP/RAP problems will have been identified, causes will have been considered, and a preliminary care plan initiated. However, the final written care plan is not required until 7 days after the RAI-MDS 2.0 assessment is completed.

For triggered problems that have already resulted in a care plan intervention, the final CAP/RAP review will ensure that all causal factors have been considered. For CAP/RAP conditions for which facility staff have not yet initiated a care program, the CAP/RAP review will focus on whether these conditions are, in fact, problems that require facility intervention. For any triggered problem, staff will apply the CAP/RAP Guidelines to evaluate the resident's status and determine whether a situation exists that warrants care planning. If it does, the CAP/RAP Guidelines will next be used to help identify the factors that should be considered for developing the care plan.

For an Annual Assessment or a Significant Change in Status Full Assessment, the process is basically the same as that described for newly admitted residents. In these cases, however, the care plan will already be in place, and staff are unlikely to be actively instituting a new approach to care as they simultaneously complete the assessment form. Here, review of the CAPs/RAPs when the RAI-MDS 2.0 is complete will raise questions about the need to modify or continue services. The condition that originally triggered the CAP/RAP may no longer be present because it was resolved, or consideration of alternative causal factors may be necessary because the initial approach to a problem did not work, or was not fully implemented.

Care Plan Completion

RAPS

For facilities using the RAPs, after reviewing triggered RAPs, the RAP Summary form is used to document decisions about care planning and to specify where key information from the assessment for triggered RAP conditions is noted in the record. Facilities have 7 days after the completion of the RAI-MDS 2.0 assessment to develop or revise the resident's care plan. If RAPs are still in use in your organization, the Assessment Coordinator signs and dates the RAP Summary form after all triggered RAPs have been reviewed to certify completion of the Full Assessment. Facilities should use this date to determine the date by which the care plan must be completed.

CAPs

The goal of the clinical team is to use the information in the CAP Guidelines to develop a plan of care. The RAP Summary form, including the requirement to document the "Location and Date" of information related to the RAP assessment, has been discontinued with the new CAPs. Rather, it is expected that facilities use clinically appropriate decision-making processes and documentation standards for care planning. When a CAP is triggered, the clinical team can use the guidelines in the assessment protocol help think through underlying issues related to the problem area and move toward a care plan that resolves the problem, reduces the risk of decline, or increases the potential for improvement.

The 7-day requirement for completion or modification of the care plan applies to the Admission, Significant Change in Status, or Annual Full Assessment. A new care plan does not need to be developed after each Significant Change in Status or Full assessment. Rather, the facility may revise an existing care plan using the results of the latest comprehensive assessment. Facilities should also evaluate the appropriateness of the care plan after each quarterly assessment and modify the care plan if necessary.

Becoming Familiar With the RAI-MDS 2.0

Use this manual alongside the RAI-MDS 2.0 form, keeping the form in front of you at all times. The RAI-MDS 2.0 forms itself contains a wealth of information. Learn to rely on it for many of the definitions and procedural instructions necessary for good assessment. The amplifying information in this chapter should facilitate successful use of the RAI-MDS 2.0 forms. The items from the RAI-MDS 2.0 forms are presented in a sequential basis in Chapter 2. Where items are presented on a form other than the full RAI-MDS 2.0 assessment form, this fact is noted in the text.

The following section summarizes the recommended approach to assist you in becoming familiar with RAI-MDS 2.0. The initial time investment in this multi-step review process will have a major payback.

This manual will serve as an up-to-date reference for use with the Canadian version of the RAI-MDS 2.0, which can be used on an ongoing basis to increase and maintain the accuracy of your assessments.

Recommended Approach for Becoming Familiar With the RAI-MDS 2.0

A. First, review the RAI-MDS 2.0 form itself.

- Notice how sections are organized and where information is to be recorded.
- Work through one section at a time.
- Examine item definitions and response categories.
- Review procedural instructions, time frames, and general coding conventions.
- Are the definitions and instructions clear? Do they differ from current practice at your facility? What areas require further clarification?
- Complete the RAI-MDS 2.0 assessment for a resident at your facility. For this practice assessment, draw only on your knowledge of this individual. Enter the appropriate codes on the RAI-MDS 2.0 form. Where your review could benefit from additional information, make note of that fact. Where might you secure additional information?

B. Complete the initial pass through Chapter 2.

- Go on to this step only after first reviewing the RAI-MDS 2.0 form and trying to complete all items for a resident who is well known to you.
- As you read this chapter, clarify questions that arose as you used the RAI-MDS 2.0 for the first time to assess a resident. Note sections of this manual that help to clarify coding and procedural questions you may have had.
- Once again, read the instructions that apply to a single section of the RAI-MDS 2.0. Make sure you understand this information before going on to another section. Review the test case you completed. Would you still code it the same? It will take time to go through all this material. Do it slowly. Do not rush. Work through the manual one section at a time.
- Are you surprised by any RAI-MDS 2.0 definitions, instructions, or case examples? For example, do you understand how to code ADLs? Or Mood?

- Do any definitions or instructions differ from what you thought you learned when you reviewed the RAI-MDS 2.0 form?
- Would you now complete your initial case differently?
- Are there definitions or instructions that differ from current practice patterns in your facility?
- Make notations next to any section(s) of this manual you have questions about. Be prepared to discuss these issues during any formal training program you attend, or contact your Provincial/Territorial RAI-MDS 2.0 resource person or CIHI.

C. In a second pass through Chapter 2 focus on issues that were more difficult or problematic in the first pass.

- Make notes on the RAI-MDS 2.0 form of issues that warrant attention.
- Further familiarize yourself with definitions and procedures that differ from current practice patterns or seem to raise questions.
- Reread each of the case examples presented throughout this chapter.

D. The third pass through Chapter 2 may occur during the formal RAI-MDS 2.0 training program at your facility and will provide you with another opportunity to review the material in this chapter. If you have questions, raise them during the training session.

E. Future use of information in Chapter 2:

- Keep Chapter 2 at hand during the assessment process.
- Where necessary, review the intent of each item in question.
- This manual is a source of information. Use it to increase the accuracy of your assessments.

Interviewing Techniques

Performing an accurate and comprehensive assessment requires that the assessor communicate effectively with a number of individuals. The following suggestions can be used by an individual assessor to obtain information from residents, facility staff and resident families. There are other possible models for resident data collection and interviewing, especially when conducted by a team, which you may want to consider in your specific facility.

When conducting any interview to collect information in the RAI-MDS 2.0 process, there are some general concepts that you should consider.

First, emphasize to all individuals that you interview (i.e. residents, families and staff) that the RAI-MDS 2.0 process is a way to "get to know the resident". You should explain that the RAI-MDS 2.0 assessment provides valuable information that will be used by facility staff to develop the resident's care plan. This is an opportunity to bring residents and families into the assessment and care-planning process.

Second, be flexible as to how you conduct the RAI-MDS 2.0 process with each resident. It is not necessary for you to complete the assessment in the same order sequence as sections appear on the assessment form. The RAI-MDS 2.0 assessment is not a questionnaire; it is a set of common items and definitions for assessment, which provides a structure for systematically recording the information you obtain**. You should let the resident's needs guide you during the assessment process.**

You may wish to use the following general techniques, if appropriate, when conducting interviews:

To elicit complete and satisfactory answers, you will often need to ask neutral or nondirective questions. **Examples are:**

- "What do you mean?"
- "Tell me what you have in mind."
- "Tell me more about that."
- "Please be more specific."
- "Give me an example."

Repeat a question if you think it has been misunderstood or misinterpreted.

Pause or hesitate to indicate that you are listening and need more or better information. This is a good technique to use while you are determining the individual's response pattern.

Some items will require special sensitivity during the questioning process (e.g. the items in Section B dealing with memory), and you should note the instructions in Chapter 2 on how to assess each item or gather the information to respond to each item.

Some respondents may be eager to talk with you and will stray from the topic at hand. When a person strays, you should gently guide the conversation back to the topic. For example you may say:

- "That's interesting."
- "Now I need to know..."
- "Let's get back to..."
- "Tell me about..."

Validate your understanding of what a respondent is saying. Be careful that you do not appear to be challenging a respondent when clarifying a statement. For example you may say:

- "I think I hear you saying that..."
- "Let's see if I understood you correctly. You said ... Is that right?"

When respondents (resident/family/caregivers) disagree or when a resident (who you believe is capable of rational judgment) says something contrary to information contained in the record, you should clarify the information. Ultimately, use your best clinical judgment to weigh all information.

Consider developing and using a printed questionnaire to help residents and families contribute important information (e.g. Customary Routine).

Finally and most importantly, validate with the resident, through observations or interview, what you have heard from other facility staff, family members or what you have read in the record.

When collecting information from facility staff there are other important considerations which may make the process easier and more efficient.

You should respect the professional status of staff. Consider their need to perform their other duties in addition to providing necessary assessment information for you. The following suggestions may assist you when conducting facility staff interviews:

- Post a schedule of residents who are being assessed during a given period (e.g. month) so that staff can prepare to participate in the assessment.
- Provide prior notice to other staff members that an assessment is due, giving direct care staff an opportunity to gather their thoughts about residents. You may wish to provide a worksheet that staff (e.g. nursing assistants) could use to note particular resident information (e.g. ADLs).
- Schedule interviews in advance, at mutually convenient times; avoid busy workload times.
- Know what you want to cover. Leave a few minutes for staff to provide open-ended comments that may pertain to the well-being of the resident.
- Provide other staff members with a list of areas you wish to cover to expedite the process.
- Key your questions to the time period for which resident performance is being assessed.

You will often need to discuss a resident with more than one facility staff member. For example, an individual staff member who has been on a 3-week vacation may recall the resident's function a month ago instead of during the last 7 days. A nurse that floats from unit to unit may not know the residents well enough to respond appropriately. If a facility staff respondent struggles with answers or seems vague in referring to the time period in question, you should consider seeking another respondent.

Reinforce to all staff at the onset of the interview that you are gathering information to learn as much about the resident as possible to best plan for the resident's care. Reassure any staff that your purpose is the RAI process and not an evaluation of their job performance.

Chapter 2—Item-by-Item Guide to the RAI-MDS 2.0 Assessment Form

To facilitate completion of the RAI-MDS 2.0 Assessment and to ensure consistent interpretation of items, this chapter presents the following types of information for many **(but not all)** items:

Intent

Reason(s) for including the item (or set of items) in the RAI-MDS 2.0 Assessment, including discussions of how the information will be used by clinical staff to identify issues and provide direction for assessors to identify resident problems and develop the plan of care.

Definition

Explanation of key terms.

Process

Sources of information and methods for determining the response for an item.[iii]

Sources include:

- Resident interview and observation
- Discussion with facility staff—licensed and non-licensed staff members Clinical records (including physician orders, laboratory data, medication records, treatment sheets, flow sheets such as vital signs, weights, intake and output), facility administration records, transfer records (at admission)— care plans, and other relevant documents in the facility record system
- Discussion with the resident's family
- Attending physician.

Coding

Proper method of recording each response for each item, with explanations of individual response options. It is also important to note the time frame of each item.

iii. The above sources of information must be utilized in such a way as to maintain compliance with privacy and other appropriate legislation within your jurisdiction such as health care consent legislation.

Unless specified in the item itself, the time frame is the "last 7 days". **Note**: if the information is unknown or the assessor is unable to elicit a response using all available sources of information, the "no" response should be used to complete the item.

This item-by-item guide follows the sequence of items on the RAI-MDS 2.0 Assessment Form.

Note that Resident Assessment Protocols (RAPs) are referenced throughout this manual. As of March 2008, jurisdictions across Canada have started to replace the RAPs with the interRAI Clinical Assessment Protocols (CAPs).

To order a copy of the *interRAI Clinical Assessment Protocols (CAPs) For Use With Community and Long-Term Care Assessment Instruments, March 2008*, send an email to orderdesk@cihi.ca.

Section AA—Name and Identification Number

This section of item-by-item instructions follows the sequence of items found on one or more of the RAI-MDS 2.0 Forms. Notice that an RAI-MDS 2.0 section designation appears at the top of the pages that follow; this will facilitate your use of this chapter as a reference tool in the future.

This section provides the key information to uniquely identify each resident, the facility in which he or she resides, and the reasons for assessment.

AA1 Unique Registration Identifier (URI)

Definition

The Unique Registration Identifier (URI) uniquely identifies the resident admission.

Coding

The URI is twenty characters long and is generated by the vendor software. The URI must not contain the resident's health card number, name, partial name, date of birth or sex.

AA2 Sex

Coding

M Male

F Female

0 Other (e.g. hermaphrodite)

AA3a Birth Date

Coding

Fill in the boxes with the appropriate number. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0". For example: January 2, 1918 should be entered as:

1	9	1	8
Year			

0	1
Month	

0	2
Day	

CIHI Tip

If only a partial birth date is known, enter the year of birth and record the first day of the first month.

Example

- A resident is born in 1918, but the specific month and day is unknown. Record the birth date as:

1	9	1	8		0	1		0	1
Year					Month			Day	

If none of the resident's birth date is known, estimate the year and record the first day of the first month.

Example

- A resident says he was born in 1918, but documentation is unavailable. Record the birth date as:

1	9	1	8		0	1		0	1
Year					Month			Day	

AA3b Estimated Birth Date

Coding

Fill in the box with the appropriate number. If the resident's birth date is not estimated enter "0". If the resident's birth date is estimated, enter "1".

0 No, birth date is known

1 Yes, birth date is estimated

AA4 Aboriginal Identity

Intent

To document self-identification as an Aboriginal person.

Definition

Aboriginal identity—Refers to self-identification as a member of an Aboriginal community and does not require proof (that is, a status card) in order to be coded "1" for "Yes."

Process

Ask the person if he or she self-identifies as an Aboriginal person. If the person says yes, clarify which group(s) of Aboriginal people he or she identifies with. If the person is unable to respond, ask a family member or another knowledgeable informant whether the person would identify him/herself with any of the listed groups. For example, ask “Do you think of yourself as an Aboriginal person? Would you describe yourself as First Nations, Métis, or Inuit?”

Coding

Select the appropriate response for each group. Use “0” (No) if the person is unable to respond and there is no other available source to provide the information, or if the person is unwilling to respond.

0 No

1 Yes

Examples of How to Code Aboriginal Identity

The person tells the assessor that her great-great grandfather was Métis but she does not think of herself as Métis, or any other aboriginal group.

Code:

AA4a (First Nations) = 0
AA4b (Métis) = 0
AA4c (Inuit) = 0

When asked, a person said that he identifies himself as a member of both the First Nations and Métis; his mother is of First Nations ancestry and his father is Métis.

Code:

AA4a (First Nations) = 1
AA4b (Métis) = 1
AA4c (Inuit) = 0

A person with cognitive impairment is unable to understand the nature of the question. However, the daughter, who is present during the assessment, tells the assessor that her mother is Inuit and would definitely self-identify as such.

Code:

AA4a (First Nations) = 0
AA4b (Métis) = 0
AA4c (Inuit) = 1

AA5a Health Card Number

Intent

To record resident's health (insurance) number as assigned by the provincial/ territorial government.

Process

Review the resident's record. If this number is missing, consult with your facility's business office.

Coding

Begin writing one number per box starting with the left most box. Recheck the number to be sure you have written the digits correctly.

In rare instances, the resident will not have a health card number. When this occurs:

- If the health card number is not available, code "0".
- If the health card number is not applicable, for example when item AA5b is coded as 99, code "1".

AA5b Province/Territory Issuing Health Card Number

Definition

To record the province/territory that issued the resident's health (insurance) number.

Coding

Code as per the legend below, using "99" only if AA5a is coded "1".

NL Newfoundland and Labrador
PE Prince Edward Island
NS Nova Scotia
NB New Brunswick
QC Quebec
ON Ontario
MB Manitoba
SK Saskatchewan
AB Alberta
BC British Columbia
NT Northwest Territories
YT Yukon
NU Nunavut
99 Not Applicable

CIHI Tip

If necessary, the Province/Territory of issue can be identified by checking the health card.

AA6 Facility Number

Intent

To record the facility number.

Definition

The identification number assigned to the facility by the province/ territory. This number must contain a total of five (5) characters.

Process

Each province/territory has a reporting code. Each facility has a unique numeric identifier.

Coding

Begin writing in the left-hand box. Enter one digit per box. The first character, a letter or number, indicates the province/territory in which the facility is located. Recheck the number to be sure you have entered the digits correctly. There must be a facility number entered.

The CIHI assigned province/territory letters for the first character are:

0 Newfoundland and Labrador
1 Prince Edward Island
2 Nova Scotia
3 New Brunswick
4 Quebec
5 Ontario
6 Manitoba
7 Saskatchewan
8 Alberta
9 British Columbia
N Northwest Territories
Y Yukon
V Nunavut

AA7 Admission Type

Intent

To record whether an admission or re-entry has occurred.

Definition

01 **Admission**—The resident is being admitted to the facility and the conditions for re-entry have not been met.

09 **Re-entry**—Use this code when a resident of your facility is readmitted following a temporary discharge (see Chapter 1 for further details).

AA8 Reason for Assessment (This item appears and must be completed on all assessment forms.)

Primary Reason for Assessment

Intent

To document the reason for completing the assessment using the various categories of assessment types. Most of the types of assessments listed below will require completion of the RAI-MDS 2.0, review of triggered CAPs/RAPs, and development or review of a comprehensive care plan within seven days of completing the RAI-MDS 2.0 and CAPs/RAPs. (Note—assessment type 5, the Quarterly review assessment, requires you to complete only a limited number of RAI-MDS 2.0 items—see Appendix A for the Quarterly Assessment Form.)

Minimum Discharge Assessment Requirement. With the release of the RAI-MDS 2.0, a minimal list of RAI-MDS 2.0 items must be completed for all discharges and facility re-entries. These items are referenced on their own forms.

Definition

01 **Admission Assessment**—A comprehensive assessment using the RAI-MDS 2.0 and CAPs/RAPs is required by day 14 of the resident's stay. (Note—this code is used if resident is being readmitted subsequent to a discharge where return was not anticipated.)

02 **Annual Assessment**—A comprehensive reassessment is required within 12 months of the most recent full assessment. If significant change is noted, use code "03" (Significant Change in Status Assessment). DO NOT CODE as an Annual assessment.

03 **Significant Change in Status Assessment**—A comprehensive reassessment is prompted by a "major change" that is not self-limited, that impacts on more than one area of the resident's clinical status, and that requires interdisciplinary review or revision of the care plan to ensure that appropriate care is given. When there is a significant change, the assessment must be completed by the end of the 14th calendar day following the determination that a significant change has occurred. For additional comments, see Chapter 1, page 13.

04 **Significant Correction of Prior Full Assessment**—A comprehensive assessment is completed at the facility's prerogative, because the previous full assessment was inaccurate or completed incorrectly. This differs from a significant change in status assessment, in which there has been an actual change in the resident's health status.

05 **Quarterly Review Assessment**—The subset of RAI-MDS 2.0 items specified on the *Quarterly Assessment Form*, which must be completed no less frequently than once every 3 months (i.e. between required full assessments). This assessment ensures that the care plan is correct and up to date. It also should identify instances where significant changes in resident status have occurred. If a significant change is noted, complete a full assessment and use code "03" (Significant Change in Status Assessment). DO NOT CODE as a Quarterly review assessment.

10 **Significant Correction of Prior Quarterly Assessment**—A quarterly assessment completed at the facility's prerogative, because the previous quarterly assessment was inaccurate or completed incorrectly. This differs from a significant change in status assessment, in which there has been an actual change in the resident's health status.

AA9 Discharge Type

Intent

To record the type of discharge that has occurred.

Definition

06 **Discharge—Return Not Anticipated—**Use this code when a resident is permanently discharged from a facility. This provides a means of "closing" the record of any resident at the point of discharge from the facility (without an anticipated return).

07 **Discharge—Return Anticipated**—Use this code when a resident is temporarily discharged. Also use this code when a respite patient returns home, with an anticipated return to this facility at a later date.

08 **Discharged Prior to Completing Initial Assessment**—Use this code when a resident is discharged during the first 14 days of residency AND the RAI-MDS 2.0 assessment remains incomplete. A subset of information is entered for all residents regardless of length of stay. Even a very short-stay resident (e.g. a person who stayed for only one day) must be tracked by the RAI-MDS 2.0 system. At the same time, remember that you have 14 days to complete the full RAI-MDS 2.0 admission assessment, and by using this code you are identifying residents who have been discharged, transferred or died prior to day 14, thereby prohibiting your completion of a full assessment.

Section AB—Demographic Information

AB1 Admission/Re-Entry Date

When AA7 Admission Type = 01 (Admission)

Intent

Enter the date the person first became a resident/patient in your facility. For RAI-MDS 2.0 purposes, the date of entry is the date the resident entered the facility for care, regardless of how the facility chooses to "open" or "close" its medical records during the course of the stay.

Definition

Date the stay began—The date the resident was most recently admitted to your facility.

For Example

If the resident was officially discharged in the past without the expectation of return (e.g. discharged home or to another facility), enter the most recent admission date.

Process

Review the clinical record. If dates are unclear or unavailable, ask the admissions office or medical record department at your facility.

Coding

Use all boxes. For a one-digit month or day, place a zero in the first box.

For Example

February 3, 2010, should be entered as:

2	0	1	0		0	2		0	3
Year					Month			Day	

Example

Mrs. F, a diabetic, had been living with her daughter when she fractured her left hip during a fall off a footstool. She spent a few days in the local hospital after surgery, followed by an admission to a facility on 2010/05/26 for rehabilitation. Three weeks later (2010/06/16), Mrs. F was transferred back to the hospital for an infected incision site over her left hip and general state of decline. Mrs. F returned to the facility eight days later. In this instance, code the following date on the original face sheet.

2	0	1	0		0	5		2	6
Year					Month			Day	

Rationale: In this case there is no need to complete a new admission date upon return readmission from a temporary hospital stay where the resident is expected to return to the facility; code AA7 Admission Type as 09 for Re-entry and complete only the re-entry items.

When AA7 Admission Type = 09 (Re-entry)

Intent

To track the date of the resident's readmission to the facility following a temporary discharge.

CIHI Tip

The re-entry date must be equal to or greater than the last discharge date. The value 09 for Re-entry is only used when a resident re-enters the facility and the conditions for re-entry are met.

Definition

The date the resident was most recently readmitted to your facility after being temporarily discharged. For further details, please refer to Chapter 1.

Process

Review the clinical record. If dates are unclear or unavailable, ask the admissions office or medical record department.

Coding

If the resident has not been hospitalized in last 90 days, leave blank. Otherwise, use all boxes. For a one-digit month or day, place a zero in front.

For Example:

February 3, 2010 should be entered as:

2	0	1	0		0	2		0	3
Year					Month			Day	

AB2a Admission/Re-Entry From Facility/Level of Care

Intent

To facilitate care planning by documenting the level of care from which the resident was admitted to the facility on the facility date given in item AB1. For example, if the admission was from an acute care service, an immediate review of current medications might be warranted since the resident could be at a higher risk for delirium or may be recovering from delirium associated with acute illness, medications or anaesthesia.

Or, if admission was from home, the resident could be grieving due to losses associated with giving up one's home and independence. Whatever the individual circumstances, the resident's prior location can also suggest a list of contact persons who might be available for issue clarification. For example, if the resident was admitted from a private home with home health services, telephone contact with a Visiting Nurse can yield insight into the resident's situation that is not provided in the written records.

Definition

AB2a Admitted From	Facility/Level of Care	Setting	Services/Programs
00	Ambulatory Health Service	• Associated with a hospital service, or • Other community/ primary care setting	• Ambulatory care encompasses all health services that are provided to clients who are not residing in health care institutions at the time the care is given • May include emergency services, day/night care, specialty or non-specialty clinics, day surgery, private medical practice
01	Inpatient Acute Care Service	• Free-standing acute care hospital, or • Acute care nursing unit in a hospital offering multiple levels of care	• Provides diagnosis and short-term treatment of patients with a wide variety of diseases or injuries • 24 hour coverage by professional nursing staff and on-call physicians
02	Inpatient Rehabilitation Service (General)	• Rehabilitation unit within a hospital offering multiple levels of care • Includes general rehabilitation unit within a free-standing rehabilitation hospital	• Provides rehabilitation to a broad range of client groups • Generally includes PT, OT and may include other professional services
03	Inpatient Continuing Care Service	• Free-standing hospital (e.g. chronic, complex continuing care, extended care, auxiliary hospital), or • Continuing care nursing unit within an acute care hospital, or facility/program offering multiple levels of continuing care services (including Alternate Level of Care (ALC) and assessment units)	• Provides care to persons who, because of chronic illness and marked functional disability, require hospitalization, but do not need acute care services • Provide assessment services to facilitate placement and/or service planning • 24 hour coverage by professional nursing staff and on-call physicians
04	Residential Care Service (24-hour nursing care)	• Free-standing residential care facility, or • Residential unit within a facility/program offering multiple levels of continuing care services	• Provides care for clients who cannot safely live at home • Provides medication supervision, 24 hour professional nursing care, assisted meal service, etc.

AB2a Admitted From	Facility/Level of Care	Setting	Services/Programs
05	Inpatient Psychiatry Service	• Free-standing psychiatric hospital, or • Psychiatry nursing unit within a hospital offering multiple levels of care	• Provides for the diagnosis and short-term treatment and continuing assessment and long-term treatment of inpatients with psychiatric disorders
06	Other/Unclassified Service		
07	Inpatient Rehabilitation Service (Specialized)	• Free-standing rehabilitation hospital, or • Rehabilitation unit within a hospital offering multiple levels of care	• Provides specialized programs (e.g. acquired brain injury, stroke, neurological conditions, spinal cord dysfunction, amputation, major multiple trauma, orthopedic conditions, etc.) • Includes a comprehensive range of professional services including medical/ surgical specialists, physio-therapists, occupational therapists, speech language pathologists, psychologists, recreational therapists, orthotists and prosthetists
08	Home Care Service	• Private home or apartment with home health and/or home support services	• Provides an array of health and support services that enable individuals, incapacitated in whole or in part to live at home
09	Residential Care Service (board and care)	• Free-standing residential care facility, or • Residential unit within a facility/program offering multiple levels of continuing care services	• Provides support for activities of daily living • Professional and nursing services may be accessed through home care or other community-based service
10	Private Home (no home care)	• Any house, condominium or apartment in the community, whether owned by the client or another person	• No formal home health or home support services are provided

Process

Review admission records. Consult the resident and the resident's family.

Coding

Choose only one answer.

Example

Mr. F, who had been living in his own home with his wife, was admitted to an acute care hospital with a CVA. From the hospital, Mr. F was transferred to this facility for rehabilitation.

Because Mr. F was admitted to your facility from the acute care hospital, "01" is the appropriate code.

AB2b Admission/Re-Entry From Facility Number

Intent

To identify the specific facility/level of care from which the resident was admitted.

Definition

The facility number is assigned by the provincial/territorial government. This number must contain a total of five (5) characters. The first character, a letter or number, indicates the province/territory in which the facility is located.

Coding

Begin writing in the left-hand box. Enter one digit per box. The first character, a letter or number, indicates the province/territory in which the facility is located (see item AA6). Recheck the number to be sure you have entered the digits correctly. If AB2a (Admission/Re-Entry From Level of Care) is coded 08 (home care program) or 09 (residential care service, board and care), or 10 (private home, no home care) AB2b must be coded with spaces. For all other AB2a codes, a valid provincial/territorial facility number should be provided.

AB3 Lived Alone (Prior to Entry)

Intent

To document the resident's living arrangements prior to admission.

Definition

0 No, resident did not live alone—If the resident was living in another facility prior to admission (e.g. nursing facility, group home, board and care) **OR** If the resident was not living in another facility prior to admission, but lived with others.

1 Yes, resident lived alone prior to admission—If the resident was not living in another facility prior to admission, and lived alone.

9 Unknown—Use only if resident's living arrangement prior to admission is unknown.

Process

Review admission records. Consult the resident and the resident's family. Code unknown only if there is no informant available to determine the resident's prior living arrangements.

Coding

0 No

1 Yes

9 Unknown

Examples

- Mrs. H lived on her own and her daughters took turns sleeping in her home so she would never be alone at night. Code "0" for No (did not live alone). If, however, her daughters stayed with her only 3–4 nights per week. **Code** "1" for Yes (lived alone).
- Mr. J lived in his own second-floor apartment of a two-family home and received constant attention from his family, who lived on the first floor. **Code** "0" for No (did not live alone).
- Mr. D lived with his wife in housing for the elderly prior to admission. **Code** "0" for No (did not live alone).
- Mrs. X was the primary caregiver for her two young grandchildren, who lived with her after their parent's divorce. **Code** "0" for No (did not live alone).
- Mrs. K was admitted directly from an acute care hospital. She had been living alone in her own apartment prior to hospital stay. **Code** "1" for Yes (lived alone).
- Mr. M, who has been blind since birth, was admitted to the facility with his seeing eye dog, Rex. Mr. M. and Rex lived together for the past 10 years in housing for the elderly. **Code** "1" for Yes (lived alone).
- Mr. G lived in a board and care home. **Code** "0" for No (did not live alone)

AB4 Prior Primary Residence Postal Code

Definition

Prior primary residence. The community address where the resident last resided prior to facility admission. A primary residence includes a primary home or apartment, board and care home, assisted living, or group home. If the resident was admitted to your facility from another institutional setting, the prior primary residence is the address of the resident's home prior to entering the other facility, etc.

Process

Review resident's admission records and transmittal records as necessary. Ask resident and family members as appropriate. Check with your facility's admissions office.

Coding

Enter one digit per box for a valid six (6) character Canadian postal code, if known. If the Prior Primary Residence Postal Code for the resident is not known, use the two (2) letter codes as per the legend below. Two (2) character codes are placed in the boxes on the right. If primary residence prior to date of admission is known and was not in Canada enter the appropriate code.

Legend (Canada)			
Alberta	AB	Nova Scotia	NS
British Columbia	BC	Ontario	ON
Manitoba	MB	Prince Edward Island	PE
New Brunswick	NB	Quebec	QC
Newfoundland and Labrador	NL	Saskatchewan	SK
Northwest Territories	NT	Yukon	YT
Nunavut	NU	Homeless Individual	Z1Z 1Z1

Legend (USA and Other)					
Alabama	AL	Louisiana	LA	Oregon	OR
Alaska	AK	Maine	ME	Palau	PW
American Samoa	AS	Maryland	MD	Pennsylvania	PA
Arizona	AZ	Massachusetts	MA	Puerto Rico	PR
Arkansas	AR	Michigan	MI	Rhode Island	RI
California	CA	Minnesota	MN	South Carolina	SC
Colorado	CO	Mississippi	MS	South Dakota	SD
Connecticut	CT	Missouri	MO	Tennessee	TN
Delaware	DE	Montana	MT	Texas	TX
District of Columbia	DC	Nebraska	NE	Utah	UT
Florida	FL	Nevada	NV	Vermont	VT
Georgia	GA	New Hampshire	NH	Virginia	VA
Guam	GU	New Jersey	NJ	Virgin Islands	VI
Hawaii	HI	New Mexico	NM	Washington	WA
Idaho	ID	New York	NY	West Virginia	WV
Illinois	IL	North Carolina	NC	Wisconsin	WI
Indiana	IN	North Dakota	ND	Wyoming	WY
Iowa	IA	Northern Mariana Islands	MP	State Unknown	US
Kansas	KS	Ohio	OH	Other Country	OC
Kentucky	KY	Oklahoma	OK		

Example

- Mr. T was admitted to the facility from the local hospital. Prior to hospital admission he lived with his wife in a trailer park in Jensen Beach, Florida.
  Enter "FL" for Florida.
- Mrs. F was admitted to the facility's Alzheimer's Special Care Unit after spending 3 years living with her daughter's family in Edmonton, AB. Prior to moving in with her daughter, Mrs. F lived in Calgary, AB for 50 years with her husband until he died. **Enter the Edmonton, AB postal code.**
  Rationale: Her daughter's home was Mrs. F's primary residence prior to facility admission.
- Ms. Q was admitted from a psychiatric hospital in Ontario where she had spent the previous 16 years of her life. Prior to that, Ms. Q lived with her parents in Kingston, ON.
  Enter the Kingston, ON postal code.

AB5 Residential History 5 Years Prior to Entry

Intent

To document the resident's previous experience living in institutional or group settings.

Definition

AB5a. Prior stay at this facility—Resident's prior stay was terminated by discharge to the community, another facility, or (in some cases) a hospitalization.

AB5b. Stay in other similar level of care facility—Prior stay in one or more facilities providing a similar level of care other than current facility.

AB5c. Prior stay in other board and care facility—Examples include board and care home, group home, and assisted living.

Ab5d. Prior stay in a psychiatric facility—Examples include mental health facility, psychiatric hospital, psychiatric ward of a general hospital, or psychiatric group home.

AB5e. Prior stay in developmental disability facility— Examples include facilities for persons with an intellectual or developmental disability, and intermediate care facilities and group homes.

AB5f. ***NONE OF ABOVE***

Process

Review the admission record. Consult the resident or family. Consult the resident's physician.

Coding

Check all institutional or group settings in which the resident lived for the five years prior to the current date of entry (as entered in AB1). Exclude limited stays for treatment or rehabilitation when the resident had a primary residence to return to (i.e. the place the resident called "home" at that time).

If the resident has not lived in any of these settings in the past five years, check *AB5f. NONE OF ABOVE*.

AB7 Education (Highest Completed)

Intent

To record the highest level of education the resident attained. Knowing this information is useful for assessment (e.g. interpreting cognitive patterns or language skills), care planning (e.g. deciding how to focus a planned activity program), and planning for resident education in self-care skills.

Definition

The highest level of education attained.

1 No Schooling

2 8th grade or less

3 9th to 11th Grade

4 High School-obtained high school diploma, or completed Adult Education Equivalency Program.

5 Technical or Trade School: Include schooling in which the resident received a non-degree certificate in any technical occupation or trade (e.g. carpentry, plumbing, acupuncture, baking, secretarial, practical/vocational nursing, computer programming, etc.).

6 Some College: Includes completion of some college courses, junior (community) college, or associate's degree.

7 Bachelor's degree: Includes any undergraduate bachelor's level university degree.

8 Graduate Degree: Master's degree or higher (M.S., Ph.D., M.D., etc.).

9 Unknown

Process

Ask the resident and significant other(s). Review the resident's record.

Coding

Code for the best response. For residents who have a developmental disability and have received special education services, code "2" (8th grade/less).

AB8 Language

Definition

AB8a. Primary language—The language the resident primarily speaks or understands.

Process

Interview the resident and family. Observe and listen. Review the clinical record.

Coding

Enter "eng" for English, "fre" for French, and for other languages refer to the *Home and Continuing Care Language Codes (For Use With CCRS, HCRS and HCRS-CA)* for the list of codes.

eng English
fre French

Example

Mrs. F emigrated with her family from East Africa several years ago. She is able to speak and understand very little English. She depends on her family to translate information in Swahili.

AB8a. Primary Language—"swa"

AB9 Mental Health History

Intent

To document a primary or secondary diagnosis of psychiatric illness or developmental disability.

Definition

Resident has one of the following:

- A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder, personality disorder; other psychotic disorder; or another mental disorder that may lead to chronic disability; but
- Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder;

AND

- The disorder results in functional limitations in major life activities that would be appropriate within the past 3 to 6 months for the individual's developmental stage;

AND

- The treatment history indicates that the individual has experienced either: (a) psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g. partial hospitalization or inpatient hospitalization); or (b) within the last 2 years due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which formal supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

Process

Review the resident's record only. For a "Yes" response to be entered, there must be written documentation (i.e. verbal reports from the resident or resident's family are not sufficient).

Coding

0 No

1 Yes

AB10 Conditions Related to Developmental Disability Status

Intent

To document conditions associated with developmental disabilities.

Definition

AB10a. Not applicable—no developmental disability (Skip to AC1).

Developmental disability with organic condition

AB10b. Down's syndrome

AB10c. Autism

AB10d. Epilepsy

AB10e. Other developmental disability related to organic condition

Examples of diagnostic conditions include congenital rubella, prenatal infection, congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macroencephaly, meningomyelocele, congenital hydrocephalus.

AB10f. Development disability with no organic condition

Process

Review the resident's record only. For any item (AB10b through AB10f) to be checked, the condition must be documented in the clinical record.

Coding

Check all conditions related to developmental disability status that were present before age 22. When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely.

- If a developmental disability condition is not present, check item AB10a ("Not Applicable—No developmental disability") and skip to item AC1.
- If a developmental disability condition is present, check each condition that applies.
- If a developmental disability condition is present but the resident does not have any of the specific conditions listed, check item AB10f ("developmental disability with No Organic Condition").

Section AC—Customary Routine

AC1 Customary Routine (In the Year Prior to DATE OF ENTRY to This Facility, or Year Last in Community if now Being Admitted From Another Facility)

Intent

These items provide information on the resident's usual community lifestyle and daily routine in the year prior to DATE OF ENTRY (AB1) to your facility. If the resident is being admitted from another facility, review the resident's routine during the last year the resident lived in the community. The items should initiate a flow of information about cognitive patterns, activity preferences, nutritional preferences and problems, ADL scheduling and performance, psychosocial well-being, mood, continence issues, etc. The resident's responses to these items also provide the interviewer with "clues" to understanding other areas of the resident's function. These clues can be further explored in other sections of the RAI-MDS 2.0 that focus on particular functional domains. Taken in their entirety, the data gathered will be extremely useful in designing an individualized plan of care.

Process

Engage the resident in conversation. A comprehensive review can be facilitated by a questioning process such as described in Guidelines for Interviewing Resident that follow. Also see Interviewing Techniques in Chapter 1 (page 32).

If the resident cannot respond (e.g. is severely demented or aphasic), ask a family member or other representative of the resident (e.g. legal guardian). For some residents you may be unable to obtain this information (e.g. a demented resident who first entered the facility many years ago and has no family to provide accurate information).

Guidelines for Interviewing Resident

Staff should regard this step in the assessment process as a good time to get to know the resident as an individual and an opportunity to set a positive tone for the future relationship. It is also a useful starting point for building trust prior to asking difficult questions about urinary incontinence, advance directives, etc.

The interview should be done in a quiet, private area where you are not likely to be interrupted. Use a conversational style to put the resident at ease. Explain at the outset why you are asking these questions:

- "Staff want to know more about you so you can have a comfortable stay with us."
- "These are things that many older people find important."
- "I'm going to ask a little bit about how you usually spend your day."
- Begin with a general question—e.g.
  - "Tell me, how did you spend a typical day before coming here (or before going to the first facility)?" or
  - "What were some of the things you liked to do?"

Listen for specific information about:

- sleep patterns;
- eating patterns;
- preferences for timing of baths or showers; and
- social and leisure activities involvements.

As the resident becomes engaged in the discussion, probe for information on each item of the Customary Routine section, i.e.:

- cycle of daily events;
- eating patterns;
- ADL patterns; and
- involvement patterns.

Realize, however, that a resident who has been in an institutional setting for many years prior to coming to your facility may no longer be able to give an accurate description of pre-institutional routines. Some residents will persist in describing their experience in the care setting, and will need to be reminded by the interviewer to focus on their usual routines prior to admission. Ask the resident, "Is this what you did before you came to live here?" If the resident has difficulty responding to prompts regarding particular items, backtrack by re-explaining that you are asking these questions to help you understand how the resident's usual day was spent and how certain things were done. It may be necessary to ask a number of open-ended questions in order to obtain the necessary information. Prompts should be highly individualized.

Walk the resident through a typical day. Focus on usual habits, involvement with others, and activities. Phrase questions in the past tense. Periodically reiterate to the resident that you are interested in the resident's routine before facility admission, and that you want to know what he or she actually did, not what he or she might like to do.

For Example:

- After you retired from your job, did you get up at a regular time in the morning?
- When did you usually get up in the morning?
- What was the first thing you did after you arose?
- What time did you usually have breakfast?
- What kind of food did you like for breakfast?
- What happened after breakfast? (Probe for naps or regular post-breakfast activity such as reading the paper, taking a walk, doing chores, washing dishes.)
- When did you have lunch? Was it usually a big meal or just a snack?
- What did you do after lunch? Did you take a short rest? Did you often go out or have friends in to visit?
- Did you ever have a drink before dinner? Every day? Weekly?
- What time did you usually bathe? Did you usually take a shower or a tub bath? How often did you bathe? Did you prefer a.m. or p.m.?
- Did you snack in the evening?
- What time did you usually go to bed? Did you usually wake up during the night?

Definition

Goes out 1+ days a week—Went outside for any reason (e.g. socialization, fresh air, clinic visit).

Use of tobacco products at least daily—Smoked any type of tobacco (e.g. cigarettes, cigars, pipe) at least once daily. This item also includes sniffing or chewing tobacco.

Distinct food preferences—This item is checked to indicate the presence of specific food preferences, with details recorded elsewhere in the clinical record (e.g. was a vegetarian; observed kosher dietary laws; avoided red meat for health reasons; hates hot dogs; allergic to wheat and avoids bread). *Do not check this item for simple likes and dislikes*.

Use of alcoholic beverage(s) at least weekly—Drank at least one alcoholic drink per week.

Wakens to toilet all or most nights—Awoke to use the toilet at least once during the night all or most of the time.

Has irregular bowel movement pattern—Refers to an unpredictable or variable pattern of bowel elimination, regardless of whether the resident prefers a different pattern.

Bathing in PM—Took shower or bath in the evening.

Daily contact with relatives/close friends—Includes visits and telephone calls. Does not include exchange of letters only.

Usually attends church, temple, synagogue (etc.)—Refers to interaction regardless of type (e.g. regular churchgoer, watched TV evangelist, involved in church or temple committees or groups).

Daily animal companion/presence—Refers to involvement with animals (e.g. house pet, seeing-eye dog, fed birds daily in yard or park).

Unknown—If the resident cannot provide any information, no family members are available, and the admission record does not contain relevant information, check ("UNKNOWN") for each activity.

Coding

Coding is limited to selected routines in the year prior to the resident's first admission to a facility. *Code the resident's actual routine rather than his or her goals or preferences* (e.g. if the resident would have liked daily contact with relatives but did not have it, do not check "Daily contact with relatives/ close friends").

If an individual item in a particular category is not known (e.g. "Finds strength in faith," under Involvement Patterns), enter "unknown".

If information is unavailable for all the items in the entire Customary Routine section, check "UNKNOWN" for each activity.

Signatures

Signatures of persons completing these items: Sections AB and AC.

Coding

Staff who completed parts of the Background sections of the RAI-MDS 2.0 enter their signatures, their title, and the date they completed their assigned sections.

Section A—Identification Information

A1 Resident Name

Definition

Legal name in record.

Coding

Print the resident's name. This information does not get submitted to the CCRS.

A2 Room Number

Intent

Another identifying number for tracking purposes. This information does not get submitted to the CCRS.

Definition

The number of resident's room in the facility.

A3 Assessment Reference Date

Intent

To establish a common temporal reference point for all staff participating in the resident's assessment. Although staff members may work on completing a resident's RAI-MDS 2.0 on different days, establishment of the assessment reference date ensures the commonality of the assessment period (i.e. "starting the clock" so that all assessment items refer to the resident's objective performance and health status during the same period of time).

Definition

Last day of RAI-MDS 2.0 observation period. This date refers to a specific end-point in the RAI-MDS 2.0 assessment process. Almost all RAI-MDS 2.0 items refer to the resident's status over a designated time period, most frequently the seven day period ending on this date. The date sets the designated endpoint of the common observation period, and all RAI-MDS 2.0 items refer back in time from this point. Some cover the 14 days ending on this day, some 30 days ending on this date, and so forth.

Coding

The first coding task is to enter the assessment reference date (i.e. the end point date of the observation period). For an admission assessment, this date can be any day up to the 14th day following admission (the last possible date for completing the admission assessment). For a follow-up assessment, select a common reference date within the period the assessment must be completed. This date is the endpoint to which all RAI-MDS 2.0 items must refer.

For an admission assessment, staff may begin to gather some information on the day of admission. An observation end date will be set, often a date prior to day 14.

CIHI Tip

If the resident dies or is discharged prior to the end of the observation period, the ARD must be adjusted to equal the date of discharge/death.

CAPs/RAPs should be completed within required time frames for completion of the RAI.

Examples of Assessment Reference Date for an Admission Assessment

Mrs. M was admitted to your facility on 2010/08/20. Your facility's policy states that all RAI-MDS 2.0 assessments for new admissions shall be completed by the 7th day of residency. Therefore, staff decided to conduct their observations, tests, interviews with resident, family and other staff, and chart reviews during the first 7 days of the resident's stay. During this time they record pertinent findings in the resident's record and, where appropriate, on the RAI-MDS 2.0 form. They record the endpoint of the RAI-MDS 2.0 observation period as follows, giving staff another 7 days in which to complete the CAPs/RAPs:

2	0	1	0		0	8		2	7
Year					Month			Day	

Mr. S was admitted to your facility on 2010/08/20. Your facility's policy states that all RAI-MDS 2.0 assessments for new admissions shall be completed by the 14th day of residency. The interdisciplinary team on the new resident's unit decides to take the full 14 days to complete the assessment. Of course they conduct observations, tests, necessary interviews, and chart reviews necessary for care planning. During this time they record pertinent findings in the resident's record. They record the endpoint of the RAI-MDS 2.0 observation period as follows, with the stipulation that the CAPs/RAPs must also be completed on that date:

2	0	1	0		0	9		0	3
Year					Month			Day	

Examples of Assessment Reference Date for an Admission Assessment (cont'd)

Rationale: As 2010/09/03 is the 14th day of residency, the period of review for the RAI-MDS 2.0 items will be the 7 days prior to that date (or the period from 2010/08/20 through 2010/09/03).

For an annual assessment, staff are likely to have extensive data on hand. In such cases, a designated observation period of seven days is usually established. The date on which the observation period ends is the Assessment Reference Date. All staff who participate in the assessment must, however, agree that their description of the resident reflects the resident's status in this seven day period.

For the month and day of the assessment, enter two digits each, using zero, ("0") as a filler. Use four digits for the year.

Example of Assessment Reference Date for an Annual Assessment

Mr. X has been living at your facility for the past 2 years. The date of his last full RAI-MDS 2.0 assessment was approximately 1 year ago (2009/09/27). It is time to think about scheduling another full assessment. The RAI-MDS 2.0 RN coordinator posts a notice to the interdisciplinary team stating Mr. X's next full assessment date is 2010/09/20. This means that the team should be evaluating Mr. X during the 7 day period that ends on this date for most RAI-MDS 2.0 items (i.e. from 2010/09/14 to 2010/09/20). Record the endpoint of the RAI-MDS 2.0 observation period as:

2	0	1	0		0	9		2	0
Year					Month			Day	

Remember, an annual assessment must be completed within 12 months of the most recent full RAI-MDS 2.0 assessment.

Coding

For the month and day of the assessment, enter two digits each, using a leading zero ("0") as a filler. Use four digits for the year. Example: June 5, 2010

2	0	1	0		0	6		0	5
Year					Month			Day	

A5 Marital Status

Process

Indicate the resident's marital status.

Coding

Code as per the legend below, choosing the answer that describes the current marital status of the resident. For the CCRS, code common law relationships as "2".

1 Never Married
2 Married
3 Widowed
4 Separated
5 Divorced
9 Unknown

A6a Health Record Number

Definition

The health record number (HRN) is the resident's unique number assigned by the facility. The HRN may be a chart number or any other unique person identifier that would meet CIHI specifications, with the exception of the person's provincial/territorial health card number. The health record number must not be blank. It can be obtained from the facility's admissions office, business office, or medical records department.

The HRN for a person remains unchanged with multiple admissions, re-entries and discharges. If an organization has multiple sites (physical locations), and if the person moves from one site to another, the HRN need not change.

The HRN may change if the person moves from one organization to another and the admitting organization has its own HRN system.

Facilities that do not have an HRN system in place may request assistance from their vendor to generate numbers that would meet the CIHI specifications.

Coding

Enter the number, right justify and zero fill if necessary.

A6b Health Register Number

Definition

The register number is the admitting number assigned to residents by the facility upon admission.

Coding

Enter ONLY the sequential numeric designation. Omit all ancillary notations such as year, hyphens, alphabetic characters, etc. Right justify and zero fill all entries. For residents who do not have a register number code as 99999.

Register number 356–96 is recorded as 00356.

Register number AB222 is recorded as 00222.

A7 Responsibility for Payment

Intent

To determine all payment source(s) that cover the daily per diem or ancillary services for the resident's stay in the facility over the last 30 days.

> **CIHI Tip**
>
> Payment for ancillary services may include, but are not limited to podiatry, optometry, dentistry or the purchase or rental of equipment.

Process

Check with the billing office to review current payment sources. Do not rely exclusively on information recorded in the resident's clinical record, as the resident's clinical condition may trigger different sources of payment over time. Usually business offices track such information.

Coding

Record all that apply.

A7a. Provincial/territorial government plan

A7b. Other province/territory

A7c. Federal government—Veterans Affairs Canada

A7d. Federal government—First Nations and Inuit Health Branch (FNIHB)

A7e. Federal government—other (RCMP, Canadian Forces, federal penitentiary inmate, refugee)

A7f. Worker's Compensation Board (WCB/WSIB)

A7g. Canadian resident—private insurance pay

A7h. Canadian resident—public trustee pay

A7i. Canadian resident—self pay

A7j. Other country resident—self pay

A7k. Responsibility for payment unknown/unavailable

A11 Decision-Maker for Personal Care and Property

Intent

To identify if the person being assessed or another individual is responsible for the person's personal care or property decision making.

Definition

A11a. Personal care—For example, decisions related to medical procedures such as initiation of a tube feeding, long-term care admission.

A11b. Property—Decisions related to real estate; life, accident, disability, and income protection insurance; pension or superannuation; cash on hand or in bank accounts/safety deposit; investments; personal property (for example, motor vehicles).

Process

Obtain information either directly from the person or from other sources, such as family, other health care workers, or available documentation. Ask directly about the current status of decision-making for personal care and property/financial matters.

Each province and territory has legislation or regulations governing who can make decisions on behalf of another person. There are differences in what these decision makers are called and the scope of the authority (to make decisions) they have. Examples of types of decision-makers in Canada include Court Ordered Guardian of the Person, Attorney/Proxy in Power of Attorney for Personal Care/ Representation Agreement/Health Directive, Continuing Power of Attorney for Property, Enduring Power of Attorney, Other Substitute Decision Maker/Proxy by order of a tribunal (if authorized by provincial/territorial law), Family member (if authorized by provincial/territorial law as Substitute Decision Maker), Public Guardian and Trustee (provincial/territorial equivalent). Having someone designated as one of the above does not automatically mean they are currently responsible for the person's decision-making. This item is intended to determine if the person being assessed is currently making decisions for him–or herself regarding personal or financial matters, or if someone else is currently making the decisions on the person's behalf.

Check your provincial/territorial statutes for the specific terminology that is applicable in your jurisdiction.

Coding

Code for a) Decision-maker for personal care and b) Decision-maker for property.

Code "1" (Person) if the person being assessed is currently managing his or her own decisions.

Code "2" (Other) should only be used if another individual is currently acting on behalf of the person being assessed.

1 Person
2 Other

A12 Advance Directives

Intent

To determine whether the person has provided guidelines for how care should be rendered in the event that he or she becomes unable to communicate this information. To record the legal existence of directives regarding treatment options for the person, whether made by the person or a legal proxy. Documentation must be available in the record for a directive to be considered current and binding. The absence of pre-existing directives for the person should prompt discussion by clinical staff with the person and family regarding the person's wishes. Any discrepancies between the person's current stated wishes and what is written in legal documents in the person's file should be resolved immediately.

Definition

A12a. Advance directives for not resuscitating—In the event of respiratory or cardiac failure, the person, family or legal guardian has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to attempt to restore the person's respiratory or circulatory function.

A12b. Advance directives for not hospitalizing—A document specifying that the person is not to be hospitalized even after developing a medical condition that usually requires hospitalization.

Process

Ask the person or family about whether advance directives have been specified. In order for a directive to be considered current and binding, there must be documentation in the person's record in accordance with relevant provincial/territorial law. Do not code the item unless such documentation is present.

Coding

Code for the appropriate response.

0 Not in place
1 In place

Section B—Cognitive Patterns

Intent

To determine the resident's ability to remember, think coherently and organize daily self-care activities. These items are crucial factors in many care-planning decisions. Your focus is on resident performance, including a demonstrated ability to remember recent and long-past events and to perform key decision-making skills.

Questions about cognitive function and memory can be sensitive issues for some residents who may become defensive or agitated or very emotional. These are not uncommon reactions to performance anxiety and feelings of being exposed, embarrassed, or frustrated if the resident knows he or she cannot answer the questions cogently.

Be sure to interview the resident in a private, quiet area without distractions—i.e. not in the presence of other residents or family, unless the resident is too agitated to be left alone. Using a non-judgmental approach to questioning will help create a needed sense of trust between staff and resident. After eliciting the resident's responses to the questions, return to the resident's family or others, as appropriate, to clarify or validate information regarding the resident's cognitive function over the last seven days. For residents with limited communication skills or who are best understood by family or specific care givers, you will need to carefully consider their insights in this area.

- Engage the resident in general conversation to help establish rapport.
- Actively listen and observe for clues to help you structure your assessment. Remember—repetitiveness, inattention, rambling speech, defensiveness, or agitation may be challenging to deal with during an interview, but they provide important information about cognitive function.
- Be open, supportive, and reassuring during your conversation with the resident (e.g. "Do you sometimes have trouble remembering things? Tell me what happens. We will try to help you").

If the resident becomes really agitated, sympathetically respond to his or her feelings of agitation and STOP discussing cognitive function. The information-gathering process does not need to be completed in one sitting but may be ongoing during the entire assessment period. Say to the agitated resident, for example, "Let's talk about something else now," or "We don't need to talk about that now. We can do it later". Observe the resident's cognitive performance over the next few hours and days and come back to ask more questions when he or she is feeling more comfortable.

B1 Comatose

Intent

To record whether the resident's clinical record includes a documented neurological diagnosis of coma or persistent vegetative state.

CIHI Tip

- Coma is a state of deep unarousable unconsciousness. A comatose person is a person in a state of deep and usually prolonged unconsciousness; unable to respond to external stimuli, for example pain. (Adapted from: www.webster-dictionary.org/definition/Comatose)
- The comatose person does not open his/her eyes, does not speak and does not move his/her extremities on command.
- A persistent vegetative state may follow a coma and is characterized by wakefulness with no evidence of awareness. Some resident who were comatose may regain wakefulness but have no evidence of any purposeful behavior or cognition.

Coding

Enter the appropriate number in the box.

If the resident has been diagnosed as comatose or in a persistent vegetative state, code "1". ***Skip to Section G***. If the resident is not comatose or is semi-comatose, code "0" and proceed to the next item (B2).

B2 Memory

Intent

To determine the resident's functional capacity to remember both recent and long-past events (i.e. short-term and long-term memory).

CIHI Tip

Observation period: last 7 days

Process

B2a. Short-Term Memory

Ask the resident to describe a recent event that both of you had the opportunity to remember. Or, you could use a more structured short-term memory test. For residents with limited communication skills, ask staff and family about the resident's memory status. Remember, if there is no positive indication of memory ability, (e.g. remembering multiple items over time or following through on a direction given five minutes earlier) the correct response is "1", Memory Problem.

Examples

Ask the resident to describe the breakfast meal or an activity just completed.

Ask the resident to remember three items (e.g. book, watch, table) for a few minutes. After you have stated all three items, ask the resident to repeat them (to verify that you were heard and understood). Then proceed to talk about something else—do not be silent, do not leave the room. In five minutes, ask the resident to repeat the name of each item. If the resident is unable to recall all three items, code "1." For persons with verbal communication deficits, non-verbal responses are acceptable (e.g. when asked how many children they have, they can tap out a response of the appropriate number).

B2b. Long-Term Memory

Engage in conversation that is meaningful to the resident. Ask questions for which you can validate the answers (from your review of record, general knowledge, the resident's family). For residents with limited communication skills, ask staff and family about the resident's memory status. Remember, if there is no positive indication of memory ability, the correct response is "1", Memory Problem.

Example

Ask the resident “Where did you live just before you came here?”

- If “at home” is the reply, ask “What was your address?”
- If “another facility” is the reply, ask “What was the name of the place?”

Then ask:

- “Are you married?”
- “What is your spouse’s name?”
- “Do you have any children?”
- “How many?”
- “When is your birthday?”
- “In what year were you born?”

Coding

Enter the numbers that correspond to the observed responses.

B3 Memory/Recall Ability

Intent

To determine the resident’s memory/recall performance within the environmental setting. A resident may have intact social graces and respond to staff and others with a look of recognition, yet have no idea who they are. This item will enable staff to probe beyond first, perhaps mistaken, impressions.

CIHI Tip

Observation period: last 7 days

Definition

B3a. Current season—Able to identify the current season (e.g. correctly refers to weather for the time of year, legal holidays, religious celebrations, etc.)

B3b. Location of own room—Able to locate and recognize own room. It is not necessary for the resident to know the room number, but he or she should be able to find the way to the room.

B3c. Staff names/faces—Able to distinguish staff members from family members, strangers, visitors, and other residents. It is not necessary for the resident to know the staff member's name, but he or she should recognize that the person is a staff member and not the resident's son or daughter, etc.

B3d. That he/she is in a facility—Able to determine that he or she is currently living in a facility. To check this item, it is not necessary that the resident be able to state the name of the facility, but he/she should be able to refer to the facility by a term such as a "home for older people", a "hospital for the elderly", "a place where older people live", etc.

B3e. *NONE OF ABOVE* are recalled

Process

Test memory/recall. Use information obtained from clinical records or staff. Ask the resident about each item. For example, "What is the current season? "What is the name of this place?" "What is this kind of place?" If the resident is not in his or her room, ask "Will you show me to your room?" Observe the resident's ability to find the way.

Coding

For each item that the resident can recall, check the corresponding answer box. If the resident can recall none, check *NONE OF ABOVE*.

B4 Cognitive Skills for Daily Decision-Making

Intent

To record the resident's actual performance in making everyday decisions about tasks or activities of daily living.

CIHI Tip

Observation period: last 7 days

Examples

- Choosing items of clothing;
- Knowing when to go to scheduled meals;
- Using environmental cues to organize and plan (e.g. clocks, calendars, posted listings of upcoming events);
- In the absence of environmental cues, seeking information appropriately (i.e. not repetitively) from others in order to plan the day;
- Using awareness of one's own strengths and limitations in regulating the day's events (e.g. asks for help when necessary);
- Making the correct decision concerning how to get to the lunchroom;
- Acknowledging need to use a walker, and using it faithfully.

Process

Review the clinical record. Consult family and nurse assistants. Observe the resident. The inquiry should focus on whether the resident is actively making these decisions, and not whether staff believe the resident might be capable of doing so. Remember the intent of this item is to record what the resident is doing (performance). Where a staff member takes decision-making responsibility away from the resident regarding tasks of everyday living, or the resident does not participate in decision-making, whatever his or her level of capability may be, the resident should be considered to have impaired performance in decision-making.

This item is especially important for further assessment and care planning in that it can alert staff to a mismatch between a resident's abilities and his or her current level of performance, or that staff may be inadvertently fostering the resident's dependence.

Coding

Enter one number that corresponds to the most correct response.

0 Independent—The resident's decisions in organizing daily routine and making decisions were consistent, reasonable, and organized reflecting lifestyle, culture, values.

1 Modified Independence—The resident organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations.

2 Moderately Impaired—The resident's decisions were poor; the resident required reminders, cues, and supervision in planning, organizing, and correcting daily routines.

3 Severely Impaired—The resident's decision-making was severely impaired; the resident never (or rarely) made decisions.

B5 Indicators of Delirium—Periodic Disordered Thinking/Awareness

Intent

To record behavioural signs that may indicate that delirium is present. Frequently, delirium is caused by a treatable illness such as infection or reaction to medications.

The characteristics of delirium are often manifested behaviorally and therefore can be observed. For example, disordered thinking may be manifested by rambling, irrelevant, or incoherent speech. Other behaviors are described in the definitions below.

A recent change (deterioration) in cognitive function is indicative of delirium (acute confusional state), which may be reversible if detected and treated in a timely fashion. Signs of delirium can be easier to detect in a person with intact cognitive function at baseline. However, when a resident has a pre-existing cognitive impairment or pre-existing behaviors such as restlessness, calling out, etc., detecting signs of delirium is more difficult. Despite this difficulty, it is possible to detect signs of delirium in these residents by being attuned to recent changes in their usual functioning. For example, a resident who is usually noisy or belligerent may suddenly become quiet, lethargic, and inattentive. Or, conversely, one who is normally quiet and content may suddenly become restless and noisy. Or, one who is usually able to find his or her way around the unit may begin to get "lost".

CIHI Tip

Observation period: last 7 days

Definition

B5a. **Easily distracted** (e.g. difficulty paying attention; gets sidetracked)

B5b. **Periods of altered perception or awareness of surroundings** (e.g. moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

B5c. **Episodes of disorganized speech** (e.g. speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)

B5d. **Periods of restlessness** (e.g. fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out)

B5e. **Periods of lethargy** (e.g. sluggishness, staring into space; difficult to arouse; little body movement)

B5f. **Mental function varies over the course of the day** (e.g. sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

Coding

Code for resident's behavior in the last seven days regardless of what you believe the cause to be—focusing on when the manifested behavior first occurred.

0 Behavior not present

1 Behavior present, not of recent onset

2 Behavior present over last 7 days appears different from resident's usual functioning (e.g. new onset or worsening)

Case Example 1

Mrs. K is a 92 year old widow of 30 years who has severe functional dependency secondary to heart disease. Her primary nurse assistant has reported during the last two days Mrs. K has "not been herself." She has been napping more frequently and for longer periods during the day. She is difficult to arouse and has mumbling speech upon awakening. She also has difficulty paying attention to what she is doing. For example, at meals instead of eating as she usually does, she picks at her food as if she doesn't know what to do with a fork. Then she stops and closes her eyes after a few minutes. Alternatively, Mrs. K has been waking up at night believing it to be daytime. She has been calling out to staff demanding to be taken to see her husband (although he is deceased). On 3 occasions Mrs. K was observed attempting to climb out of bed over the foot of the bed.

Indicators		Coding
B5a.	Easily distracted	2 (present, new)
B5b.	Periods of altered perception or awareness of surroundings	2 (present, new)
B5c.	Episodes of disorganized speech	2 (present, new)
B5d.	Periods of restlessness	2 (present, new)
B5e.	Periods of lethargy	2 (present, new)
B5f.	Mental function varies over the course of the day	2 (present, new)

Case Example 2

Mr. D has a history of Alzheimer's disease. His skills for decision-making have been poor for a long time. He often has difficulty paying attention to tasks and activities and usually wanders away from them. He rarely speaks to others, and when he does it is garbled and the contents are nonsensical. He is often observed mumbling and moving his lips as if he's talking to someone. Although Mr. D is often restless and fidgety this behaviour is not new for him and it rarely interferes with a good night's sleep.

Indicators		Coding
B5a.	Easily distracted	1 (present, not new)
B5b.	Periods of altered perception or awareness of surroundings	1 (present, not new)
B5c.	Episodes of disorganized speech	1 (present, not new)
B5d.	Periods of restlessness	1 (present, not new)
B5e.	Periods of lethargy	0 (behaviour not present)
B5f.	Mental function varies over the course of the day	1 (present, not new)

B6 Change in Cognitive Status

Intent

To document changes in the resident's cognitive status, skills, or abilities **as compared to his or her status of 90 days ago** (or since last assessment if less than 90 days ago). These can include, but are not limited to, changes in level of consciousness, cognitive skills for daily decision-making, short-term or long-term memory, thinking or awareness, or recall. Such changes may be permanent or temporary; their causes may be known (e.g. a new pain or psychotropic medication) or unknown. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Coding

Record the number corresponding to the most correct response.

0 No change

1 Improved

2 Deteriorated

Examples of Change in Cognitive Status

- Mrs. G experienced delirium (acute confusion) secondary to pneumonia approximately 30 days ago. With appropriate antibiotic therapy, hydration, and a quiet supportive milieu, she recovered. Although Mrs. G's cognitive skills did not increase beyond the level that existed prior to her pneumonia, and she remains unable to make daily decisions, she has steadily improved to her pre-pneumonia status. **Code "0" for No Change.**
- Ms. P is intellectually intact. About two and one-half months ago she was informed by her daughter that her neighbour and lifelong friend had died while on a trip to Europe. Ms. P took the news very hard; she was stunned and seemed to be confused and bewildered for days. With support of family and staff, confusion passed. Although she continued to grieve, her cognitive status returned to what it was prior to her receiving the bad news. **Code "0" for No change.**
- Mr. D was admitted to the facility three months ago upon discharge from the hospital with signs of post-operative delirium. Since that time he no longer requires frequent reminders and re-orientation throughout each day. His decision-making skills have improved. **Code "1" for Improved**.
- Mr. F has Alzheimer's disease. He did well until two months ago, when his primary nurse assistant reported that he can no longer find his way back to his room, which he was able to do three months ago. He often gets lost now while trying to find his way to the unit activity/dining room. **Code "2" for Deteriorated**.
- Mrs. F was admitted to the facility six weeks ago. Upon admission she had modified independence in daily decision-making skills, intact short and long-term memory, and good recall abilities. Since that time, Mrs. F has had a stroke, which has left her with deficits in these areas. Within this Significant Change assessment period, her decisions have become poor. She is not aware of her new physical limitations and has taken unreasonable safety risks in transferring and locomotion. She receives supervision at all times. **Code "2" for Deteriorated**.

MDS Cognitive Performance Scale©

Many facilities have asked for a system to combine RAI-MDS 2.0 cognitive items into an overall Cognitive Performance Scale. Such a scale has been produced—The RAI-MDS 2.0 Cognitive Performance Scale (CPS)© **[see Appendix A: Cognitive Performance Scale (CPS) Scoring** Rules]. Five RAI-MDS 2.0 items are used in assigning residents to one of seven CPS categories. The CPS categories are highly related to residents' average scores on the Folstein Mini-Mental Status Examination (MMSE), which has a score range of zero (worst) to thirty (best). According to Folstein, an MMSE score of 23 or lower usually suggests cognitive impairment but it may be lower for persons with an eighth grade education or less.

Section C—Communication/ Hearing Patterns

Intent

To document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others.

There are many possible causes for the communication problems experienced by elderly residents. Some can be attributed to the aging process; others are associated with progressive physical and neurological disorders. Usually the communication problem is caused by more than one factor. For example, a resident might have aphasia as well as long standing hearing loss; or he or she might have dementia and word finding difficulties and a hearing loss. The resident's physical, emotional, and social situation may also complicate communication problems. Additionally, a noisy or isolating environment can inhibit opportunities for effective communication.

Deficits in one's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written), or recognition of facial expressions. Deficits in ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and gesturing.

C1 Hearing

Intent

To evaluate the resident's ability to hear (with environmental adjustments, if necessary) during the **past seven-day period**.

Process

Evaluate hearing ability after the resident has a hearing appliance in place, if the resident uses an appliance. Review the clinical record. Interview and observe the resident, and ask about the hearing function. Consult the resident's family, direct care staff, and speech or hearing specialists. Test the accuracy of your findings by observing the resident during your verbal interactions.

Be alert to what you have to do to communicate with the resident. For example, if you have to speak more clearly, use a louder tone, speak more slowly, or use more gestures, or if the resident needs to see your face to know what you are saying, or if you have to take the resident to a more quiet area to conduct the interview—all of these are cues that there is a hearing problem, and should be so indicated in the coding.

Also, observe the resident interacting with others and in group activities. Ask the activities personnel how the resident hears during group leisure activities.

Coding

Enter one number that corresponds to the most correct response.

0 **Hears adequately**—The resident hears all normal conversational speech, including when using the telephone, watching television, and engaged in group activities.

1 **Minimal difficulty**—The resident hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations.

2 **Hears in special situations only**—Although hearing-deficient, the resident compensates when the speaker adjusts tonal quality and speaks distinctly; or the resident can hear only when the speaker's face is clearly visible.

3 **Highly impaired/absence of useful hearing**—The resident hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face to face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

C2 Communication Devices/Techniques

CIHI Tip

Observation period: last 7 days

Definition

C2a. **Hearing aid, present and used regularly**—A hearing aid or other assistive listening device is available to the resident and is used regularly.

C2b. **Hearing aid, present and not used regularly**—A hearing aid or other assistive listening device is available to the resident and is not regularly used (e.g. resident has a hearing aid that is broken or is used only occasionally).

C2c. **Other receptive communication techniques used (e.g. lip reading)**—A mechanism or process is used by the resident to enhance interaction with others (e.g. reading lips, touching to compensate for hearing deficit, writing by staff member, use of communication board).

C2d. ***NONE OF ABOVE***

Process

Consult with the resident and direct care staff. Observe the resident closely during your interaction.

Coding

Check all that apply. If the resident does not have a hearing aid or does not regularly use compensatory communication techniques, check *C2d. NONE OF ABOVE*.

C3 Modes of Expression

Intent

To record the types of communication techniques (verbal and non-verbal) used by the resident to make his or her needs and wishes known.

> **CIHI Tip**
> Observation period: last 7 days

Definition

C3a. Speech

C3b. Writing messages to express or clarify needs—Resident writes notes to communicate with others.

C3c. American Sign Language or Braille

C3d. Signs or gestures or sounds—This category includes nonverbal expressions used by the resident to communicate with others.

- Actions may include pointing to words, objects, people; facial expressions; using physical gestures such as nodding head twice for "yes" and once for "no" or squeezing another's hand in the same manner.
- Sounds may include grunting, banging, ringing a bell, etc.

C3e. Communication board—An electronic, computerized or other home-made device used by the resident to convey verbal information, wishes, or commands to others.

C3f. Other—Examples include flash cards or various electronic assistive devices.

C3g. *NONE OF ABOVE*

CIHI Tip

C3c (American Sign Language or Braille) includes other formalized sign languages [see *Home and Continuing Care Language Codes (For Use With CCRS, HCRS and HCRS-CA)]*.

Process

Consult with the primary nurse assistant and other direct-care staff from all shifts, if possible. Consult with the resident's family. Interact with the resident and observe for any reliance on non-verbal expression (physical gestures, such as pointing to objects), either in one-on-one communication or in group situations.

Coding

Check the boxes for each method used by the resident to communicate his or her needs. If the resident does not use any of the listed items, check *C3g. NONE OF ABOVE.*

C4 Making Self Understood

Intent

To document the resident'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.

CIHI Tip

Observation period: last 7 days

CIHI Tip

Note that this item is not intended to address differences in language understanding, such as only speaking in a language not familiar to the assessor. If necessary, an interpreter should be used to assist with the assessment. However, if an interpreter is not available, the assessor can utilize techniques other than oral language to elicit information about the resident's ability to understand and be understood.

Process

Interact with the resident. Observe and listen to the resident's efforts to communicate with you. Observe his or her interactions with others in different settings (e.g. one-on-one, groups) and different circumstances (e.g. when calm, when agitated). Consult with the primary nurse assistant (over all shifts) if available, the resident's family, and speech-language pathologist.

Coding

Enter the number corresponding to the most correct response.

0 **Understood**—The resident expresses ideas clearly.

1 **Usually Understood**—The resident has difficulty finding the right words or finishing thoughts, resulting in delayed responses; or the resident requires some prompting to make self understood.

2 **Sometimes Understood**—The resident has limited ability, but is able to express concrete requests regarding at least basic needs (e.g. food, drink, sleep, toilet).

3 **Rarely or Never Understood**—At best, understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language (e.g. indicated presence of pain or need to toilet).

C5 Speech Clarity

Intent

To document the quality of the resident's speech, not the content or appropriateness—just words spoken.

> **CIHI Tip**
> Observation period: last 7 days

Definition

Speech—the expression of articulate words.

Process

Listen to the resident. Confer with primary assigned caregivers.

Coding

Enter the number corresponding to the most correct response.

0 Clear speech—utters distinct, intelligible words.

1 Unclear speech—utters slurred or mumbled words.

2 No speech—absence of spoken words.

C6 Ability to Understand Others

Intent

To describe the resident's ability to comprehend verbal information whether communicated to the resident orally, by writing, or in sign language or Braille. This item measures not only the resident's ability to hear messages but also to process and understand language.

> **CIHI Tip**
> Observation period: last 7 days

Process

Interact with the resident. Consult with primary direct care staff (e.g. nurse assistants) over all shifts if possible, the resident's family, and a speech-language pathologist.

Coding

Enter the number corresponding to the most appropriate response.

0 Understands—The resident clearly comprehends the speaker's message(s) and demonstrates comprehension by words or actions/behaviours.

1 Usually Understands—The resident may miss some part or intent of the message but comprehends most of it. The resident may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.

2 Sometimes Understands—The resident demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or directions. When staff rephrase or simplify the message(s) and/or use gestures, the resident's comprehension is enhanced.

3 Rarely or Never Understands—The resident demonstrates very limited ability to understand communication. Or, staff have difficulty determining whether the resident comprehends messages, based on verbal and nonverbal responses. Or, the resident can hear sounds but does not understand messages.

C7 Change in Communication/Hearing

Intent

To document any change in the resident's ability to express, understand, or hear information **compared to his or her status of 90 days ago** (or since last assessment if less than 90 days ago). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Process

In addition to consulting primary care staff (over all shifts if possible), consulting the family of new admissions, and reviewing prior Quarterly reviews when available, ask the resident if he or she has noticed any changes in the ability to hear, talk, or understand others. Sometimes, residents do not complain of changes being experienced because they attribute them to "old age". Therefore, it is important that they be asked directly. Some types of deterioration are easily corrected (e.g. by new hearing aid batteries or removal of earwax).

Coding

Enter the number corresponding to the most correct response.

0 No change

1 Improved

2 Deteriorated

Examples of Change in Communication/Hearing

- Mrs. L has had expressive aphasia for two years. Although she periodically says a word or phrase that is understood by others, this is not new for her. During the last 90 days her communication status has essentially remained unchanged. **Code "0" for No change.**
- Mrs. R's hearing is severely impaired. Five months ago the occupational therapist developed flash cards for staff to use when communicating with her. This was a tremendous boost for both Mrs. R and staff. Her ability to understand others continues to improve. **Code "1" for Improved.**
- Mr. S has complained for the last two weeks of ringing in his ears, saying "Please do something, it's driving me crazy! **Code "2" for Deteriorated.**
- Upon admission two months ago Mrs. T had difficulty hearing unless the speaker adjusted his or her tone of voice and spoke more distinctly. She has worn hearing aids in the past but lost them during a hospital admission. Since admission to the facility, Mrs. T was tested and fitted with new hearing aids. She hears much better with the aids though she is still trying to adjust to wearing them. **Code "1" for Improved.**

Section D—Vision Patterns

Intent

To record the resident's visual abilities and limitations over the past seven days, assuming adequate lighting and assistance of visual appliances, if used.

D1 Vision

Intent

To evaluate the resident's ability to see close objects in adequate lighting, using the resident's customary visual appliances for close vision (e.g. glasses, magnifying glass).

> **CIHI Tip**
> Observation period: last 7 days

Definition

"Adequate" lighting—What is sufficient or comfortable for a person with normal vision.

Process

- Ask direct care staff over all shifts if possible, if the resident has manifested any change in usual vision patterns over the past seven days—e.g. is the resident still able to read newsprint, menus, greeting cards, etc.?
- Then ask the resident about his or her visual abilities.
- Test the accuracy of your findings by asking the resident to look at regular-size print in a book or newspaper with whatever visual appliance he or she customarily uses for close vision (e.g. glasses, magnifying glass). Then ask the resident to read aloud, starting with larger headlines and ending with the finest, smallest print.
- Be sensitive to the fact that some residents are not literate or are unable to read English. In such cases, ask the resident to read aloud individual letters of different size print or numbers, such as dates or page numbers, or to name items in small pictures.
- If the resident is unable to communicate or follow your directions for testing vision, observe the resident's eye movements to see if his or her eyes seem to follow movement and objects. Though these are gross measurements of visual acuity, they may assist you in assessing whether the resident has any visual ability.

Coding

Enter the number corresponding to the most correct response.

0 **Adequate**—The resident sees fine detail, including regular print in newspapers/books.

1 **Impaired**—The resident sees large print, but not regular print in newspapers/books.

2 **Moderately Impaired**—The resident has limited vision, is not able to see newspaper headlines, but can identify objects in his or her environment.

3 **Highly Impaired**—The resident's ability to identify objects in his or her environment is in question, but the resident's eye movements appear to be following objects (especially people walking by). 1

Note: Many residents with severe cognitive impairment are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such residents appear to "track" or follow moving objects in their environment with their eyes. For residents who appear to do this, use code "3", Highly Impaired. With our current limited technology, this is the best assessment you can do under the circumstances.

4 **Severely Impaired**—The resident has no vision; sees only light colors or shapes; or eyes do not appear to be following objects (especially people walking by).

D2 Visual Limitations/Difficulties

Intent

To document whether the resident experiences visual limitations or difficulties related to diseases common in aged persons (e.g. cataracts, glaucoma, macular degeneration, diabetic retinopathy, neurologic diseases). It is important to identify whether these conditions are present. Some eye problems may be treatable and reversible; others, though not reversible, may be managed by interventions aimed at maintaining or improving the resident's residual visual abilities.

CIHI Tip

Observation period: last 7 days

Process

D2a. **Side vision problems**—Observe the resident during his or her daily routine (e.g. eating meals, traveling down a hallway). Also, ask the resident about any vision problems (e.g. spilling food, bumping into objects and people). Ask the primary nurse assistant and other direct-care staff on each shift if possible, whether the resident appears to have difficulties related to decreased peripheral vision (e.g. leaves food on one side of tray, has difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self).

D2b. **Experiences any of the following**—Ask the resident directly if he or she is seeing halos or rings around lights, flashes of light, or "curtains" over the eyes. Ask staff members if the resident complains about any of these problems.

Coding

0 No

1 Yes

D3 Visual Appliances

Intent

To determine if the resident uses visual appliances regularly.

Definition

Glasses; contact lenses; magnifying glass—Includes any type of corrective device used at any time during the **last seven days**.

Coding

1 Yes, if the resident used glasses, contact lenses, or a magnifying glass during the past seven days.

0 No, if none apply.

Section E—Mood and Behaviour Patterns

Mood distress is a serious condition and is associated with significant morbidity. Associated factors include poor adjustment to the facility, functional impairment, resistance to daily care, inability to participate in activities, isolation, increased risk of medical illness, cognitive impairment, and an increased sensitivity to physical pain. It is particularly important to identify signs and symptoms of mood distress among elderly residents because they are very treatable.

In many facilities, staff have not received specific training in how to evaluate residents who have distressed mood or behavioural symptoms. Therefore, many problems are underdiagnosed and undertreated. In facilities where such training has not occurred, an in-service program under the direction of a professional mental health specialist is recommended. At a minimum, staff in such facilities have found the various mental health CAPs/RAPs (e.g. Mood, Behaviour) to be helpful and these should be carefully reviewed.

E1 Indicators of Depression, Anxiety, Sad Mood

Intent

To record the frequency of indicators observed in the last 30 days, irrespective of the assumed cause of the indicator (behaviour).

Definition

Feelings of psychic distress may be expressed directly by the resident who is depressed, anxious, or sad. However, statements such as "I'm so depressed" are rare in the older facility population. Rather, distress is more commonly expressed in the following ways:

Verbal Expressions of Distress

E1a. Resident made negative statements—e.g. "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die."

E1b. Repetitive questions—e.g. "Where do I go; What do I do?"

E1c. Repetitive verbalizations—e.g. Calling out for help, ("God help me").

E1d. Persistent anger with self or others—e.g. easily annoyed, anger at placement in facility; anger at care received.

CIHI Tip

Persistent anger may be exhibited by verbal statements and non-verbal expressions of anger.

E1e. Self deprecation—e.g. “I am nothing; I am of no use to anyone”.

E1f. Expressions of what appear to be unrealistic fears—e.g. fear of being abandoned, left alone, being with others.

E1g. Recurrent statements that something terrible is about to happen—e.g. believes he or she is about to die, have a heart attack.

E1h. Repetitive health complaints—e.g. persistently seeks medical attention, obsessive concern with body functions.

E1i. Repetitive anxious complaints or concerns—non-health-related
e.g. persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues.

Distress may also be expressed non-verbally and identified through observation of the resident in the following areas during usual daily routines:

Sleep Cycle Issues—Distress can also be manifested through disturbed sleep patterns.

E1j. Unpleasant mood in morning

E1k. Insomnia or change in usual sleep pattern—e.g. difficulty falling asleep, fewer or more hours of sleep than usual, waking up too early and unable to fall back to sleep

Sad, Apathetic, Anxious Appearance

E1l. Sad, pained, worried facial expressions—e.g. furrowed brows

E1m. Crying, tearfulness

E1n. Repetitive physical movements—e.g. pacing, hand wringing, restlessness, fidgeting, picking

Loss of Interest—These items refer to a change in resident’s usual pattern of behaviour.

E1o. Withdrawal from activities of interest—e.g. no interest in long-standing activities or being with family/friends

CIHI Tip

If the resident cannot participate in activities of interest due to illness, but he/she has NOT lost interest in being involved in activities with family and friends, code 0 (Indicator not exhibited in last 30 days).

E1p. Reduced social interaction—e.g. less talkative, more isolated

Process

Initiate a conversation with the resident. Some residents are more verbal about their feelings than others and will either tell someone about their distress, or tell someone only when directly asked how they feel. Other residents may be unable to articulate their feelings (i.e. cannot find the words to describe how they feel, or lack insight or cognitive capacity). Observe residents carefully for any indicator. Consult with direct-care staff over all shifts, if possible, and family who have direct knowledge of the resident's behaviour. Relevant information may also be found in the clinical record.

Coding

For each indicator apply one of the following codes based on interactions with and observations of the resident in the **last 30 days**.

Remember, code regardless of what you believe the cause to be.

0 Indicator not exhibited in last 30 days

1 Indicator of this type exhibited up to five days a week (i.e. exhibited at least once during the last 30 days but less than 6 days a week)

2 Indicator of this type exhibited daily or almost daily (6, 7 days a week)

CIHI Tip

For a code of "1," the indicator does not have to occur on a weekly basis. Use this code if the indicator occurred at any time in the last 30 day period.

Use code "2", if the indicator occurred on 6 or 7 days in at least one week in the last 30 day period.

Example

Mr. F is a new admission who becomes upset and angry when his daughter visits (3 times a week). He complains to her and staff caregivers that "she put me in this terrible dump." He chastizes her "for not taking him into her home", and berates her "for being an ungrateful daughter." After she leaves, he becomes remorseful, sad looking, tearful, and says "What's the use. I'm no good. I wish I died when my wife did."

Code "1" (Indicator of this type exhibited up to five days a week) for:

- E1a. (Resident made negative statements)
- E1d. (Persistent anger with self or others)
- E1e. (Self-deprecation)
- E1l. (Sad, pained, worried facial expressions)
- E1m. (Crying, tearfulness)

Code "0" (Indicator not exhibited in last 30 days) for remaining Mood items.

E2 Mood Persistence

Intent

To identify if one or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over the **last seven days**.

Process

Observe the resident and discuss the situation with direct caregivers over all shifts, if possible, and family members or friends who visit frequently or have frequent telephone contact with the resident.

Coding

0 If the resident did not exhibit any mood indicators over last 7 days,

1 If indicators were present and easily altered by staff interactions with the resident or

2 If any indicator was present but not easily altered (e.g. behaviour persisted despite staff efforts to console resident).

Note

A resident can be coded as having indicators of depression, anxiety and sad mood (observation period of 30 days) in E1 and be coded "0" in E2 (observation period of 7 days) because he/she did not exhibit any mood indicators in the last 7 days.

E3 Change in Mood

Intent

To document changes in the resident's mood **as compared to his or her status of 90 days ago** (or since last assessment if less than 90 days ago). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Definition

Change in Mood—Refers to status of any of the symptoms (new onset, improvement, worsening) described in item E1 (verbal expressions of distress, sleep cycle issues, sad apathetic, anxious appearance, loss of interest or other signs) and item E2 (mood persistence). Such changes include:

- increased or decreased **numbers** of expressions or signs of distress
- increased or decreased **frequency** of distress occurrence
- increased or decreased **intensity** of expressions or signs of distress

Process

Review the clinical records including the last assessment findings and transmittal records of newly admitted residents. Interview and observe the resident. Consult with staff from all shifts, if possible, to clarify your observations.

Coding

0 No change

1 Improved

2 Deteriorated as compared to status of 90 days ago

Examples of Changes in Mood

- Mrs. Y has bipolar disease. Historically, she has responded well to lithium and her mood state has been stable for almost a year. About two months ago, she became extremely sad and withdrawn, expressed the wish that she were dead, and stopped eating. She was transferred to a psychiatric hospital for evaluation and treatment. Since her return to the facility three weeks ago, her mood and appetite have improved while on a new lithium dose and an additional antidepressant drug. She is back to her "old self" of 90 days ago. **Code "0" for No change.**
- During the admission assessment period of 90 days ago, Mr. M was tearful and expressed great sadness and anger over entering the facility. He had difficulties falling asleep at night, was restless off and on during the night, and awakened too early in the morning, upset that he couldn't fall back to sleep. Since that time, Mr. M has been involved in a twice-weekly support group, and has been enjoying socializing in activities with new friends. He is currently sleeping through the night and feels well in the morning. Although he still expresses sadness and anger over his need for facility care, it is less frequent and intense. **Code "1" for Improved.**
- Mrs. D has a long history of depression. Two months ago she had an adverse reaction to a psychoactive drug. She expressed fears that she was going out of her mind and was observed to be quite agitated. Her attention span diminished and she stopped attending group activities because she was too restless. After the medication was discontinued, intensity of feelings and behaviours diminished and she has less frequent episodes of agitation. Mrs. D is better than she was, but she still has feelings of sadness. Mrs. D is now better than her worst status two months ago, but she has not fully recovered to her status of 90 days ago. **Code "2" for Deteriorated.**
- During the admission assessment 6 weeks ago, Mrs. Z was very agitated. She had multiple daily complaints of vague aches and pains. She repetitively asked the nurses to "Call the doctor, I'm sick". After no physical problems could be identified, Mrs. Z was evaluated by a psychiatrist who diagnosed a clinical depression and prescribed an antidepressant drug. Its effect on Mrs. Z has been dramatic. During this Significant Change assessment, Mrs. Z had many fewer complaints about her health and was more involved in unit activities. **Code "1" for Improved.**

E4 Behaviour Symptoms

Intent

To identify the:

- **frequency (column A)**, and
- **alterability (column B)** of behavioural symptoms in the last seven days that cause distress to the resident, or are distressing or disruptive to facility residents or staff members

Such behaviours include those that are potentially harmful to the resident himself or herself or disruptive in the environment, even if staff and other residents appear to have adjusted to them (e.g. "Mrs. R's calling out isn't much different than others on the unit. There are many noisy residents;" or "Mrs. L doesn't mean to hit me. She does it because she's confused").

Acknowledging and documenting the resident's behavioural symptom patterns on the RAI-MDS 2.0 provides a basis for further evaluation, care planning, and delivery of consistent, appropriate care towards ameliorating the behavioural symptoms. Documentation in the clinical record of the resident's current status may not be accurate or valid, and it is not intended to be the one and only source of information. (See Process below). However, once the frequency and alterability of behavioural symptoms is accurately determined, subsequent documentation should more accurately reflect the resident's status and response to interventions.

Definition

E4a. **Wandering**—Locomotion with no discernible, rational purpose. A wandering resident may be oblivious to his or her physical or safety needs. Wandering behaviour should be differentiated from purposeful movement (e.g. a hungry person moving about the unit in search of food). Wandering may be manifested by walking or by wheelchair.

Do not include pacing as wandering behaviour. Pacing back and forth is not considered wandering, and if it occurs, it should be documented in Item E1n, "Repetitive physical movements".

CIHI Tip

There is a difference between wandering, exit-seeking behaviour and elopement attempt.

For example, residents who have a rational purpose in their exit-seeking and/or elopement attempts DO NOT necessarily meet the definition of wandering.

E4b. Verbally Abusive Behavioural Symptoms—Other residents or staff were threatened, screamed at, or cursed at.

E4c. Physically Abusive Behavioural Symptoms—Other residents or staff were hit, shoved, scratched, or sexually abused.

CIHI Tip

If a resident strikes out with the intent to make physical contact with the targeted individual, but does not make physical contact (for example, the individual moved out of the line of contact), it would be considered physical abuse.

E4d. Socially Inappropriate or Disruptive Behavioural Symptoms—Includes disruptive sounds, excessive noise, screams, self-abusive acts, or sexual behaviour or disrobing in public, smearing or throwing food or feces, hoarding, rummaging through others' belongings.

E4e. Resists Care—Resists taking medications/injections, ADL assistance or help with eating. This category does not include instances where the resident has made an informed choice not to follow a course of care (e.g. resident has exercised his or her right to refuse treatment, and reacts negatively as staff try to reinstitute treatment).

Signs of resistance may be verbal and/or physical (e.g. verbally refusing care, pushing caregiver away, scratching caregiver). These behaviours are not necessarily positive or negative, but are intended to provide information about the resident's responses to nursing interventions and to prompt further investigation of causes for care planning purposes (e.g. fear of pain, fear of falling, poor comprehension, anger, poor relationships, eagerness for greater participation in care decisions, past experience with medication errors and unacceptable care, desire to modify care being provided).

Process

Take an objective view of the resident's behavioural symptoms. The coding for this item focuses on the resident's actions, not intent. It is often difficult to determine the meaning behind a particular behavioural symptom. Therefore, it is important to start the assessment by recording any behavioural symptoms. The fact that staff have become used to the behaviour and minimize the resident's presumed intent ("He doesn't really mean to hurt anyone. He's just frightened.") is not pertinent to this coding. Does the resident manifest the behavioural symptom or not? Is the resident combative during personal care, striking out at staff, or not?

Observe the resident. Observe how the resident responds to staff members' attempts to deliver care to him or her. Consult with staff who provide direct care on all three shifts. A symptomatic behaviour can be present and the RN Assessment Co-ordinator might not see it because it occurs during intimate care on another shift. Therefore, it is especially important that input from all nurse assistants having contact with the resident be solicited.

Also, be alert to the possibility that staff might not think to report a behavioural symptom if it is part of the unit norm (e.g. staff are working with severely cognitively and functionally impaired residents and are used to residents' wandering, noisiness, etc.). Focus staff attention on what has been the individual resident's actual behaviour over the last seven days. Finally, although it may not be complete, review the clinical record for documentation.

Coding

Column A—Behavioural symptom frequency in last 7 days

Record the frequency of behavioural symptoms manifested by the resident across all three shifts.

0 If the described behavioural symptom was not exhibited in last seven days.

For each type of behaviour described on the RAI-MDS 2.0 form, Code "0" if the resident did not exhibit that type of symptom in the last seven days. This code applies to residents who have never exhibited the behavioural symptom or those who have previously exhibited the symptom but now no longer exhibit it, including those whose behavioural symptoms are fully managed by psychotropic drugs, restraints, or a behaviour-management program. For example: A "wandering" resident who did not wander in the last seven days because he was restricted to a geri-chair would be coded "0"—Behavioural symptom not exhibited in last seven days. The questionable clinical practice of restricting wandering by placing a person in a geri-chair to restrict movement would then be evaluated using the Physical Restraints CAP/RAP.

1 If the described behavioural symptom occurred 1 to 3 days, in last 7 days.

2 If the described behavioural symptom occurred 4 to 6 days, but less than daily.

3 If the described behavioural symptom occurred daily or more frequently (i.e. multiple times each day).

Column B—Behavioural symptom alterability in last 7 days

0 If either the behavioural symptom was not present or the behavioural symptom was easily altered with current interventions.

1 If the described behavioural symptom occurred with a degree of intensity that is not responsive to staff attempts to reduce the behavioural symptom through limit setting, diversion, adapting unit routines to the resident's needs, environmental modification, activities programming, comfort measures, appropriate drug treatment, etc.

For example: A cognitively impaired resident who hits staff during morning care and swears at staff with each physical contact on multiple occasions per day, and the behaviour is not easily altered, would be coded "1".

Examples for Wandering	Column A Frequency	Column B Alterability
Ms. T has dementia and is severely impaired in making decisions about daily life on her unit. She is dependent on others to guide her through each day. When she is not involved in some type of activity (leisure, dining, ADLs, etc.) she wanders about the unit. Despite the repetitive, daily nature of her wandering, this behaviour is easily channeled into other activities when staff redirect Ms. T by inviting her to activities. Ms. T is easily engaged and is content to stay and participate in whatever is going on.	3	0
Mr. W has dementia and is severely impaired in making daily decisions. He wanders all around the residential unit throughout each day. He is extremely hard of hearing and refuses to wear his hearing aid. He is easily frightened by others and cannot stay still for activities programs. Numerous attempts to redirect his wandering have been met with Mr. W hitting and pushing staff. Over time, staff has found him to be most content while he is wandering within a structured setting.	3	1

E5 Change in Behavioural Symptoms

Intent

To document whether the behavioural symptoms or resistance to care exhibited by the resident remained stable, increased or decreased in frequency of occurrence or alterability **as compared to his or her status of 90 days ago** (or since last assessment if less than 90 days ago). Consider changes in any area, including (but not limited to) wandering, symptoms of verbal or physical abuse or aggressiveness, socially inappropriate behaviour, or resistance to care. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Definition

Change in behavioural symptoms—refers to the status (new onset, improvement, worsening) of any of the symptoms described in item E4 (Behavioural Symptoms). Such changes include:

- increased or decreased **numbers** of behavioural symptoms
- increased or decreased **frequency** of behavioural symptoms occurrence
- increased or decreased **intensity** of behavioural symptoms
- increased or decreased **alterability** of behavioural symptoms

Process

Review nursing notes and resident's records, including the last Quarterly Assessment findings and transmittal records of newly admitted residents. Observe the resident. Consult with direct care staff across all shifts, if possible, and family to clarify your observations.

Coding

0 No change. If no change has occurred in behavioural symptoms. This code should also be used for the resident who has no behavioural symptoms currently or 90 days ago.

1 Improved. If the behavioural symptoms became fewer, less frequent, less intense, and were not complicated by the onset of additional behavioural symptoms as compared to 90 days ago.

2 Deteriorated. If the behavioural symptoms became more frequent or more intense or were complicated by the onset of additional behavioural symptoms as compared to 90 days ago.

Examples of Change in Behavioural Symptoms

- Despite staff efforts to provide support and structure over the last 90 days, Mrs. H continues to hoard food in her room every day. Staff understand the needs of this formerly homeless woman, but because they have found ants and cockroaches in her room, they feel a need to re-evaluate their approach to care. **Code "0" for No change since last assessment.**
- During the seven-day assessment period, Mrs. D had a difficult time with bowel regularity. She had a history of constipation that became worse during an episode of pneumonia and poor fluid intake that resulted in dehydration. During this time Mrs. D was more confused and subdued. She was found on several occasions during the assessment period disimpacting herself and smearing feces (Socially Inappropriate/Disruptive Behaviour). Upon examination Mrs. D was found to have a fecal impaction. She received treatment and was placed on a bowel regimen. The program was successful in eliminating the socially inappropriate behavioural symptoms that was induced by discomfort. However, once Mrs. D started to feel better and was more alert, she resumed her former daily wandering (of 4 months ago), pushing others and rummaging through their dresser drawers. **Code "0" for No change since last assessment.**
- Mrs. F has always been a quiet passive woman who has never exhibited any behavioural symptoms since her admission to the facility. During this Significant Change assessment following Mrs. F's stroke, no problematic behavioural symptoms were noted. **Code "0" for No change since last assessment.**
- Mr. C wanders in and out of other residents' rooms and rummages through their belongings at least once a day and sometimes more often. Despite this behaviour, during the last few weeks, he has been easier to work with now that he is more familiar with staff. Although wandering and rummaging continue, he no longer screams, curses, and shoves residents and staff who try to stop this behaviour as he did 90 days ago. **Code "1" for Improved.**
- Ninety days ago Mrs. R banged her cane loudly and repetitively on the dining/activity room table about once a week. In the past week, staff have noticed that this socially inappropriate behavioural symptom (disruptive sounds) now occurs multiple times daily. **Code "2" for Deteriorated.**

Section F—Psychosocial Well-Being

To determine the resident's emotional adjustment to the facility, including his or her general attitude, adaptation to surroundings, and change in relationship patterns.

F1 Sense of Initiative/Involvement

Intent

To assess the degree to which the resident is involved in the life of the facility and takes initiative in participating in various social and recreational programs, including solitary pursuits.

> **CIHI Tip**
> Observation period: last 7 days

Definitions

F1a. **At ease interacting with others**—Consider how the resident behaves during the time you are together, as well as reports of how the resident behaves with other residents, staff, and visitors. A resident who tries to shield himself or herself from being with others, spends most time alone, or becomes agitated when visited, is not "at ease interacting with others."

F1b. **At ease doing planned or structured activities**—Consider how the resident responds to organized social or recreational activities. A resident who feels comfortable with the structure or not restricted by it is "at ease doing planned or structured activities." A resident who is unable to sit still in organized group activities and either acts disruptive or makes attempts to leave, or refuses to attend any such activities, is not "at ease doing planned or structured activities."

F1c. **At ease doing self-initiated activities**—These include leisure activities (e.g. reading, watching TV, talking with friends), and work activities (e.g. folding personal laundry, organizing belongings). A resident who spends most of his or her time alone and unoccupied, or who is always looking for someone to find something for him or her to do, is not "at ease doing self-initiated activities."

F1d. Establishes own goals—Consider statements the resident makes, such as "I hope I am able to walk again," or "I would like to get up early and visit the beauty parlor." Goals can be as traditional as wanting to learn how to walk again following a hip replacement, or wanting to live to say goodbye to a loved one. However, some goals may not actually be verbalized by the resident, but inferred in that the resident is observed to have an individual way of living at the facility (e.g. organizing own activities or setting own pace).

F1e. Pursues involvement in life of facility—In general, consider whether the resident partakes of facility events, socializes with peers, and discusses activities as if he or she is part of things. A resident who conveys a sense of belonging to the community represented by the facility or the particular nursing unit is "involved in the life of the facility."

F1f. Accepts invitations into most group activities—A resident who is willing to try group activities even if later deciding the activity is not suitable and leaving, or who does not regularly refuse to attend group programs, "accepts invitations into most group activities."

F1g. *NONE OF ABOVE*

Process

Selected responses should be confirmed by objective observation of the resident's behaviour (either verbal or non-verbal) in a variety of settings (e.g. in own room, in unit dining room, in activities room) and situations (e.g. alone, in one-on-one situations, in groups) over the past seven days. The primary source of information is the resident.

Talk with the resident and ask about his or her perception (how he or she feels), how he or she likes to do things, and how he or she responds to specific situations.

Then talk with staff members who have regular contact with the resident (e.g. nurse assistants, activities personnel, social work staff, or therapists if the person receives active rehabilitation). Remember, it is possible for discrepancies to exist between how the resident sees himself or herself and how he or she actually behaves. Use your best clinical judgment as a basis for planning care.

Coding

Check all that apply in the past seven days. None of the choices are to be construed as negative or positive. Each is simply a statement to be checked if it applies and not checked if it does not apply.

If you do not check any items in Section F1, check *F1g. NONE OF ABOVE*.

For individualized care-planning purposes, remember that information conveyed by unchecked items is no less important than information conveyed by checked items.

F2 Unsettled Relationships

Intent

To indicate the quality and nature of the resident's interpersonal contacts (i.e. how the resident interacts with staff members, family, and other residents).

CIHI Tips

Observation period: last 7 days

Definition

F2a. Covert/open conflict with or repeated criticism of staff—The resident chronically complains about some staff members to other staff members, verbally criticizes staff members in therapeutic group situations causing disruption within the group, or constantly disagrees with routines of daily life on the unit. Checking this item does not require any assumption about why the problem exists or how it might be remedied.

F2b. Unhappy with roommate—This category also includes "bathroom mate" for residents who share a private bathroom. Unhappiness may be manifested by frequent requests for roommate changes, or grumbling about "bathroom mate" spending too long in the bathroom, or complaints about roommate rummaging in one's belongings, or complaints about physical, mental, or behavioural status of roommate. Other examples of roommate compatibility issues include early bedtime vs. staying up and watching TV, neat vs. sloppy maintenance of personal area, roommate spending too much time on the telephone, or snoring, or odours from incontinence or poor hygiene.

F2c. Unhappy with residents other than roommate—May be manifested by chronic complaints about the behaviours of others, poor quality of interaction with other residents, or lack of peers for socialization. This definition refers to conflict or disagreement outside of the range of normal criticisms or requests (i.e. repetitive, ongoing complaints beyond a reasonable level).

F2d. Openly expresses conflict/anger with family/friends—Includes expressions of feelings of abandonment, ungratefulness on part of family, lack of understanding by close friends, or hostility regarding relationships with family or friends.

F2e. Absence of personal contact with family or friends—Absence of visitors or telephone calls from others in the last seven days.

F2f. Recent loss of close family member or friend—Includes relocation of family member/friend to a more distant location, even temporarily (e.g. for the winter months), incapacitation or death of a significant other, or a significant relationship that recently ceased (e.g. a favourite nurse assistant transferred to work on another unit).

F2g. Does not adjust easily to change in routines—Signs of anger, prolonged confusion, or agitation when changes in usual routines occur (e.g. staff turnover or reassignment; new treatment or medication routines; changes in activity or meal programs; new roommate).

F2h. *NONE OF ABOVE*

Example

For the past 6 months Mrs. A has been receiving 2 white pills, 1 blue pill, 1 yellow pill and 2 puffs of medication from an orange hand-held aerosol inhaler. The drug company that makes the inhaler recently changed its packaging. When Mrs. G is given the new blue inhaler to use and is told that it is the same drug with a different color holder, she becomes very agitated and upset. It takes a lot of patience and reassurance by the nurse before Mrs. G uses the new inhaler. This happened for several days during the past week. Check F2g. Does not adjust easily to change in routines.

Process

Ask the resident for his or her point of view. Is he or she generally content in relationships with staff and family, or are there feelings of unhappiness? If the resident is unhappy, what specifically is he or she unhappy about?

It is also important to talk with family members who visit or have frequent telephone contact with the resident. How have relationships with the resident been in the last seven days? During routine nursing care activities, observe how the resident interacts with staff members and other residents. Do you see signs of conflict? Talk with direct-care staff (e.g. nurse assistants, dietary aides who assist in the dining room, social work staff, or activities aides) and ask for their observations of behaviour that indicate either conflicted or harmonious interpersonal relationships. Consider the possibility that some staff members describing these relationships may be biased. As the evaluator, you are seeking to gain an overall picture, a consensus view.

Coding

Check all that apply over the last seven days.

If none apply, check *F2h. NONE OF ABOVE.*

F3 Past Roles

Intent

To document the resident's recognition or acceptance of feelings regarding previous roles or status now that he or she is living in a facility.

Definition

F3a. **Strong identification with past roles and life status**—This may be indicated, for example, when the resident enjoys telling stories about his or her past, or takes pride in past accomplishments or family life, or continues to be connected with prior lifestyle (e.g. celebrating family events, carrying on life-long traditions).

F3b. **Expresses sadness, anger or empty feeling over lost roles or status**—Resident expresses feelings such as "I'm not the man I used to be" or "I wish I had been a better mother to my children" or "It's no use, I'm not capable of doing things I like to do anymore." Resident cries when reminiscing about past failures, accomplishments, memories.

F3c. **Resident perceives that daily life (customary routine, activities) is very different from prior pattern in the community**—In general, the resident's pattern of routines is perceived by the resident not to be comparable with his or her previous lifestyle.

Examples

- In the facility, resident takes a shower 2 mornings a week vs. taking a daily tub bath before going to bed as she did at home.
- The resident now retires at 7 pm whereas at home he stayed up to watch the 11 pm news.
- In the community Mrs. L enjoyed multiple daily telephone conversations with her 5 daughters. In the facility there is only one public telephone that seems to be in constant use by residents and staff. Mrs. L now speaks with each daughter only once a week.

Process

Initiate a conversation with the resident about life prior to facility admission. It is often helpful to use environmental cues to prompt discussions (e.g. family photos, grandchildren's letters or art work). This information may emerge from discussions around other RAI-MDS 2.0 topics (e.g. Customary Routine, Activity Pursuits, ADLs). Direct care staff and family visitors may also have useful insights.

Coding

Code the presence of each indicator over the **last seven days.**

0 No

1 Yes

9 Unknown (admission only)

Section G—Physical Functioning and Structural Problems

Most facility residents are at risk of physical decline. Most residents also have multiple chronic illnesses and are subject to a variety of other factors that can severely impact self-sufficiency. For example, cognitive deficits can limit ability or willingness to initiate or participate in self-care or constrict understanding of the tasks required to complete ADLs. A wide range of physical and neurological illnesses can adversely affect physical factors important to self-care such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to needless loss of self-sufficiency.

Due to these many, possibly adverse influences, a resident's potential for maximum functionality is often greatly underestimated by family, staff, and the resident himself or herself. Thus, all residents are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs. Individualized plans of care can be successfully developed only when the resident's self-performance has been accurately assessed and the amount and type of support being provided to the resident by others has been evaluated.

G1A Activities of Daily Living (ADL) Self-Performance

Intent

To record the resident's self-care performance in activities of daily living (i.e. what the resident actually did for himself or herself and/or how much verbal or physical help was required by others during the **last seven days**).

Definition

ADL Self-performance—Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last seven days according to a performance-based scale.

G1a. Bed Mobility—How the resident moves to and from a lying position, turns from side to side, and positions body while in bed.

> **CIHI Tip**
>
> This would apply if a recliner is used in lieu of a bed.

G1b. Transfer—How the resident moves between surfaces—i.e. to/from bed, chair, wheelchair, standing position. Exclude from this definition movement to/from bath or toilet, which is covered under Toilet Use and Bathing.

G1c. Walk in room—How resident walks between locations in his/her room.

G1d. Walk in corridor—How resident walks in corridor on unit.

CIHI Tip

If a resident practices walking in a location other than his/her room or the corridor (for example, a physiotherapy gym), record the level of performance in section G1dA (Walk in corridor - self-performance). Section G1dA would not be coded 8 (Activity did not occur) if the resident actually walked in the gym.

G1e. Locomotion on unit—How the resident moves between locations in his or her room and adjacent corridor on the same floor. If the resident is in a wheelchair, locomotion is defined as self-sufficiency once in the chair.

G1f. Locomotion off unit—How the resident moves to and returns from off unit locations (e.g. areas set aside for dining, activities, or treatments). If the facility has only one floor, locomotion off the unit is defined as how the resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair.

G1g. Dressing—How the resident puts on, fastens, and takes off all items of street clothing, including donning/removing a prosthesis.

CIHI Tip

Dressing includes self-care performance in dressing and undressing of night clothes as well as street clothes.

G1h. Eating—How the resident eats and drinks, regardless of skill. Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition).

G1i. Toilet Use—How the resident uses the toilet room, commode, bedpan, or urinal, transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes.

CIHI Tip

Toilet use does not include getting to and from the bathroom.

G1j. Personal Hygiene—How the resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, and washing/drying face, hands, and perineum. Exclude from this definition personal hygiene in baths and showers, which is covered under Bathing.

Process

In order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cueing, physical support, etc.).

A resident's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g. willing to perform for a nurse assistant he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the seven day period, 24 hours a day—i.e. not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

In order to accomplish this, it is necessary to gather information from multiple sources—i.e. interviews/discussion with the resident and direct care staff on all three shifts, including weekends and review of documentation used to communicate with staff across shifts. Ask questions pertaining to all aspects of the ADL activity definitions.

For example, when discussing Bed Mobility with a nurse assistant, be sure to inquire specifically:

- how the resident moves to and from a lying position,
- how the resident turns from side to side, and
- how the resident positions himself or herself while in bed.

A resident can be independent in one aspect of Bed Mobility yet require extensive assistance in another aspect. Since accurate coding is important as a basis for making decisions on the type and amount of care to be provided, be sure to consider each activity definition fully.

The wording used in each coding option is intended to reflect real-world situations in facilities, where slight variations are common. Where variations occur, the coding ensures that the resident is not assigned to an excessively independent or dependent category.

For example, by definition, codes 0, 1, 2 and 3 (Independent, Supervision, Limited Assistance and Extensive Assistance) **permit one or two exceptions for the provision of heavier care**.

This is clinically useful and increases the likelihood that staff will code ADL Self-Performance items consistently and accurately.

Because this section involves a two-part evaluation (Item G1A. ADL Self-Performance and Item G1B. ADL Support), each using its own scale, it is recommended that you complete the Self-Performance evaluation for all ADL Self-Performance activities before beginning the ADL Support evaluation.

- To evaluate a resident's ADL Self-Performance, begin by reviewing the documentation in the clinical record. Talk with clinical staff from each shift to ascertain what the resident does for himself or herself in each ADL activity as well as the type and level of staff assistance being provided. As previously noted, be alert to differences in resident performance from shift to shift, and apply the ADL codes that capture these differences. For example, a resident may be independent in Toilet Use during daylight hours but receive non-weight bearing physical assistance every evening. In this case, the resident would be coded as "2" (Limited Assistance) in Toilet Use.

The following section provides **general guidelines** for recording accurate ADL Self-Performance and ADL Support assessments.

Guidelines for Assessing ADL Self-Performance and ADL Support

- The scales in Items G1A and G1B are used to record the resident's actual level of involvement in self-care and the type and amount of support actually received during the last seven days.
- Do not record your assessment of the resident's capacity for involvement in self-care—i.e. what you believe the resident might be able to do for himself or herself based on demonstrated skills or physical attributes. An assessment of potential capability is covered in Item G8 (ADL Functional Rehabilitation Potential).
- Do not record the type and level of assistance that the resident "should" be receiving according to the written plan of care. The type and level of assistance actually provided might be quite different from what is indicated in the plan. Record what is actually happening.
- Engage direct care staff from all shifts who have cared for the resident over the last seven days in discussions regarding the resident's ADL functional performance. Remind staff that the focus is on the last seven days only. To clarify your own understanding and observations about each ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific.

Example

Here is a **typical conversation** between the RN Assessment Coordinator and a nurse assistant regarding a resident's Bed Mobility assessment:

R.N. "Describe to me how Mrs. L positions herself in bed. By that I mean, once she is in bed, how does she move from sitting up to lying down, lying down to sitting up, turning side to side, and positioning herself?"

N.A. "She can lay down and sit up by herself, but I help her turn on her side."

R.N. "She lays down and sits up without any verbal instructions or physical help?"

N.A. "No, I have to remind her to use her trapeze every time. But once I tell her how to do things, she can do it herself."

R.N. "How do you help her turn side to side?"

N.A. "She can help turn herself by grabbing onto her side rail. I tell her what to do. But she needs me to lift her bottom and guide her legs into a good position."

R.N. "Do you lift her by yourself or does someone help you?"

N.A. "I do it by myself."

R.N. "How many days during the last week did you give this type of help?

N.A. "Every day."

Provided that ADL function in Bed Mobility was similar on all shifts, **Coding for Mrs. L:**

- ADL Self-Performance Code of "3" (Extensive Assistance)
- ADL Support Provided Code of "2" (one person physical assist).

Now review the first two exchanges in the conversation between the RN Assessment Coordinator and nurse assistant. If the RN did not probe further, he or she would not have received enough information to make an accurate assessment of either the resident's skills or the nurse assistant's actual workload, or whether the current plan of care was being implemented.

Coding

For each ADL category, code the appropriate response for the resident's **actual performance during the past seven days**. Enter the code in column (A), labelled "SELF-PERFORMANCE." Consider the resident's performance **during all shifts**, as functionality may vary. In the pages that follow two types of supplemental instructional material are presented to assist you in learning how to use this code: a schematic flow chart for scoring ADL Self-performance and a series of case examples for each ADL.

In your evaluations, you will also need to consider the type of assistance known as "**set-up help**" (e.g. comb, brush, toothbrush, toothpaste have been laid out at the bathroom sink by the nurse assistant). Set-up help is recorded under ADL Support Provided (Item G1B). But in evaluating the resident's ADL Self-performance, include set-up help within the context of the "0" (Independent) code.

For example: If a resident grooms independently once grooming items are set up for him, code "0" (Independent) in G1jA. Personal Hygiene.

CIHI Tip

For all items in section G1A, do not code "totally dependent" unless the resident was totally dependent for ALL episodes during the seven day observation period. If he or she participated or made any effort with anyone (for example, PT, OT, family, or any staff member) during the observation period, he/she would not be coded as totally dependent.

Many factors may have an impact on ADL performance. The guidelines are intended to help staff determine which factors are impeding performance so that they can address those factors and improve performance as much as possible.

0 **Independent**—No help or staff oversight -OR- Staff help/oversight provided only one or two times during the last seven days.

1 **Supervision**—Oversight, encouragement, or cueing provided three or more times during last seven days -OR- Supervision (3 or more times) plus physical assistance provided only one or two times during last seven days.

2 **Limited Assistance**—Resident highly involved in activity, received physical help in guided maneuvering of limbs or other nonweight-bearing assistance on three or more occasions -OR- limited assistance (3 or more times) plus more help provided only one or two times during last seven days.

3 **Extensive Assistance**—While the resident performed part of activity over last seven days, help of following type(s) was provided three or more times:

- Weight-bearing support provided three or more times
- Full staff performance of activity (3 or more times) during part (but not all) of last seven days

4 **Total Dependence**—Full staff performance of the activity during entire seven-day period. Complete non-participation by the resident in all aspects of the ADL definition.

For example, for a resident to be coded as totally dependent in eating, he or she would be fed all food and liquids at all meals and snacks (including tube feeding delivered totally by staff), and never initiate any subtask of eating (e.g. picking up finger foods, giving self tube feeding or assisting with procedure) at any meal.

8 Activity did not occur during the entire 7-day period—Over the last seven days, the ADL activity was not performed by the resident or staff. In other words, the particular activity did not occur at all.

For example, the definition of dressing specifies changing items of clothing (street clothes, underwear). During the seven day period, if the resident did not change his or her clothing, a code of "8" would apply (i.e. the activity did not occur during the entire seven day period). Likewise, a resident who was restricted to bed for the entire seven day period and was never transferred from bed would receive a code of "8" for transfer.

However, do not confuse a resident who is totally dependent in an ADL activity (code 4—Total Dependence) with the activity itself not occurring.

For example, even a resident who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment), and must be evaluated under the eating category for his or her level of assistance in the process. A resident who is highly involved in giving himself a tube feeding is not totally dependent and should not be coded as "4".

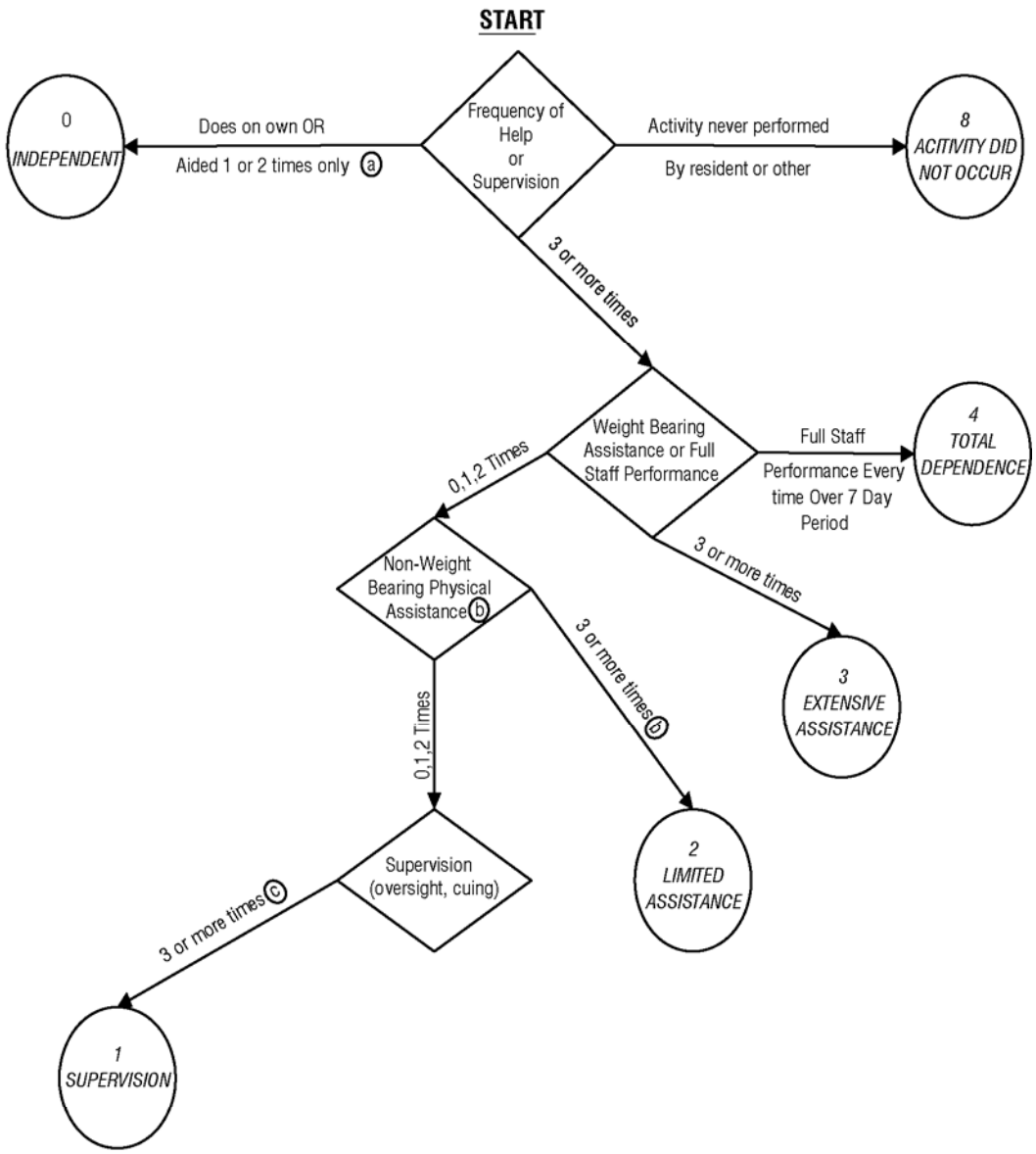
Each of these ADL Self-Performance codes is exclusive; there is no overlap between categories. Changing from one self-performance category to another demands an increase or decrease in the number of times that help is provided. Thus, to move from Independent to Supervision to Limited Assistance, non weight-bearing supervision or physical assistance must increase from one or two times up to three or more times during the last seven days.

There will be times when no one type or level of assistance is provided to the resident 3 or more times during a 7-day period. However, the sum total of support of various types will be provided 3 or more times. In this case, code for the least dependent self-performance category where the resident received that level or more dependent support 3 or more times during the 7-day period.

Examples

- The resident received supervision for walking in the corridor on two occasions and non weight-bearing assistance on two occasions.
  Code "1" for Supervision in Walking in Corridor.
  Rationale: Supervision is the least dependent category.
- The resident received supervision in dressing on one occasion, non weight-bearing assistance (e.g. putting a hat on resident's head) on two occasions, and weight-bearing assistance (e.g. lifting resident's arm into a sleeve) on one occasion during the last 7 days.
  Code "2" for Limited Assistance in Dressing.
  Rationale: There were 3 episodes of physical assistance in the last 7 days: 2 non-weight-bearing episodes, and 1 weight-bearing episode. Limited Assistance is the correct code because it reflects the least dependent support category that encompasses 3 or more activities that were at least at that level of support.

SCORING ADL SELF PERFORMANCE



a. Can include one or two events where received supervision, non-weight bearing help, or weight bearing help.

b. Can include one or two episodes of weight bearing help--e.g., two events with non-weight bearing plus two of weight bearing would be coded as a "2".

c. Can include one or two episodes where physical help received--e.g., two episodes of supervision, one of weight bearing, and one of non-weight bearing would be coded as a "1".

G1B ADL Support Provided

Intent

To record the type and highest level of support the resident received in each ADL activity over the **last seven days**.

Definition

ADL Support Provided—Measures the highest level of support provided by staff over the last seven days, even if that level of support only occurred once. ***This is a different scale, and is entirely separate from the ADL Self-performance assessment.***

Set-up help—The type of help characterized by providing the resident with articles, devices or preparation necessary for greater resident self-performance in an activity. This can include giving or holding out an item that the resident takes from the caregiver.

Examples of Setup Help

- **For bed mobility**—handing the resident the bar on a trapeze.
- **For transfer**—giving the resident a transfer board or locking the wheels on a wheelchair for safe transfer.
- For locomotion:
  - **Walking**—handing the resident a walker or cane.
  - **Wheeling**—unlocking the brakes on the wheelchair or adjusting foot pedals to facilitate foot motion while wheeling.
- **For dressing**—retrieving clothes from closet and laying out on the resident's bed; handing the resident a shirt.
- **For eating**—cutting meat and opening containers at meals; giving one food category at a time.
- **For toilet use**—handing the resident a bedpan or placing articles necessary for changing ostomy appliance within reach.
- **For personal hygiene**—providing a washbasin and grooming articles.
- **For bathing**—placing bathing articles at tub side within the resident's reach; handing the resident a towel upon completion of bath.

Process

For each ADL category, code the maximum amount of support the resident received over the last seven days irrespective of frequency, and enter in the "SUPPORT" column. Be sure your evaluation considers all nursing shifts, 24 hours per day, including weekends. Code independently of the resident's Self-Performance evaluation. For example, a resident could have been Independent in ADL Self-performance in Transfer but received a one-person physical assist one or two times during the seven-day period. Therefore, the ADL Self-Performance Coding for Transfer would be "0" (Independent), and the ADL Support coding "2" (One person physical assist).

Coding

Note: The highest code of physical assistance in this category (other than the "8" code) is a code of "3" not "4" as in Self-performance.

0 No setup or physical help from staff

1 Setup help only—The resident is provided with materials or devices necessary to perform the activity of daily living independently.

2 One person physical assist

3 Two+ persons physical assist

8 ADL activity itself did not occur during the entire 7-days—When an "8" code is entered for an ADL Support Provided category, enter an "8" code for ADL Self-Performance in the same category.

For example, if a resident never left the unit during the assessment period, code "8" for locomotion off unit. The activity did not occur, there was no help provided.

The examples that follow clarify coding for both Self-Performance and Support. The answers appear to the right of the resident descriptions. Cover the answers, read and score the example, and then compare your answers with those provided.

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Bed Mobility • Resident was physically able to reposition self in bed but had a tendency to favour and remain on his left side. He received frequent reminders and monitoring to reposition self while in bed.	1	0
• Resident received supervision and verbal cueing for using a trapeze for all bed mobility. On two occasions when arms were fatigued, he received heavier physical assistance of two persons.	1	3
• Resident usually repositioned himself in bed. However, because he sleeps with the head of the bed raised 30 degrees, he occasionally slides down towards the foot of the bed. On 3 occasions the night nurse assistant helped him to reposition by providing weight-bearing support as he bent his knees and pushed up off the footboard.	3	2
• To turn over, the resident always began by reaching for a side rail for support. He received physical assistance of one person to guide his legs into position and complete the turn by guiding him with a turn sheet (using weight-bearing assistance).	3	2
• Resident independently turned on his left side whenever he wanted. Because of left-sided weakness he received physical weight bearing help of 1–2 persons to turn to his right side or sit up in bed.	3	3
• Because of severe, painful joint deformities, resident was totally dependent on two persons for all bed mobility. Although unable to contribute physically to positioning process, she was able to cue staff for the position she wanted to assume and at what point she felt comfortable.	4	3
Transfer • Despite bilateral above-the-knee amputations, resident almost always moved independently from bed to wheelchair (and back to bed) using a transfer board he retrieves independently from his bedside table. On one occasion in the past week, staff had to remind resident to retrieve the transfer board. On one other occasion, the resident was lifted by a staff member from the wheelchair back into bed.	0	2
• Resident was physically independent for all transfers. However, he would not get up in the morning until the nurse assistant rearranged his bed covers and released the half side rail on his bed.	0	1

Examples: ADL Self-Performance and Support	Self-Perf.	Support
• Once someone correctly positioned the wheelchair in place and locked the wheels, the resident transferred independently to and from the bed.	0	1
• Resident moved independently in and out of armchairs but always received light physical guidance of one person to get in and out of bed safely.	2	2
• Transferring ability varied throughout each day. Resident received no assistance at some times and heavy weight-bearing assistance of one person at other times.	3	2
Walk in room • Resident walked in his/her room while holding on to furniture for support.	0	0
• Resident walked independently during the day and received non-weight bearing physical help of 1 person for getting to the bathroom in room at night.	2	2
• Resident received non-weight bearing physical assistance of one person for all walking in own room.	2	2
• Resident did not walk but wheeled self independently in own room.	8	8
Walk in corridor • A timid, fearful resident is usually physically independent in walking. During the last week she was very anxious and fearful of falling, and therefore received reassurance and encouragement from someone walking next to her while walking back to her room from meals in the unit dining room.	1	0
• A resident with memory loss ambulated independently on the unit corridor albeit with a walker. Several times a day she left her walker in the bathroom, in the dining room, etc., necessitating that someone return it to her and offer her reminders to use it for safety.	1	1
• Resident walked in corridor on unit by supporting self on one side with the handrail along the wall and receiving verbal cues from another person.	1	0
• Resident walked twice daily 4–6 feet in the corridor outside his room. He received weight bearing assistance of 1 person for each walk.	3	2
• Resident walked in room for short distances with heavy assistance of 2 persons but traveled independently in corridor on unit by wheelchair.	8	8

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Locomotion on unit • Resident ambulated slowly on unit pushing a wheelchair for support, stopping to rest every 15–20 feet. She has good safety awareness and has never fallen. Staff felt she was reliable enough to be on her own.	0	0
• A resident with a history of falling and an unsteady gait always received physical guidance (non-weight-bearing) of one person for all ambulation. Two nights last week the resident was found in his bathroom after getting out of bed and walking independently.	2	2
• Resident ambulated independently around the unit "ad lib," socializing with others and attending activities during the day. Loves dancing and yoga. Because she can become afraid at night, she received contact guard of one person to walk her to the bathroom at least twice every night.	2	2
• During last week resident was learning to walk short distances with new leg prosthesis with heavy partial weight-bearing assistance of two persons. He refuses to ride in a wheelchair.	3	3
Locomotion off unit • Resident independently walked with a cane to all meals in the Main Dining Room (off the unit) and social and recreational activities in the nearby hobby shop. Received no set-up or physical help during the assessment period.	0	0
• Resident walked independently to the off unit dining room for all meals. For one visit to a clinic held at the opposite end of the building she was given a ride in a wheelchair by a volunteer. She was wheeled to the clinic and after her session she was wheeled back to her unit.	0	2
• Resident is independent in walking about her residential unit. She does get lost and has difficulty finding her room but enjoys stopping to chat with others. Because she would get lost, she was always accompanied by a staff member for her daily walks around the facility.	1	0
• Resident did not leave the residential unit during the 7-day assessment period.	8	8
Dressing • Resident usually dressed self. After a seizure, she received total help from several staff members once during the week.	0	3
• Resident is totally independent in dressing herself except for donning and removing TED stockings. Nurse assistant applied the TED stockings each AM and removed them at bedtime.	3	2

Examples: ADL Self-Performance and Support	Self-Perf.	Support
• Nurse assistant provided physical weight-bearing help with dressing every morning. Later each day, as resident felt better (joints were more flexible), she required staff assistance only to undo buttons and guide her arms in/out of sleeves every pm.	3	2
• A 325 lb. resident received total care by two persons in dressing. He did not participate by putting arms through sleeves, lifting legs into shoes, etc.	4	3
Eating • Resident arose daily after 9:00 am, preferring to skip breakfast and just munch on fresh fruit later in the morning. She ate lunch and dinner independently in the facility's main dining room.	0	0
• Resident on long standing tube feedings via gastrostomy tube was completely independent in self-administration including self-medication via the tube once set up by staff.	0	1
• Resident with a history of dysphagia and choking, ate independently as long as a staff member sat with him during every meal (stand-by assistance if necessary).	1	0
• Resident is blind and confused. He ate independently once staff oriented him to types and whereabouts of food on his tray and instructed him to eat.	1	1
• Cognitively impaired resident ate independently when given one food item at a time and monitored to assure adequate intake of each item.	1	1
• Resident fed self solid foods independently at all meals and snacks. Self-administered all fluids and medications via G-tube with supervision once set up appropriately.	1	1
• Resident with difficulty initiating activity always ate independently after someone guided her hand with the first few bites and then offered encouragement to continue.	2	2
• Resident with fine motor tremors fed self finger foods (e.g. sandwiches, raw vegetables and fruit slices, crackers) but always received supervision and total physical assistance with liquids and foods requiring utensils.	3	2
• Resident fed self with staff monitoring at breakfast and lunch but tired later in day. She was fed totally by nursing assistant at supper meal.	3	2
• Resident who was being weaned from gastrostomy tube feedings continued to receive total care for twice daily tube feedings. Additionally, she ate small amounts of food by mouth with staff supervision.	3	2

Examples: ADL Self-Performance and Support	Self-Perf.	Support
• Resident received tube feedings via a jejunostomy for all nutritional intake. Feedings were given by a nurse.	4	2
Toileting Use • Resident used bathroom independently once up in a wheelchair; used bedpan independently at night after it was set up on bedside table.	0	1
• In the toilet room resident is independent. As a safety measure, the nurse assistant stays just outside the door, checking with her periodically.	1	0
• Resident uses the toilet independently but occasionally required minor physical assistance for hygiene and straightening clothes afterwards. She received such help twice during the last week.	0	2
• When awake, resident was toileted every two hours with minor assistance of one person for all toileting activities (e.g. contact guard for transfers to/from toilet, drying hands, zipping/buttoning pants). She required total care of one person several times each night after incontinence episodes.	3	2
• Resident received heavy assistance of two persons to transfer on/off toilet. He was able to bear weight partially, and required only standby assistance with hygiene (e.g. being handed toilet tissue or incontinence pads).	3	3
• Obese, severely physically and cognitively impaired resident receives a hoyer lift for all transfers to and from her bed. It is impossible to toilet her and she is incontinent. Complete personal hygiene is provided at least every 2 hours by 2 persons.	4	3
Personal Hygiene • New resident, in adjustment phase, liked to sleep in his clothes in case of fire. He remained in the same clothes for 2–3 days at a time. He cleaned his hands and face independently and would not let others help with any personal hygiene activities.	0	0
• Once grooming articles were laid out and arranged by staff, resident regularly performed the tasks of personal hygiene by receiving verbal directions from one person throughout each task.	1	1
• Resident carried out personal hygiene but was not motivated. She received daily cueing and positive feedback from nursing staff to keep self clean and neat. Once started, she could be left alone to complete tasks successfully.	1	0
• Resident shaves self with an electric razor, washes his face and hands, brushes his teeth, and combs his hair. Because he is losing his sight, staff stand-by to hand grooming articles to the resident and return articles to their proper location.	1	1

G2 Bathing

Bathing is the only ADL activity for which the ADL Self-Performance codes in item G1A do not apply. A unique set of Self-Performance codes, to be used only in the Bathing assessment, are described below. The Self-Performance codes for the other ADL items would not be applicable for bathing given the normal frequency with which the bathing activity is carried out during a one-week period. Assuming that the average frequency of bathing during a **seven-day period** would be one or two baths, the coding for the other ADL Self-Performance items, which permits one or two exceptions of heavier care, would result in the inaccurate classification of almost all residents as "Independent" for Bathing.

The ADL Support Provided codes given in item G1B, however, continue to apply to the Bathing activity.

Intent

To record the resident's Self-Performance and Support provided in bathing, including how the resident transfers into and out of the tub or shower.

Definition

Bathing—How the resident takes a full body bath, shower, or sponge bath, including transfers in and out of the tub or shower. The definition does not, however, include the washing of back or hair.

Coding

G2A. Bathing Self-performance Codes—Record the resident's self-performance in bathing according to the codes listed below. When coding, apply the code number that reflects the maximum amount of assistance the resident received during bathing episodes.

0 Independent—No help provided

1 Supervision—Oversight help only.

2 Physical help limited to transfer only

3 Physical help in part of bathing activity

4 Total dependence

8 Bathing did not occur during the entire 7 days

G2B. Support—Next, score the maximum amount of support provided in bathing activities using the ADL Support Scale (Item G1B).

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Bathing • Resident received verbal cueing and encouragement to take twice-weekly showers. Once staff walked resident to bathroom, he bathed himself with periodic oversight.	1	0
• On Monday, one staff member helped transfer resident to tub and washed his legs. On Thursday, resident had physical help of one person to get into tub but washed himself completely.	3	2
• Resident afraid of hoyer lift. Given full sponge or bed bath by nurse assistant twice weekly. Actively involved in this activity.	3	2
• For one bath, resident received light guidance of one person to position self in bathtub. However, due to her fluctuating moods, she received total help for her other bath. **Rationale***:* The coding directions for bathing state, "***code for most dependent in self performance and support***."	4	2

G3 Test for Balance

Residents with impaired balance in standing and sitting are at greater risk of falling. It is important to assess an individual's balance abilities so that interventions can be implemented to prevent injuries (e.g. strength training exercises; safety awareness; restorative nursing; nursing-based rehabilitation).

Intent

To record the resident's capacity of a. Balance while standing (not walking) without an assistive device or assistance of a person, and b. Balance while sitting without using the back or arms of the chair for support.

CIHI Tip

Observation period: last 7 days

Process

G3a. Balance While Standing

Preparation

- Obtain a watch with a second hand to time the test.
- Pick a time to test the resident when he or she is likely to be at his or her best. If the resident refuses, negotiate a better time and try again later.
- Place a chair directly behind the resident in case the resident needs to sit down.
- Stand close to the resident while testing balance in order to catch or balance the resident, if necessary.
- If the resident is heavy or tall or seems frail, ask another staff person to stand by with you in case the resident needs assistance.
- Test balance without assistive devices (but with prostheses, if used). For residents who use walkers, make sure the walker is placed directly in front of the resident within easy reach in case it is needed for rebalancing.

Conducting the Tests

- **DO** each of the following tests (10 seconds each) on residents who are able to stand without physical help.
- **DO NOT** attempt to test residents who cannot stand by themselves. Code these residents as "3", Not able to attempt test without physical help.
- For persons with visual impairment who may not be able to see your demonstrations of feet placement, provide rich verbal descriptions.

Position 1

- I would like you to stand with your feet together, side-by-side, like this (demonstrate as illustrated). [Note, in this and all tests, both feet should be firmly on the floor for support.]
- "Do not move your feet until I say stop. Ready, OK, begin." If the resident is ABLE to maintain this position for 10 seconds, proceed to test resident in Position 2. If the resident is NOT ABLE to maintain this position for 10 seconds, stop testing here. Do not proceed with Position 2 for balance testing.

Position 2

- "Now I would like you to stand with one foot halfway in front of the other like this" (demonstrate as illustrated).
- "You may use either foot, whichever is more comfortable for you. Ready, OK, begin." If the resident is ABLE to maintain this position for 10 seconds, proceed to test resident in Position 3. **If the resident is NOT ABLE to do this, stop testing here.**

Position 3

- "Now I would like you to stand with the heel of one foot in front of you touching the toes of the other foot like this (demonstrate as illustrated). You may use either foot, whichever is more comfortable for you. Ready, OK, begin."

Coding

0 Maintained position as required in test—Resident was able to ***maintain all 3 standing positions for 10 seconds*** without moving feet out of position.

1 Unsteady, but able to rebalance self without physical support—Resident was unable to maintain one or more standing positions for 10 seconds each without moving feet out of position. Resident was unsteady but was able to rebalance self without physical support from others or from an assistive device in at least the first position.

2 Partial physical support during test, or stands but does not follow directions for test—While the resident performed part of the activity, resident was unable to maintain one or more standing positions without physical support from other(s) or from an assistive device. This category also includes residents who can stand but are unable or refuse to follow your directions to perform a test of balance.

3 Not able to attempt test without physical help—Resident is not able to stand without physical help from another person or an assistive device.

Examples of Balance Testing

- Mrs. R usually walks with a walker. After completing the test preparation steps for safety, which include placing Mrs. R's walker directly in front of her in case she needs it during the test, you briefly explain to Mrs. R what you are going to ask her to do. You also demonstrate the actions. Once Mrs. R is standing, start to test her in Position 1 by giving her the brief directions and your demonstration of the position. You start timing her once you say, "Ready, OK, begin".

  Results: During the 10-second test, Mrs. R moves her feet out of position to rebalance herself.

  How to proceed: Tell Mrs. R, "That was a good try." STOP the test because the next 2 positions are harder to perform. If Mrs. R cannot maintain Position 1, it is unlikely she will be able to maintain Positions 2 or 3.

  Coding: "1", Unsteady, but able to rebalance self without physical support.

  Rationale: Mrs. R moved her feet out of position but did not need to hold her walker, or lean against the chair behind her, or receive assistance from you during the 10 seconds.

- Mr. C has cognitive and hearing impairment and restlessness. He usually walks independently (wandering) and occasionally stands at the nurses' station to be with the unit secretary. Therefore, you know he can stand, but you do not know if he would be able to maintain his balance if her were asked to "hold" specific standing positions for 10 seconds each. After completing the test preparation, and steps for safety, you give Mr. C the brief directions and demonstration for testing position 1.

  Results: During your interaction with Mr. C he becomes agitated, says "No, no" and walks away.

  How to proceed: STOP the test.

  Coding: "2", Partial physical support during test or stands but does not follow directions for test.

  Rationale: This is the best you can do under the circumstances. Although Mr. C did not need physical help to balance, you really do not know what his true balance capacity is. All you know is that he is able to stand, but you can't test his balance capacity because he refuses and is unable to follow directions.

- Ms. M has multiple sclerosis and has been confined to her bed and reclining chair for the last 2 years.

  How to proceed: DO NOT perform any standing balance tests. Ms. M cannot stand.

  Coding: "3", Not able to attempt test without physical help.

Process

G3b. Balance While Sitting—Position, Trunk Control

Preparation

- Obtain a watch with a second hand to time the test.
- Do not conduct sitting balance in wheelchair. Find a chair with a firm, solid seat to conduct the test.
- The height of the chair seat should be low enough to allow the bottom of the resident's feet to rest on the floor for support. (Of course, this does not apply to persons with bilateral leg amputations.)
- It is safer to use a chair with arms in case the resident needs physical support during the test.
- Stand close to the resident while testing sitting balance in order to catch or balance the resident, if necessary.
- If the resident is heavy or tall or seems frail, ask another staff person to stand by with you in case the resident needs assistance.

Conducting the test

- **DO NOT** attempt to test residents who are clearly unable to sit without physical help. Code these residents as "3", Not able to attempt test without physical help.
- Instruct the resident to sit in a chair with arms folded across his or her chest without using the back or arms of the chair for support. Make sure the resident's feet are both flat on the floor for support. Demonstrate the action to the resident. Observe balance for 10 seconds, then ask resident to stop.

Coding

0 Maintained position as required in test—Resident was ABLE to sit for 10 seconds without touching the back or sides of the chair for support.

1 Unsteady, but able to rebalance self without physical support—Resident was unable to maintain sitting balance for 10 seconds without touching the back or sides of the chair for support. Resident was unsteady but was ABLE to rebalance self.

2 Partial physical support during test or sits but does not follow directions for test—While resident performed part of activity, resident was UNABLE to maintain sitting balance without physical support **from** other(s) or from touching the backs or sides of the chair for support. This category also includes residents who can sit but are unable or refuse to follow your directions to perform this test of sitting balance.

3 Not able to attempt test without physical help—Resident is not able to sit without physical help from another, or an assistive/adaptive device, or chair back/arms for support.

Examples of Sitting Balance

- Ms. Z spends a lot of time sitting in a wheelchair on a gel cushion for pressure relief. She has a left-sided below-the-knee amputation. She does not have a leg prosthesis. She also has a left-sided hemiparesis from a CVA 1 year ago. You complete the test preparation activities for safety, assist Ms. Z to transfer into a chair with a firm seat, and ask her to place her right foot firmly on the floor. You instruct her to cross her arms over her chest. She cannot lift her left arm across her chest but is able to hold it across her abdomen. You instruct her to "sit up in the chair without leaning on the chair back or arms for support". You demonstrate this activity from another chair. Once the resident begins, you time for 10 seconds.

  Results: Ms. Z maintained the position for the full 10 seconds without touching the chair back/arms for support.

  How to proceed: Tell Ms. Z, "You did an excellent job. That's all we have to do." STOP testing. The test is complete.

  Coding: "0", Maintained position as required in test.

G4 Functional Limitation in Range of Motion

Intent

Limitation in the range of motion—To record the presence of (A) functional limitation in range of joint motion or (B) loss of voluntary movement.

Column A—Functional Limitation in Range of Motion

Definition

Limitation in the capacity of a joint to move through its range that interferes with daily functioning (particularly with activities of daily living), or places the resident at risk. Range of motion can be assessed actively, with partial physical assistance (active assisted) or passively.

Process

Assessing for functional limitations. This test is a screening item used to determine the need for a more intensive evaluation. It does not need to be performed by a physical therapist. Rather, it can be administered by a member of any clinical discipline in accordance with these instructions.

- Do each of the following tests on all residents unless contraindicated (e.g. recent fracture or joint replacement).
- Perform each test on both sides of the resident's body.
- If the resident is unable to follow verbal directions demonstrate each movement (e.g. Ask the resident to do what you're doing).

- If resident is still unable to perform the activity after your demonstration, move the resident's limbs through slow, active assisted or passive range of motion to assess for limitations. In active assistive range of motion movements, the health professional provides support and direction with the resident performing some of the activity. In passive range of motion movements, the health professional moves the resident's limb through slow range of motion.
- If resident is unable to move the body part voluntarily, assess passive range of motion as it relates to functional activities such as bathing the resident, personal care, dressing the resident and positioning for daily activities (e.g. seating).
- STOP if a resident experiences pain.

G4a. **Neck**—With resident seated in a chair, ask him or her to turn the head slowly, looking side to side. Then ask the resident to return head to centre and then try to reach the right ear towards the right shoulder, and then left ear towards left shoulder. If the resident requires physical assistance to assess neck range of motion, complete the assessment with the resident lying down or supported in bed with the head of the bed raised to provide support to the head throughout the movements.

G4b. **Arm**—including shoulder or elbow—With resident seated in a chair instruct him or her to reach with both hands and touch palms to back of the head (mimics the action needed to comb hair). Then ask the resident to touch each shoulder with the opposite hand. Alternatively, observe the resident donning or removing a shirt over the head.

G4c. **Hand**—including wrist or fingers—For each hand, instruct the resident to make a fist, then open the hand (useful actions for grasping utensils, letting go).

G4d. **Leg**—including hip or knee—While resident is lying supine in a flat bed, instruct the resident to lift his or her leg (one at a time), bending it at the knee, drawing the heel toward the buttock. [The knee will be at a right angle (90 degrees)]. Then ask the resident to slowly lower his or her leg, and straighten leg on the mattress.

G4e. **Foot**—including ankle or toes—While supine in bed, instruct the resident to flex (pull toes up towards head) and extend (push toes down away from head) each foot. Alternatively, observe the resident's ability to place foot flat on ground to prepare to stand, or to place feet flat on wheelchair footrests. Observe resident's ability to keep heel flat on ground during standing or standing transfer, wearing usual footwear.

G4f. **Other limitation or loss**—Decreased mobility in spine, jaw, or other joints that are not listed.

Coding

For each body part, code the appropriate response for the resident's active (or active-assisted or passive) range of motion function during the **past seven days**. Enter the code in the column labelled (A).

If the resident has an amputation on one side of the body, use Code "1", Limitation on one side of the body. If there are bilateral amputations, use code "2", Limitation on both sides of the body.

0 No limitation—Resident has full functional range of motion on the right and left side.

1 Limitation on one side (either right or left side).

2 Limitation on both sides

Example of Coding for (A) Limitation in Range of Motion

Mr. O was admitted to the facility for rehabilitation following right knee surgery. His right leg is in an immobilizer. With the exception of his right leg, Mr. O has full active range of motion in all other areas.

Coding (Column A: Functional Limitation in Range of Motion)

Neck	0
Arm	0
Hand	0
Leg	1
Foot	0
Other	0

Column B—Loss of Voluntary Movement

Definition

Loss of voluntary movement—Impairment in purposeful (intentional) functional movement. This category refers to a range of impairments exhibited when a resident tries to perform a task and includes deficits such as incoordination, tremors, spasms, muscular rigidity, "freezing", choreiform movements (jerking) as well as lack of initiation of movement. Impairments in voluntary movement are often due to injury or disease of muscles, bones, nerves, spinal cord or the brain and can place a resident at risk for functional disability and injury.

Process

While performing the assessment of range of motion in item G4(A) above, observe the resident for impairment(s) in purposeful movement on each side of the resident's body.

Coding

For each body part, code the appropriate response for the resident's function during the past seven days. Enter the code in the column labelled (B). If the body part is missing on one side (e.g. left above knee amputation), code "1", Partial loss of voluntary movement. If missing bilaterally, code "2", Full loss of voluntary movement.

0 **No loss**—Resident voluntarily moves body part to complete the required task. Movements are smooth and co-ordinated.

1 **Partial loss**—Resident is able to initiate and complete the required task but movements are slow, spastic, uncoordinated, rigid, choreiform, etc. on one or both sides.

2 **Full loss**—Resident is not able to initiate the required task. There is no voluntary movement on either side.

Example of Functional Limitation (A and B)

Mrs. X is a diabetic, with bilateral foot amputations, who sustained a CVA two months ago. She can only turn her head slightly from side to side and tip her head towards each shoulder, even with physical assistance (due to limited neck range of motion). She can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. She is unable to move her left side (limited arm, hand, and leg movement) as she has a flaccid left hemiparesis, but staff are able to passively move her left side (arm, hand, and leg) through functional range of motion. She is able to extend her legs flat on the bed. She has no other limitations.

Coding

	(A) Limitation in Range of Motion	(B) Loss of Voluntary Movement
G4a. Neck	2	0
G4b. Arm	0	1
G4c. Hand	0	1
G4d. Leg	0	1
G4e. Foot	2	2
G4f. Other	0	0

G5 Modes of Locomotion

Intent

To record the type(s) of appliances, devices, or personal assistance the resident used for locomotion (on and off unit).

Definition

G5a. Cane, walker, or crutch—Also check this item in those instances where the resident walks by pushing a wheelchair for support.

G5b. Wheeled self—Includes using a hand-propelled or motorized wheelchair, as long as the resident takes responsibility for self-mobility, even for part of the time.

G5c. Other person wheeled—Another person pushed the resident in a wheelchair.

G5d. Wheelchair primary mode of locomotion—Even if resident walks some of the time, he or she is primarily dependent on a wheelchair to get around. The wheelchair may be motorized, self-propelled, or pushed by another person.

G5e. NONE OF ABOVE

Coding

Check all that apply during the **last 7 days**. If no appliances or assistive devices were used, check *G5e. NONE OF ABOVE*.

G6 Modes of Transfer

Intent

To record the type(s) of appliances or assistive devices the resident used for transferring in and out of bed or chair, and for bed mobility.

> **CIHI Tip**
> Observation period: last 7 days

Definition

G6a. Bedfast all or most of the time—Resident is in bed or in a recliner for 22 hours or more per day. This definition also includes residents who are primarily bedfast but have bathroom privileges. For care planning purposes this information is useful for identifying residents who are at risk of developing physical and functional problems associated with restricted mobility, as well as cognitive, mood, and behaviour impairment related to social isolation. **Code this item when it was true on at least 4 of the last 7 days.**

G6b. Bed rail(s) used for bed mobility or transfer—Refers to any type of side rail(s) attached to the bed USED by the resident as a means of support to facilitate turning and repositioning in bed, as well as for getting in and out of bed. **Do not check this item if resident did not use rails for this purpose.**

G6c. Lifted manually—The resident was completely lifted by one or more persons.

G6d. Lifted mechanically—The resident was lifted by a mechanical device (e.g. Hoyer lift). Does not include a bath lift.

G6e. Transfer Aid—Includes devices such as slide boards, trapezes, canes, walkers, braces and other assistive devices.

G6f. NONE OF ABOVE

Coding

Check all that apply. If none of these items apply, check *G6f. NONE OF ABOVE*.

G7 Task Segmentation

Intent

To identify residents who are more involved and independent in personal care tasks (such as eating, bathing, grooming, dressing) because they have received help in breaking tasks down into smaller steps. Some residents become overwhelmed and anxious when there are expectations for greater independence and they are no longer able to perform the steps necessary to complete an ADL activity. Such residents are at great risk for becoming dependent on others unless activities are made easier for them to manage by task segmentation. These residents usually have some deficits in memory, thinking, or paying attention to the task consequent to problems such as dementia, head injury, CVA, or depression. Other residents receive task segmentation care because of body-control problems, poor stamina, or other physical difficulties that limit self-performance.

Definition

Task segmentation provides the resident with directions—such as verbal cues, physical cues, or verbal and physical cues—for performing each constituent step in an ADL activity.

Verbal cueing involves giving a verbal direction to complete the first step in a task, and once the step is accomplished, giving another verbal direction to complete the next step. Verbal encouragement, praise, and feedback for the resident's successful completion of the steps are usually given by the direct care staff person prior to providing the next verbal cue. For example, "That looks good. Now put on this skirt."

Physical cueing involves giving the resident an object as a reminder of what needs to be done—e.g. handing the resident some toilet paper as a cue to wipe self, or placing an item from a food tray in front of the resident and handing him or her a fork as a cue to eat the item.

Physical and verbal cueing involves use of objects and words to stimulate action—e.g. giving the resident one item of clothing at a time and saying "Put this shirt on," which is less confusing to a cognitively impaired resident than putting all clothing items before him or her and saying "Get dressed."

Examples

Task Segmentation

- When handed a soapy face cloth and asked, "Would you please wash your face?"—the resident washes her face.
- When a nurse assistant sets a mirror in front of the resident, and hands him a brush, the resident brushes his hair.
- When the nurse assistant hands the resident a sock and says "Put this sock on this foot" and upon completion of the step hands the resident another sock and says "Put this sock on this foot," the resident dons his socks.
- When single food items and only one utensil are presented to the resident in succession, the resident eats independently.
- When a nurse assistant gives verbal directions for each step in transferring from a wheelchair (e.g. "Lock the brakes... Hold onto the arms of the chair and push yourself up... Hold onto your walker with both hands like this [demonstrates]"), the resident succeeds in transferring himself from a seated to a standing position.

For all above examples:

Code "1" for Yes.

No Task Segmentation

- When a washbasin, a face cloth, a towel, and various grooming supplies are placed before the resident, the resident becomes overwhelmed.
- When a nurse assistant places the resident's clothes for the day on the bed and says, "Get dressed," the resident becomes confused and is unable to dress self.
- When a tray containing an entire meal and several different utensils are placed before the resident on a table, the resident becomes confused and is unable to eat by herself.
- When a nurse assistant lifts a resident from a sitting to a standing position and does not involve the resident in the process of self-care in the activity, the resident becomes more physically dependent on the nurse assistant.

For all above examples:

Code "0" for No.

Process

Ask the nurse assistant to think about how the resident completes activities of daily living, or ways the nurse assistant helped the resident complete an activity of daily living over the last seven days. Specifically: Did the nurse assistant break the ADL activity into subtasks (smaller steps) so that the resident could perform them? Did this occur in the **last seven days**?

Coding

0 If task segmentation was not done.

1 If ADLs were broken into a series of subtasks so that resident could perform them.

G8 ADL Functional Rehabilitation Potential

Intent

To describe beliefs and characteristics related to the resident's functional status that may indicate he or she has the capacity for greater independence and involvement in self-care in at least some ADL areas. Even if highly independent in an activity, the resident may believe he or she can do better (e.g. walk longer distances, shower independently).

> **CIHI Tip**
> Observation period: last 7 days

Process

G8a. Resident believes self to be capable of increased independence in at least some ADLs

Ask if the resident thinks he or she could be more self-sufficient given more time. Listen to and record what the resident believes, even if it appears unrealistic. Also, as a clue to whether the resident might do better all the time, ask if his or her ability to perform ADLs varies from time to time, or if ADL function or joint range of motion has declined or improved in the last three months.

G8b. Direct care staff believe resident is capable of increased independence in at least some ADLs

G8c. Resident is able to perform tasks/activity but is very slow

G8d. Difference in ADL self-performance or ADL support, comparing mornings to evenings

Ask direct care staff (e.g. nurse assistants on all shifts) who routinely care for the resident if they think he or she is capable of greater independence, or if the resident's performance in ADLs varies from time to time. Ask if ADL function or range of motion of joints declined or improved in the last three months. **You may need to prompt staff to consider such factors as:**

- Has self-performance in any ADL varied over the last week (e.g. the resident usually requires two-person assistance but on one day transferred out of bed with assistance of one person)?
- Has resident's performance varied during the day (e.g. more involved and independent in the afternoon than in the morning)?
- Was the resident so slow in performing some activities that staff members intervened and performed the task or activity? Is the resident capable of increased self-performance when given more time?—OR— Is the resident capable of increased self-performance when tasks are broken into manageable steps?
- Does the resident tire noticeably during most days?
- Does the resident avoid an ADL activity even though physically or cognitively capable (e.g. refuses to walk alone for fear of falling, demands that others attend to personal care because they do it better)?
- Has the resident's performance in any ADL improved?

Coding

Check all that apply. If none of these items apply check *G8e. NONE OF ABOVE*.

Examples

- Mr. N, who is cognitively impaired, receives limited physical assistance in locomotion for safety purposes. However, he believes he is capable of walking alone and often gets up and walks by himself when staff aren't looking. **Check G8a (Resident believes he/she capable of increased independence).**
- The nurse assistant who totally feeds Mrs. W has noticed in the past week that Mrs. W has made several attempts to pick up finger foods. She believes Mrs. W could become more independent in eating if she received close supervision (cueing) in a small group for restorative care in eating. **Check G8b (Direct care staff believes resident is capable of increased independence).**
- Mrs. Y has demonstrated the ability to get dressed, but has missed breakfast on several occasions because she was slow getting organized. Therefore, every morning her nurse assistant physically helped her to dress so that she would be ready for breakfast. **Check G8c (Resident able to perform task but is very slow).**

Examples (cont'd)

- Mrs. F remained continent during day shifts while receiving supervision in toileting. During the evening and night shifts she was incontinent because she was not helped out of bed to the toilet room. After incontinence episodes, direct-care staff provided total help in hygiene. **Check G8d (Difference in ADL self-performance or ADL support, comparing mornings to evenings).**
- Mr. K has hemiplegia secondary to a CVA. He receives extensive assistance in bed mobility transfer, dressing, toilet use, personal hygiene and eating. He is totally dependent in locomotion (wheelchair). Whenever he has tried to do more for himself he has experienced chest pain and shortness of breath. Both Mr. K and direct care staff believe that he is involved in self-care as much as he is physically able.

  Check G8e (*NONE OF ABOVE*).

G9 Change in ADL Function

Intent

To document any changes occurring in the resident's overall ADL self-performance, as compared **to status of 90 days ago** (or since last assessment if less than 90 days ago). These include, but are not limited to, changes in the resident's level of involvement in ADL activities as well as the amount and the type of support received by staff. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Process

Review the record for indications of a change. Consult with the resident and direct care staff. Review Section G from the last assessment and compare these findings with current findings. For new residents, consult with the primary family caregiver.

Coding

0 If there has been no change.

1 If the resident's ADL function has improved.

2 If the resident's function has deteriorated.

You may find that some ADLs have improved, some deteriorated, and others remain unchanged. You must weigh all of the information and make an overall clinical judgment (e.g. in general, the resident's ADL function has...).

Examples

- Dr. B had been highly involved in self-care in most ADL activities. Seven weeks ago he slipped, fell, and bruised his right wrist. For several weeks he received more extensive assistance with dressing, grooming, and eating. However, in the last three weeks he is functioning at the same level of involvement in ADLs as before the fall. Code "0" for No change.
- Ms. A participated in a structured feeding group during the past six weeks. With lots of encouragement and supervision from the group leader, she has progressed from requiring extensive assistance to feeding herself under staff supervision. Her performance in other ADLs remains unchanged. Code "1" for Improved.
- Since fracturing her left hip three weeks ago, Mrs. Z receives more weight bearing help with transfers, locomotion, dressing, toileting, personal hygiene, and bathing. However, she has made strides in OT and PT. Her improvement in self-care has been steady although she still has a long way to go to reach her Self-Performance level of 90 days ago. Code "2" for Deteriorated.
- Mr. L's favorite nurse (Miss McC) transferred to another unit 30 days ago. Although he says he's happy for her, he has become more passive and withdrawn. He no longer dresses himself in a suit and tie. His personal hygiene habits have deteriorated and he now must be frequently coaxed to shave and wash himself and comb his hair. Because he now wears stained clothing, staff have started to select and set out his clothes each day. Despite these losses, Mr. L is now somewhat more self-sufficient in locomotion, making twice-a-week trips to see Miss McC on her new unit. Code "2" for Deteriorated.

  The rationale for the coding decision is that although some improvement is noted in one ADL activity (locomotion) it only occurs twice weekly. In general, Mr. L has deteriorated in his self-care performance in two ADL activities (dressing and personal hygiene) that require multiple daily tasks.
- During a Significant Change assessment for severe mood distress, Mrs. M was found to be more dependent on others for physical assistance in personal hygiene, dressing and toileting. She also received more coaxing and encouragement to eat. These changes represented less involvement in self-care since the last assessment two months ago. Code "2" for Deteriorated.

Section H—Continence in Last 14 Days

H1 Continence Self-Control Categories

H1a. Bowel Continence

H1b. Bladder Continence

Note: This section differs from the other ADL assessment items in that the time period for review has been extended to 14 days. Research has shown that 14 days are the minimum required to obtain an accurate picture of bowel continence patterns. For the sake of consistency, both bowel continence and bladder continence are evaluated over 14 days.

Intent

To determine and record the resident's pattern of bladder and bowel continence (control) over the last 14 days.

Definition

Bladder and Bowel Continence—Refers to control of urinary bladder function and/or bowel movement. **This item describes the resident's bowel and bladder continence pattern even with scheduled toileting plans, continence training programs, or appliances**. It does not refer to the resident's ability to toilet self—e.g. a resident can receive extensive assistance in toileting and yet be continent, perhaps as a result of staff help. The resident's self-performance in toilet use is recorded in Item G1iA.

CIHI Tips

- Bladder incontinence includes any level of dribbling or wetting of urine.
- If a resident has an ostomy that leaks, a code of 1 to 4 would apply, depending on the frequency that the ostomy bag has leaked.

Process

Review the resident's clinical record and any urinary or bowel elimination flow sheets (if available). Validate the accuracy of written records with the resident. Make sure that your discussions are held in private. Control of bladder and bowel function are sensitive subjects, particularly for residents who are struggling to maintain control. Many people with poor control will try to hide their problems out of embarrassment or fear of retribution. Others will not report problems to staff because they mistakenly believe that incontinence is a natural part of aging and that nothing can be done to reverse the problem. Despite these common reactions to incontinence, many elders are relieved when a health care professional shows enough concern to ask about the nature of the problem in a sensitive, straightforward manner.

- Validate continence patterns with people who know the resident well (e.g. primary family caregiver of newly admitted resident; direct care staff).
- Remember to consider continence patterns over the last 14-day period, 24 hours a day, including weekends. If staff assignments change frequently, consider initiating and maintaining a bladder and bowel elimination flow sheet in order to gather more accurate information as a basis for coding decisions and, ultimately, care planning.

A five-point coding scale is used to describe continence patterns. Notice that in each category, different frequencies of incontinent episodes are specified for bladder and bowel. The reason for these differences is that there are more episodes of urination per day and week, whereas bowel movements typically occur less often.

0 **Continent**—Complete control (including control achieved by care that involves prompted voiding, habit training, reminders, etc.).

1 **Usually Continent**—Bladder incontinent episodes occur once a week or less. Bowel incontinent episodes occur less than once a week.

2 **Occasionally Incontinent**—Bladder incontinent episodes occur two or more times a week but not daily. Bowel incontinent episodes occur once a week.

3 **Frequently Incontinent**—Bladder incontinent episodes tend to occur daily, but some control is present (e.g. on day shift). Bowel incontinent episodes occur two to three times per week.

4 **Incontinent**—Has inadequate control. Bladder incontinent episodes occur multiple times daily. Bowel incontinent is all (or almost all) of the time.

Coding

Choose one response to code level of bladder continence and one response to code level of bowel continence for the resident over the last 14 days.

Code for the resident's actual bladder and bowel continence pattern— i.e. the frequency with which the resident is wet and dry during the 14-day assessment period. Do not record the level of control that the resident might have achieved under optimal circumstances.

For bladder incontinence, the difference between a code of "3" (Frequently Incontinent) and "4" (Incontinent) is determined by the presence ("3") or absence ("4") of any bladder control.

Examples of Bladder Continence Coding

- Mr. Q was taken to the toilet after every meal, before bed, and once during the night. He was never found wet and is considered continent. **Code "0" for "Continent"—Bladder.**
- Mr. R had an indwelling catheter in place during the entire 14-day assessment period. He was never found wet and is considered continent. **Code "0" for "Continent"—Bladder.**
- Although she is generally continent of urine, every once in a while (about once in 2 weeks) Mrs. T doesn't make it to the bathroom to urinate in time after receiving her daily diuretic pill. **Code "1" for "Usually Continent"—Bladder.**
- Mrs. A has less than daily episodes of urinary incontinence, particularly late in the day when she is tired. **Code "2" for "Occasionally Incontinent"—Bladder.**
- Mr. S is comatose. He wears an external (condom) catheter to protect his skin from contact with urine. This catheter has been difficult for staff to manage as it keeps slipping off. They have tried several different brands without success. During the last 14 days Mr. S has been found wet at least twice daily on the day shift. **Code "3" for "Frequently Incontinent"—Bladder.**
- Mrs. U is terminally ill with end-stage Alzheimer's disease. She is very frail and has stiff, painful contractures of all extremities. She is primarily bedfast on a special water mattress, and is turned and re-positioned hourly for comfort. She is not toileted and is incontinent of urine for all episodes.
  Code "4" for Incontinent"—Bladder.

CIHI Tips

- Mrs. C has a non-leaking indwelling catheter; however she is incontinent of bowel most of the time. **Code "0" for Continent—Bladder and code "4" for Incontinent—Bowel**.
- Mr B's colostomy bag leaks 2 to 3 times a week. **Code "3" for Frequently incontinent—Bowel**.

H2 Bowel Elimination Pattern

Intent

To record the effectiveness of resident's bowel function.

Definition

H2a. Bowel elimination pattern regular—at least one movement every three days.

H2b. Constipation—Resident passes two or fewer bowel movements per week, or strains more than one out of four times when having a bowel movement.

H2c. Diarrhea—Frequent elimination of watery stools from any etiology (e.g. diet, viral or bacterial infection).

H2d. Fecal impaction—The presence of hard stool upon digital rectal exam. Fecal impaction may also be present if stool is seen on abdominal x-ray in the sigmoid colon or higher, even with a negative digital exam or documentation in the clinical record of daily bowel movement.

H2e. *NONE OF ABOVE*

Process

Ask the resident. Examine, if necessary. Review the clinical record, particularly any documentation flow sheets of bowel elimination patterns. Ask direct care staff (e.g. nurse assistants from all shifts).

Coding

Check all that apply in the **last 14 days**. If no items apply, check H2e. *NONE OF ABOVE*.

H3 Appliances and Programs

Definition

H3a. Any scheduled toileting plan—A plan whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet. Includes habit training and/or prompted voiding.

CIHI Tip

A scheduled toileting plan aims to **improve** the bladder and/or bowel continence of a resident.

Note: The following are not considered a scheduled toileting plan:

- provision of incontinence care
- changing pads and/or linens on a regular schedule

H3b. Bladder retraining program—A retraining program where the resident is taught to consciously delay urinating (voiding) or resist the urgency to void. Residents are encouraged to void on a schedule rather than according to their urge to void. This form of training is used to manage urinary incontinence due to bladder instability.

CIHI Tip

A bladder retraining program may consist of a regimen where the indwelling catheter is clamped and the resident or staff is consciously delaying the release of the clamp in order to improve urinary continence.

H3c. External (condom) catheter—A urinary collection appliance worn over the penis.

H3d. Indwelling catheter—A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by supra-pubic incision.

H3e. Intermittent catheter—A catheter that is used periodically for draining urine from the bladder. This type of catheter is usually removed immediately after the bladder has been emptied. Includes intermittent catheterization whether performed by a licensed professional or by the resident. Catheterization may occur as a one-time event (e.g. to obtain a sterile specimen) or as part of a bladder-emptying program (e.g. every shift in a resident with an underactive or a contractile bladder muscle).

H3f. Did not use toilet, commode, urinal—Resident never used any of these items during the last 14 days, nor used a bedpan.

H3g. Pads or briefs used—Any type of absorbent, disposable or reusable undergarment or item, whether worn by the resident (e.g. diaper, adult brief) or placed on the bed or chair for protection from incontinence. Does not include the routine use of pads on beds when a resident is never or rarely incontinent.

H3h. Enemas, irrigation—Any type of enema or bowel irrigation, including ostomy irrigations.

H3i. Ostomy present—Any type of ostomy of the gastrointestinal or genitourinary tract.

H3j. *NONE OF ABOVE*

Process

Check the clinical record. Consult with nurse assistant and the resident. Be sure to ask about any items that are usually hidden from view because they are worn under street clothing (e.g. pads or briefs).

Coding

Check all that apply. If none of the items apply, check *H3j. NONE OF ABOVE*.

H4 Change in Urinary Continence

Intent

To document changes in the resident's urinary continence status **as compared to 90 days ago** (or since last assessment if less than 90 days ago), including any changes in self-control categories, appliances, or programs. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Process

Review the resident's clinical record and Bladder Continence patterns as recorded in the last assessment (if available). Validate findings with the resident and direct care staff on all shifts. For new residents, consult with the primary family caregiver.

Coding

0 No change

1 Improvement

2 Deteriorated

A resident who was incontinent 90 days ago who is now continent by virtue of a catheter should be coded as "1", Improved. See fourth example below.

Examples of Change in Urinary Continence

- During an outbreak of gastroenteritis at the facility six weeks ago, Mrs. L, who is usually continent, became totally incontinent of bladder and bowel. This problem lasted only two weeks and she has been continent for the last month. **Code "0" for No change.**
- Dr. R had prostate surgery three months ago. Prior to surgery, he was frequently incontinent. Upon returning from the hospital, his indwelling catheter was discontinued. Although he initially experienced incontinence, he now remains dry with only occasional incontinence. He sings the praises of surgery to his peers. **Code "1" for Improved.**
- Mrs. B is a new admission. Both she and her daughter report that she has never been incontinent of urine. By her third day of residency, her urinary incontinence became evident, especially at night. **Code "2" for Deteriorated.**
- Two weeks ago Mr. K returned from the hospital following plastic surgery for a pressure ulcer. Prior to hospital admission, Mr. K was totally incontinent of urine. He is now continent with an indwelling catheter in place. **Code "1" for Improved.**
- ***Rationale:*** Although one could perceive that Mr. K had "deteriorated" because he now has a catheter for bladder control, remember that the RAI-MDS 2.0 definition for bladder continence states "Control of bladder function with appliances (e.g. foley) or continence programs, if employed."

Section I—Disease Diagnoses

Intent

To document the presence of diseases that have a relationship to the resident's current ADL status, cognitive status, mood or behaviour status, medical treatments, nursing monitoring or risk of death. In general, these are conditions that drive the current care plan. Do not include conditions that have been resolved or no longer affect the resident's functioning or care plan. In many facilities, clinical staff and physicians neglect to update the list of resident's "active" diagnoses. There may also be a tendency to continue old diagnoses that are either resolved or no longer relevant to the resident's plan of care. One of the important functions of the RAI-MDS 2.0 assessment is to generate an updated, accurate picture of the resident's health status.

Definition

Nursing monitoring—Includes clinical monitoring by a licensed nurse (e.g. serial blood pressure evaluations, medication management, etc.)

I1 Diseases

Definition

Endocrine/Metabolic/Nutritional

a. Diabetes mellitus—Includes insulin-dependent diabetes mellitus (IDDM) and diet-controlled diabetes mellitus (NIDDM or AODM).

b. Hyperthyroidism

c. Hypothyroidism

Heart/Circulation

d. Arteriosclerotic heart disease (ASHD)

e. Cardiac dysrhythmias—Disorder of heart rate or heart rhythm.

f. Congestive Heart Failure—A condition in which the heart cannot pump out all the blood that enters it , which leads to an accumulation of blood in the vessels, fluid in the body tissues and lung congestion.

g. Deep vein thrombosis

h. Hypertension

i. Hypotension

j. Peripheral vascular disease—Vascular disease of the lower extremities that **can** be of venous and/or arterial origin.

k. Other cardiovascular disease

Musculoskeletal

l. Arthritis—Includes degenerative joint disease (DJD), osteoarthritis (OA), and rheumatoid arthritis (RA). Record more specific forms of arthritis (e.g. Sjogren's syndrome; gouty arthritis) in Item I3 (with ICD-10-CA code).

m. Hip fracture—Includes any hip fracture that occurred at any time that continues to have a relationship to current status, treatments, monitoring, etc. Hip fracture diagnoses also include femoral neck fractures, fractures of the trochanter, subcapital fractures.

n. Missing limb (e.g. amputation)—Includes loss of any part of **any** upper or lower extremity.

o. Osteoporosis

p. Pathological bone fracture—Fracture of any bone due to weakening of the bone, usually as a result of a cancerous process.

Neurological

q. Amyotrophic lateral sclerosis (ALS)

r. Alzheimer's disease—A degenerative and progressive dementia that is diagnosed by ruling out other dementias and physiological reasons for the dementia.

s. Aphasia—A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e. speaking, writing), or understanding spoken or written language.

t. Cerebral palsy—Paralysis related to developmental brain defects or birth trauma.

u. Cerebrovascular accident (CVA/Stroke)— A sudden rupture or blockage of a blood vessel within the brain, causing serious bleeding or local obstruction.

v. Dementia other than Alzheimer's—Includes diagnoses of organic brain syndrome (OBS) or chronic brain syndrome (CBS), senility, senile dementia, multi-infarct dementia, and dementia related to neurologic diseases other than Alzheimer's (e.g. Picks, Creutzfeld-Jacob, Huntington's disease, etc.).

w. Hemiplegia/hemiparesis—Paralysis/partial paralysis(temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor. There must be a diagnosis of hemiplegia or hemiparesis in the resident's record.

x. Huntington's chorea

y. Multiple sclerosis—A disease involving demyelination throughout the central nervous system. Typical symptoms are weakness, uncoordination, parasthesias, speech disturbances and visual complaints.

z. Paraplegia—Paralysis (temporary or permanent impairment of sensation, function, motion) of the lower part of the body, including both legs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury. There must be a diagnosis of paraplegia in the resident's record.

aa. Parkinson's disease

bb. Quadriplegia—Paralysis (temporary or permanent impairment of sensation, function, motion) of all 4 limbs and trunk.

cc. Seizure disorder—Includes any disorder characterized by a sudden disruption of the brain's normal electrical activity resulting in muscular convulsions or altered mental states (for example, petit mal seizures, grand mal seizures).

dd. Transient ischemia attack—A sudden, temporary, inadequate supply of blood to a localized area of the brain. Often recurrent.

ee. Traumatic brain injury—Damage to the brain as a result of physical injury to the head.

Psychiatric/Mood

ff. Anxiety disorder—A non-psychotic mental disorder. There are five types:

- Generalized anxiety disorder
- Obsessive-compulsive disorder
- Panic disorder
- Phobias
- Post traumatic stress disorder

gg. Depression—A mood disorder often characterized by a depressed mood (e.g., feels sad or empty; appears tearful), decreased ability to think or concentrate, loss of interest or pleasure in usual activities, insomnia or hypersomnia, loss of energy, change in appetite, feelings of hopelessness or worthlessness or guilt. May include thoughts of death or suicide.

hh. Bipolar Disorder—Includes documentation of clinical diagnoses of either manic depression or bipolar disorder. "Bipolar disorder" is the current term for manic-depressive illness.

ii. Schizophrenia— A disturbance characterized by delusions, hallucinations, disorganized speech, grossly disorganized behaviour, disorganized thinking or flat affect. This category includes schizophrenia subtypes (e.g., paranoid, disorganized, catatonic, undifferentiated, residual).

Pulmonary

jj. Asthma

kk. Emphysema/COPD—Includes COPD (chronic obstructive pulmonary disease) or COLD (chronic obstructive lung disease), chronic restrictive lung diseases such as asbestosis, and chronic bronchitis.

Sensory

ll. Cataracts

mm. Diabetic retinopathy

nn. Glaucoma

oo. Macular degeneration

Other

pp. Allergies—Any hypersensitivity caused by exposure to a particular allergen. Includes agents (natural and artificial) to which the resident is susceptible for an allergic reaction, not only those to which he or she currently reacted to in the last seven days. This item includes allergies to drugs (e.g. aspirin, antibiotics), foods (e.g. eggs, wheat, strawberries, shellfish, milk), environmental substances (e.g. dust, pollen), animals (e.g. dogs, birds, cats), and cleaning products (e.g. soap, laundry detergent), etc. Hypersensitivity reactions include but are not limited to, itchy eyes, runny nose, sneezing, contact dermatitis, etc.

qq. Anemia—Includes anemia of any etiology.

rr. Cancer—Any malignant growth or tumor caused by abnormal and uncontrolled cell division; may spread to other parts of the body through the lymphatic system or the blood stream.

ss. Gastrointestinal disease—Includes any disease of the GI tract including the stomach, the small and large intestines (for example, gastric ulcer, Crohn's Disease).

tt. Liver disease—Includes any disease or disorder that is characterized by cessation or malfunctioning of the liver (for example, cirrhosis, hepatic failure).

uu. Renal failure

vv. *NONE OF ABOVE*

Process

Consult transfer documentation and medical record (including current physician treatment orders and nursing care plans). If the resident was admitted from an acute care or rehabilitation hospital, the discharge forms often list diagnoses and corresponding ICD-10-CA codes that were current during the hospital stay. If these diagnoses are still active, record them on the RAI-MDS 2.0 form. Also, accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation and initiate necessary physician documentation.

Physician involvement in this part of the assessment process is crucial. The physician should be asked to review the items in Section I at the time of visit closest to the scheduled RAI-MDS 2.0 assessment. Use this scheduled visit as an opportunity to ensure that active diagnoses are noted and "inactive" diagnoses are designated as resolved. This is also an important opportunity to share the entire RAI-MDS 2.0 assessment with the physician. In many facilities physicians are not brought into the RAI-MDS 2.0 review and assessment process. It is the responsibility of facility staff to aggressively solicit physician input. Inaccurate or missed diagnoses can be a serious impediment to care planning. Thus, you should share this section of the RAI-MDS 2.0 with the physician and ask for his or her input. Physicians completing a portion of the RAI-MDS 2.0 assessment should sign in Item R2 (Signatures of Those Completing the Assessment).

Full physician review of the most recent RAI-MDS 2.0 assessment or ongoing input into the assessment currently being completed can be very useful. For the physician, the RAI-MDS 2.0 assessment completed by facility staff can provide insights that would have otherwise not been possible. For staff, the informed comments of the physician may suggest new avenues of inquiry, or help to confirm existing observations, or suggest the need for additional follow-up.

Check a disease item only if the disease has a relationship to current ADL status, cognitive status, behaviour status, medical treatment, nursing monitoring, or risk of death. For example, it is not necessary to check "hypertension" if one episode occurred several years ago unless the hypertension is either currently being controlled with medications, diet, biofeedback, etc., or is being regularly monitored to prevent a recurrence.

Coding

Do not record any conditions that have been resolved and no longer affect the resident's functional status or care plan.

Check all that apply.

If none of the conditions apply, check *I1vv. NONE OF ABOVE*.

If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section I1, check the more general diagnosis in I1 and then enter the more detailed diagnosis (with ICD-10-CA code) under I3. Refer to the ***Common ICD-10-CA Codes Used in Continuing Care*** for a list of more detailed diagnosis. This is also the list to use in computer applications of the RAI-MDS 2.0.

For Example

If the record reveals that the resident has "osteoarthritis" you check item I1l (Arthritis) and record "Osteoarthritis" with ICD-10-CA Code in Section I3.

Consult the resident's transfer documentation (in the case of new admissions or re-admissions) and current medical record including current nursing care plans. There will be times when a particular diagnosis will not be documented in the medical record. If that is the case, as indicated above, accept statements by the resident that seem to have clinical validity, consult with the physician for confirmation, and initiate necessary physician documentation.

If a new resident says he or she had a severe depression and was seeing a private psychiatrist in the community, this information may have been missed if the information was not carried forward in records accompanying the resident from an acute care hospital to the facility.

I2 Infections

Definition

I2a. Antibiotic resistant infection (e.g. Methicillin resistant staph)— An infection in which bacteria have developed a resistance to the effective actions of an antibiotic. Check this item only if there is supporting documentation in the clinical record (including transmittal records of new admissions and recent transfers from other institutions).

I2b. Cellulitis

I2c. **Clostridium difficile (C.diff)**—Diarrheal infection caused by the Clostridium difficile bacteria. Check this item only if there is supporting documentation in the clinical record of new admissions and recent transfers (e.g. hospital referral or discharge summary, laboratory report).

I2d. **Conjunctivitis**—Inflammation of the mucous membranes lining the eyelids. May be of bacterial, viral, allergic, or traumatic origin.

I2e. **HIV infection**—Check this item only if there is supporting documentation or the resident (or surrogate decision-maker) informs you of the presence of a positive blood test result for the Human Immunodeficiency Virus or diagnosis of AIDS.

I2f. **Pneumonia**—Inflammation of the lungs; most commonly of bacterial or viral origin.

I2g. **Respiratory infection**—Any upper or lower (e.g. bronchitis) respiratory infection other than pneumonia.

I2h. **Septicemia**—Morbid condition associated with bacterial growth in the blood.

I2i. **Sexually transmitted diseases**—Check this item only if there is supporting documentation of a current diagnosis including but not limited to of gonorrhea, or syphilis. DO NOT include HIV in this category.

I2j. **Tuberculosis**—Includes residents with active tuberculosis or those who have converted to PPD positive tuberculin status and are currently receiving drug treatment (e.g. isoniazid (INH), ethambutol, rifampin, cycloserine) for tuberculosis.

I2k. **Urinary tract infection**—Includes chronic and acute symptomatic infection(s) in the last 30 days. Check this item only if there is current supporting documentation and significant laboratory findings in the clinical record.

I2l. **Viral hepatitis**—Inflammation of the liver of viral origin. This category includes diagnoses of hepatitis A, hepatitis B, hepatitis non-A non-B, and hepatitis C.

I2m. **Wound infection**—Infection of any type of wound (e.g. surgical; traumatic; pressure) on any part of the body.

I2n. ***NONE OF ABOVE***

Process

Consult transfer documentation and the resident's clinical record (including current physician treatment orders and nursing care plans). Accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation and initiate necessary physician documentation.

Physician involvement in this part of the assessment process is crucial.

Coding

Check an item only if the infection has a relationship to current ADL status, cognitive status, mood and behaviour status, medical treatment, nursing monitoring, or risk of death. Do not record any conditions that have been resolved and no longer affect the resident's functional status or care plan. For example, do not check "tuberculosis" if the resident had TB several years ago unless the TB is either currently being controlled with medications or is being regularly monitored to detect a recurrence.

Check all that apply.

If none of the conditions apply, check *I2n. NONE OF ABOVE*.

If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section I2 check the appropriate box in I2 and enter the more detailed information (with the ***Common ICD-10-CA Codes Used in Continuing Care***) under I3.

I3 Other Current Diagnoses and ICD-10-CA Codes

Intent

To identify conditions not listed in Item I1 and I2 that affect the resident's current ADL status, mood and behavioural status, medical treatments, nursing monitoring, or risk of death. Also, to record more specific designations for general disease categories listed under I1 and I2.

Coding

Enter the description of the diagnoses on the lines provided. For each diagnosis, an ICD-10-CA code must be entered in the boxes to the right of the line. If this information is not available in the medical records, consult the most recent version of the full set of volumes of ICD-10-CA codes. The person assigned to enter these codes should be trained in the ICD-10-CA assignment system. The task is best completed by a member of the medical record staff or the facility's medical record consultant. The person entering the ICD-10-CA codes must also enter his or her signature under RAI-MDS 2.0 item R2, indicating that these codes were entered.

CIHI provides vendors with a pick list of commonly used, current ICD-10-CA Codes that facility staff can use in lieu of coding the diagnoses themselves.

The most recently updated version of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision—Canada (ICD-10-CA) must be used. To receive a copy of the ICD-10-CA/CCI, 2003 CD-ROM, send an email to the Canadian Institute for Health Information's order at orderdesk@cihi.ca.

Section J—Health Conditions

J1 Problem Conditions

To record specific problems or symptoms that affect or could affect the resident's health or functional status, and to identify risk factors for illness, accident, and functional decline.

Indicators of Fluid Status—It is often difficult to recognize when a frail, chronically ill elder is experiencing fluid overload that could precipitate congestive heart failure, or alternatively dehydration. Ways to monitor the problem, particularly in residents who are unable to recognize or report the common symptoms of fluid variation, are as follows:

Definition

J1a. Weight gain or loss of 1.5 or more kilograms in last 7 days—This can only be determined in residents who are weighed in the same manner at least weekly. However, the majority of residents will not require weekly or more frequent weights, and for these residents you will be unable to determine whether there has been a 1.5 kilogram or more gain or loss. When this is the case, leave this item blank.

J1b. Inability to lie flat due to shortness of breath—Resident is uncomfortable lying supine. Resident requires more than one pillow or having the head of the bed mechanically raised in order to get enough air. This symptom often occurs with fluid overload. If the resident has shortness of breath when not lying flat, also check item J1l "Shortness of breath." If the resident does not have shortness of breath when upright (e.g. O.K. when using two pillows or sitting up) do not check item J1l.

J1c. Dehydrated; e.g. output exceeds intake—Check this item if the resident has 2 or more of the following indicators.

- Resident usually takes in less than the recommended 2500 ml of fluids daily (water or liquids in beverages, and water in food).
- Resident has clinical signs of dehydration.
- Resident's fluid loss exceeds the amount of fluids he or she takes in (e.g. loss from vomiting, fever, diarrhea that exceeds fluid replacement).

J1d. Insufficient fluid; did NOT consume all or almost all liquids provided during LAST 3 DAYS—Liquids can include water, juices, coffee, gelatins, and soups.

Other

J1e. Delusions—Fixed, false beliefs not shared by others that the resident holds even when there is obvious proof or evidence to the contrary (e.g. belief that he or she is terminally ill; belief that spouse is having an affair; belief that food served by the facility is poisoned).

J1f. Dizziness/vertigo—The resident experiences the sensation of unsteadiness, that he or she is turning, or that the surroundings are whirling around.

J1g. Edema—Excessive accumulation of fluid in tissues, either localized or systemic (generalized). Includes all types of edema (e.g. dependent, pulmonary, pitting).

J1h. Fever—A rise in a person's body temperature, frequently as a result of infection. Rectal temperatures above 38 Celsius are considered significant in an elderly population. Many frail elders have normally low rectal baseline temperatures (e.g. 35.6 to 37.2 C).

J1i. Hallucinations—False perceptions that occur in the absence of any real stimuli. A hallucination may be auditory (e.g. hearing voices), visual (e.g. seeing people, animals), tactile (e.g. feeling bugs crawling over skin), olfactory (e.g. smelling poisonous fumes), or gustatory (e.g. having strange tastes).

J1j. Internal bleeding—Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting "coffee grounds", hematuria (blood in urine), hemoptysis (coughing up blood), and **severe** epistaxis (nosebleed).

J1k. Recurrent lung aspirations in last 90 days—Note the extended time frame. Often occurs in residents with swallowing difficulties or who receive tube feedings (ie. esophageal reflux of stomach contents). Clinical indicators include productive cough, shortness of breath, wheezing. It is not necessary that there be X-ray evidence of lung aspiration for this item to be checked.

J1l. Shortness of breath—Difficulty breathing (dyspnea) occurring at rest, with activity, or in response to illness or anxiety. If the resident has shortness of breath while lying flat, also check item J1b ("Inability to lie flat due to shortness of breath").

J1m. Syncope (fainting)—Transient loss of consciousness, characterized by unresponsiveness and loss of postural tone with spontaneous recovery.

J1n. Unsteady gait—A gait that places the resident at risk of falling. Unsteady gaits take many forms. The resident may appear unbalanced or walk with a sway. Other gaits may have uncoordinated or jerking movements. Examples of unsteady gaits may include fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps.

J1o. Vomiting—Regurgitation of stomach contents; may be caused by any etiology (e.g. drug toxicity; influenza; psychogenic).

J1p. *NONE OF ABOVE*

Process

Ask the resident if he or she has experienced any of the listed symptoms in the last seven days. Review the clinical records (including current nursing care plan) and consult with facility staff members and the resident's family if the resident is unable to respond. A resident may not complain to staff members or others, attributing such symptoms to "old age." Therefore, it is important to ask and observe the resident, directly if possible, since the health problems being experienced by the resident can often be remedied.

Coding

Check all conditions that occurred within the **past seven days unless otherwise indicated** (i.e. lung aspirations in the last 90 days).

If no conditions apply, check *J1p. NONE OF ABOVE*.

J2 Pain Symptoms

Intent

To record the frequency and intensity of signs and symptoms of pain. For care planning purposes this item can be used to identify indicators of pain as well as to monitor the resident's response to pain management interventions.

Definition

Pain—For RAI-MDS 2.0 assessment purposes, pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area, or may be more generalized. It may be acute or chronic, continuous or intermittent (comes and goes), or occur at rest or with movement. The pain experience is very subjective; pain is whatever the resident says it is.

Shows evidence of pain—depends on the observation of others (i.e. cues), either because the resident does not verbally complain, or is unable to verbalize.

Process

Ask the resident if he or she has experienced any pain in the last seven days. Ask him/her to describe the pain. **If the resident states he or she has pain, take his or her word for it. Pain is a subjective experience**. Also observe the resident for indicators of pain. Indicators include moaning, crying, and other vocalizations; wincing or frowning and other facial expressions; or body posture such as guarding/protecting an area of the body, or lying very still; or decrease in usual activities.

In some residents, the pain experience can be very hard to discern. For example, in residents who have dementia and cannot verbalize that they are feeling pain, symptoms of pain can be manifested by particular behaviours such as calling out for help, pained facial expressions, refusing to eat, or striking out at a nurse assistant who tries to move them or touch a body part. Although such behaviours may not be solely indicative of pain, but rather may be indicative of multiple problems, code for the frequency and intensity of symptoms if in your clinical judgement it is possible that the behaviour could be caused by the resident experiencing pain.

Ask nurse assistants and therapists who work with the resident if the resident had complaints or indicators of pain the last week.

Coding

Code for the frequency the resident complains of, or shows evidence of pain (a), and code for the highest level of pain present in the **last seven days** (b). If the resident has no pain, code "0", (No pain) and then Skip to item J4.

J2a. Frequency—How often the resident complains or shows evidence of pain.

Codes

0 No pain (Skip to item J4)
1 Pain less than daily
2 Pain daily

> **CIHI Tip**
>
> If a resident does not experience any pain because he/she is on a medication regimen that renders him/her pain free, section J2a (Frequency) is coded 0 (No pain).

J2b. Intensity—The severity of pain as described or manifested by the resident.

Codes

1 Mild pain—Although the resident experiences some ("a little") pain he or she is usually able to carry on with daily routines, socialization, or sleep.

2 Moderate pain—Resident experiences "a medium" amount of pain.

3 Times when pain is horrible or excruciating—Worst possible pain. Pain of this type usually interferes with daily routines, socialization and sleep.

Use your best clinical judgement when coding. If you have difficulty determining the exact frequency or intensity of pain, code for the more severe level of pain.

***Rationale*:** Residents having pain will usually require further evaluation to determine the cause and to find interventions that promote comfort. You never want to miss an opportunity to relieve pain. Pain control often enables rehabilitation, greater socialization and activity involvement.

Examples	Pain Frequency	Pain Intensity
• Mrs. G, a resident with poor short-and-long term memory and moderately impaired cognitive function asked the charge nurse for "a pill to make my aches and pains go away" once a day during the last 7 days. The medication record shows that she received Tylenol every evening. The charge nurse states that Mrs. G usually rubs her left hip when she asks for a pill. However, when you ask her about pain, Mrs. G tells you that she is fine and never has pain. ***Rationale for coding*:** It appears that Mrs. G has forgotten that she has reported having pain during the last 7 days. Best clinical judgement calls for coding that reflects that Mrs. G has mild, daily pain.	2	1
• Mr. T is cognitively intact. He is up and about and involved in self-care, social and recreational activities. During the last week he has been cheerful, engaging and active. When checked by staff at night, he appears to be sleeping. However, when you ask him how he's doing, he tells you that he has been having horrible cramps in his legs every night. He's only been resting, but feels tired upon arising. ***Rationale for coding*:** Although Mr. T may look comfortable to staff, he reports to you that he has terrible cramps. Best clinical judgement for coding this "screening" item for pain would be to record codes that reflect what Mr. T tells you. It is highly likely that Mr. T warrants a further evaluation.	2	3

J3 Pain Site

Intent

To record the location of physical pain as described by the resident, or discerned from objective physical and laboratory tests. Sometimes it is difficult to pinpoint the exact site of pain, particularly if the resident is unable to describe the quality and location of pain in detail. Likewise, it will be difficult to pinpoint the exact site if the resident has not had physical or laboratory tests to evaluate the pain. In order to begin to develop a responsive care plan for promoting comfort, the intent of this item is to help residents and caregivers begin a pain evaluation by attempting to target the site of pain.

Definition

J3a. **Back pain**—Localized or generalized pain in any part of the neck or back.

J3b. **Bone pain**—Commonly occurs in metastatic disease. Pain is usually worse during movement but can be present at rest. May be localized and tender but may also be quite vague.

J3c. **Chest pain during usual activities**—The resident experiences any type of pain in the chest area, which may be described as burning, pressure, stabbing, vague discomfort, etc. “Usual activities” are those that the resident engages in normally. For example, the resident’s usual activities may be limited to minor participation in dressing and grooming, short walks from chair to toilet room.

J3d. **Headache**—The resident regularly complains or shows evidence (clutching or rubbing the head) of headache.

J3e. **Hip pain**—Pain localized to the hip area. May occur at rest or with physical movement.

J3f. **Incisional pain**—The resident complains or shows evidence of pain at the site of a recent surgical incision.

J3g. **Joint pain (other than hip)**—The resident complains or shows evidence of discomfort in one or more joints either at rest or with physical movement.

J3h. **Soft tissue pain (e.g. lesion, muscle)**—Superficial or deep pain in any muscle or non-bony tissue. Examples include abdominal cramping, rectal discomfort, calf pain, and wound pain.

J3i. **Stomach Pain**—The resident complains or shows evidence of pain or discomfort in the left upper quadrant of the abdomen.

J3j. **Other site**—Includes either localized or diffuse pain of any other part of the body. Examples include general “aches and pains,” etc.

Process

Ask the resident and observe for signs of pain. Consult staff members. Review the clinical record. Use your best clinical judgement.

Coding

Check all that apply during the **last 7 days**.

If the resident has mouth pain, check item K1c (Mouth pain) in Section K, "Oral/Nutritional Status."

J4 Accidents

Intent

To determine the resident's risk of future falls or injuries. Falls are a common cause of morbidity and mortality among elderly residents. Residents who have sustained at least one fall are at risk of future falls. About half of all residents fall each year, with serious injury resulting from 6 to 10 percent of falls. Hip fractures account for approximately one-half of all serious injuries.

Definition

A fall can be defined as any unintentional change in position where the resident ends up on the floor, ground or other lower level.

> **CIHI Tip**
> An intercepted fall where the person is caught before falling to a lower surface is not considered a fall.

J4a. Fell in past 30 days

J4b. Fell in past 31–180 days

J4c. Hip fracture in last 180 days—Note time frame (last 180 days).

J4d. Other fracture in last 180 days—Any fracture other than a hip fracture. Note time frame (last 180 days).

J4e. *NONE OF ABOVE*

Process

New admissions—Consult with the resident and the resident's family. Review transfer documentation.

Current residents—Review the resident's records (including incident reports, current nursing care plan, and monthly summaries). Consult with the resident. Sometimes, a resident will fall, and believing that he or she "just tripped," will get up and not report the event to anyone. Therefore, do not rely solely on the clinical records but also ask the resident directly if he or she has fallen during the indicated time frame.

Coding

Check all conditions that apply.

If no conditions apply, check *J4e. NONE OF ABOVE.*

J5 Stability of Conditions

Intent

To determine if the resident's disease or health conditions present over the last seven days are acute, unstable, or deteriorating.

Definition

J5a. **Conditions or diseases make resident's cognitive, ADL, mood, or behaviour patterns unstable** (fluctuating, precarious or deteriorating)—Denotes the changing and variable nature of the resident's condition. For example, a resident may experience a variable response to the intensity of pain and the analgesic effect of pain medications. On "good days" over the last seven days, he or she will participate in ADLs, be in a good mood, and enjoy preferred leisure activities. On "bad days," he or she will be dependent on others for care, be agitated, cry, etc. Likewise, this category reflects the degree of difficulty in achieving a balance between treatments for multiple conditions.

J5b. **Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem**—Resident is symptomatic for an acute health condition (e.g. new myocardial infarction; adverse drug reaction; influenza), a recurrent (acute) condition (e.g. aspiration pneumonia; urinary tract infection) or an acute phase of a chronic disease (e.g. shortness of breath, edema, and confusion in a resident with congestive heart disease; acute joint pain and swelling in a resident who has had arthritis for many years). An acute episode is usually of sudden onset, has a time-limited course, requires physician evaluation and a significant increase in licensed nursing monitoring.

J5c. **End-stage disease**; 6 months or less to live—In one's best clinical judgement, the resident with any end-stage disease has only six **or** fewer months to live. This judgement should be substantiated by a well documented disease diagnosis and deteriorating clinical course.

J5d. ***NONE OF ABOVE***

Process

Observe the resident. Consult staff members, especially the resident's physician. Review the resident's clinical record.

Coding

Check all that apply during **last seven days**.

If none apply, check *J5d. NONE OF ABOVE.*

Examples

- Mrs. M is diabetic. She requires daily or more frequent blood sugar tests in conjunction with administering sliding-scale insulin dosages. She has been confused on one occasion in the past week when she was hypoglycemic. **Check J5a for unstable—fluctuating, precarious, or deteriorating.**
- If Mrs. M (above) were also to have pneumonia and fever during her assessment period. **Check J5a for unstable and J5b for acute**.
- Ms. F had been doing well and was ready for discharge to her apartment in elderly housing until she came down with the flu. Currently she has a low-grade fever, general aches and pains, and respiratory symptoms of productive cough and nasal congestion. Although she has taken to bed for a few days she has had no change in ADL function, mood, etc. and is looking forward to discharge in a few days. **Check J5b for acute.**
- Mrs. T was admitted to the unit with a diagnosis of chronic congestive heart failure. During the past few months she has had 3 hospital admissions for acute CHF. Her heart has become significantly weaker despite maximum treatment with medications and oxygen. Her physician has discussed her deteriorating condition with her and her family and has documented that her prognosis for survival in the next couple of months is poor. **Check J5c for end-stage disease.**
- Mr. R is a diabetic who receives a daily dose of NPH insulin 20 units q.a.m. sc. He requires only monthly blood sugar determinations for follow-up, and has no current acute illness. **Check J5d for *NONE OF ABOVE.***

Section K—Oral/Nutritional Status

K1 Oral Problems

Intent

To record any oral problems present in the **last seven days**.

Definition

K1a. **Chewing problem**—Inability to chew food easily and without pain or difficulties, regardless of cause (e.g. resident uses ill-fitting dentures, or has a neurologically impaired chewing mechanism, or has temporomandibular joint pain, or a painful tooth). Code chewing problem present even when compensatory strategies have been successfully introduced but the resident remains unable to chew all types of food.

K1b. **Swallowing problem**—Dysphagia. Clinical manifestations include frequent choking and coughing when eating or drinking, holding food in mouth for prolonged periods of time, or excessive drooling. Code swallowing problem present even when compensatory strategies have been successfully introduced but the resident remains unable to swallow all types of food and liquids.

K1c. **Mouth pain**—Any pain or discomfort associated with any part of the mouth, regardless of cause. Clinical manifestations include favoring one side of the mouth while eating, refusing to eat, refusing food or fluids of certain temperatures (hot or cold).

K1d. ***NONE OF ABOVE***

Process

Ask the resident about difficulties in these areas. Observe the resident during meals. Inspect the mouth for abnormalities that could contribute to chewing or swallowing problems or mouth pain.

Coding

Check all that apply. If none apply, check *K1d. NONE OF ABOVE*.

K2 Height and Weight

Intent

To record a current height and weight in order to monitor nutrition and hydration status over time; also, to provide a mechanism for monitoring stability of weight over time. For example, a resident who has had edema can have an intended and expected weight loss as a result of taking a diuretic. Or weight loss could be the result of poor intake, or adequate intake accompanied by recent participation in a fitness program.

K2a. Height

Process

New admissions—Measure height in centimeters.

Current resident—Check the clinical records. If the last height recorded was more than one year ago, measure the resident's height again.

Coding

Round height upward to nearest whole centimeter. Measure height consistently over time in accord with standard facility practice (shoes off, etc.).

In **exceptional circumstances only** there are two other codes that may be used.

- If the resident refuses to have height measured, code "001"
- If the resident is palliative, and cannot be measured, code "248"

K2b. Weight

Process

Check the clinical records. If the last recorded weight was taken more than one month ago or weight is not available, weigh the resident again. If the resident's weight was taken more than once during the preceding month, record the most recent weight.

Coding

Round weight to one decimal place, for example 64.6kg. Measure weight consistently over time in accord with standard facility practice (after voiding, before meal, etc.).

In **exceptional circumstances only** there are two other codes that may be used.

- If the resident refuses to be weighed, code "0001", and
- If the resident is palliative, and cannot be weighed, code "9999"

K3 Weight Change

Intent

To record variations in the resident's weight over time.

K3a. Weight Loss

Definition

Weight loss in percentages (e.g. 5% or more in last 30 days, or 10% or more in last 180 days).

Process

New admission—Ask the resident or family about weight changes over the last 30 and 180 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight loss in percentages during the specified time periods.

Current resident—Review the clinical records and compare current weight with weights of 30 and 180 days ago. Calculate weight loss in percentages during the specified time periods.

Coding

0 No
1 Yes
9 Unknown. If, on admission there is no weight to compare to

K3b. Weight Gain

Definition

Weight gain in percentages (i.e. 5% or more in last 30 days, or 10% or more in last 180 days).

Process

New admission—Ask the resident or family about weight changes over the last 30 and 180 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight gain in percentages during the specified time periods.

Current resident—Review the clinical records and compare current weight with weights of 30 and 180 days ago. Calculate weight gain in percentages during the specified time periods.

Coding

0 No
1 Yes
9 Unknown. If, on admission there is no weight to compare to

K4 Nutritional Problems

Intent

To identify specific problems, conditions, and risk factors for functional decline present in the **last seven days** that affect or could affect the resident's health or functional status. Such problems can often be reversed and the resident can improve.

Definition

K4a. **Complains about the taste of many foods**—The sense of taste can change as a result of health conditions or medications. Also, complaints can be culturally based—e.g. someone used to eating spicy foods may find facility meals bland.

K4b. **Regular or repetitive complaints of hunger**—On most days (at least 2 out of 3), resident asks for more food or repetitively complains of feeling hungry (even after eating a meal).

K4c. **Leaves 25% or more of food uneaten at most meals**—Eats less than 75 percent of food (even when substitutes are offered) at least 2 out of 3 meals a day.

K4d. ***NONE OF ABOVE***

Process

Consult resident's records (including current nursing care plan), dietary/fluid intake flow sheets, dietary progress notes/assessments. Consult with direct-care staff and consulting dietitian. Ask the resident if he or she experienced any of these symptoms in the last seven days. Sometimes a resident will not complain to staff members because he or she attributes symptoms to "old age." Therefore, it is important to ask the resident directly. Observe the resident while eating. If he or she leaves food or picks at it, ask, "Why are you not eating? Would you eat if something else were offered?" Note if resident winces or makes faces while eating.

Coding

Check all conditions that apply. If no conditions apply, check *K4d. NONE OF ABOVE.*

K5 Nutritional Approaches

CIHI Tip

To record the types of dietary modifications necessary to plan nutritional approaches, hydration and address swallowing difficulties.

Definition

K5a. Parenteral/IV—Intravenous (IV) fluids or hyperalimentation given continuously or intermittently. This category also includes administration of fluids via IV lines with fluids running at KVO (keep vein open), or via heparin locks. This category does not include administration of IV medications. If the resident receives IV medications, check item P1c in "Special Treatments and Procedures".

CIHI Tip

Hypodermoclysis can be captured in K5a (Parenteral/IV).

K5b. Feeding tube—Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tube.

K5c. Mechanically altered diet—A diet specifically prepared to alter the consistency of food in order to facilitate oral intake. Examples include soft solids, pureed foods, ground meat. Diets for residents who can only take liquids that have been thickened to prevent choking are also included in this definition.

K5d. Syringe (oral feeding)—Use of syringe to deliver liquid or pureed nourishment directly into the mouth.

K5e. Therapeutic diet—A diet ordered to manage problematic health conditions. Examples include calorie-specific, low-salt, low-fat lactose, no added sugar, and supplements during meals.

K5f. Dietary supplement between meals—Any type of dietary supplement provided between scheduled meals (e.g. high protein/calorie shake, or 3 p.m. snack for resident who receives q.a.m. dose of NPH insulin). Do not include snacks that everyone receives as part of the unit's daily routine.

K5g. Plate guard, stabilized built-up utensils, etc.—Any type of specialized, altered, or adaptive equipment to facilitate the resident's involvement in self-performance of eating.

K5h. On a planned weight change program—Resident is receiving a program of which the documented purpose and goal are to facilitate weight gain or loss (e.g. double portions; high calorie supplements; reduced calories; 10 grams fat).

K5i. *NONE OF ABOVE*

Coding

Check all that apply. If none apply, check *K5i. NONE OF ABOVE*.

K6 Parenteral or Enteral Intake—Skip to Section L if neither item K5a nor K5b is checked.

Intent

To record the proportion of calories received, and the average fluid intake, through parenteral or tube feeding in the **last seven days**.

K6a. Proportion of Total Calories

Definition

Code the proportion of total calories the resident received through parenteral or tube feedings in the LAST 7 DAYS—the proportion of all calories during the last seven days ingested that the resident actually received (not ordered) by parenteral or tube feedings. Determined by calorie count.

Process

Review Intake record. If the resident took no food or fluids by mouth, or took just sips of fluid, stop here and code "4" (76%–100%). If the resident had more substantial oral intake than this, consult with the dietitian who can derive a calorie count received from parenteral or tube feedings.

Coding

Code for the best response.

0 None
1 1% to 25%
2 26% to 50%
3 51% to 75%
4 76% to 100%

Example

Calculation for Proportion of Total Calories From IV or Tube Feeding

Mr. H has had a feeding tube since his surgery. He is currently more alert, and feeling much better. He is very motivated to have the tube removed. He has been taking soft solids by mouth, but only in small to medium amounts. For the past week he has been receiving tube feedings for nutritional supplementation. As his oral intake improves, the amount received by tube will decrease. The dietitians has totalled his calories per day as follows:

Step 1

	Oral		Tube
Sun.	500	+	2000
Mon.	250	+	2250
Tues.	250	+	2250
Wed.	350	+	2250
Thurs.	500	+	2000
Fri.	800	+	1800
Sat.	800	+	1800
TOTAL	**3,450**	**+**	**14,350**

Step 2 Total calories =3,450 + 14,350 =17,800

Step 3 Calculate percentage of total calories by tube feeding.[multiply total tube amount by 100, then divide by total calories]

1,435,000 divided by 17,800 =80.6% of total calories received by tube.

Step 4 **Code “4” for 76% to 100%**

K6b. Average Fluid Intake

Definition

Code the average fluid intake per day by IV or tube in the last 7 days. Average fluid intake per day by IV or tube feeding in last seven days refers to the actual amount of fluid the resident received by these modes (not the amount ordered).

Process

Review the Intake and Output record from the last seven days. Add up the total amount of fluid received each day by IV and/or tube feedings only. Divide the week’s total fluid intake by 7. This will give you the average of fluid intake per day.

Coding

Code for the average number of cc's of fluid the resident received per day by IV or tube feeding.

Codes:

0 None
1 1 to 500 cc/day
2 501 to 1000 cc/day
3 1001 to 1500 cc/day
4 1501 to 2000 cc/day
5 2001 to or more cc/day

Example of Calculation for Average Daily Fluid Intake

Ms. A has swallowing difficulties secondary to Huntington's disease. She is able to take oral fluids by mouth with supervision, but not enough to maintain hydration. She received the following daily fluid totals by supplemental tube feedings (including water, prepared nutritional supplements, juices) during the last 7 days.

Step 1

Sun.	1250 cc
Mon.	775 cc
Tues.	925 cc
Wed.	1200 cc
Thurs.	1200 cc
Fri.	1200 cc
Sat.	1000 cc
TOTAL	7550 cc

Step 2
7550 divided 7 =1078.6 cc

Step 3
Code "3" for 1001 to 1500 cc/day

CIHI Tip

Sections K6a (**Proportion of Total Calories)** and K6b (**Average Fluid Intake)** should be completed if the resident received hypodermoclysis in the last seven days.

Section L—Oral/Dental Status

L1 Oral Status and Disease Prevention

Intent

To document the resident's oral and dental status as well as any problematic conditions.

> **CIHI Tip**
> Observation period: last 7 days

Definition

L1d. Broken, loose or carious teeth

Carious—Pertains to tooth decay and disintegration (cavities).

> **CIHI Tip**
> Broken or loose dentures are not captured in item L1d.

Process

Ask the resident, and examine the resident's mouth. Ask direct care staff if they have noticed any problems. Review the clinical record.

Coding

Check all that apply. If none apply, check *NONE OF ABOVE*.

Section M—Skin Condition

The intent of section M is to determine the condition of the resident's skin, identify the presence, stage, type, and number of ulcers, and document other problematic skin conditions. Additionally, to document any skin treatments for active conditions as well as any protective or preventive skin or foot care treatments the resident has received in the **last seven days**.

M1 Ulcers (due to any cause)

Intent

To record the number of ulcers, of any type at each ulcer stage, on any part of the body.

> **CIHI Tip**
>
> Observation period: last 7 days

Definition

M1a. **Stage 1**—A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

M1b. **Stage 2**—A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

M1c. **Stage 3**—A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

M1d. **Stage 4**—A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

Process

Review the resident's record and consult with the nurse assistant about the presence of an ulcer. Examine the resident and determine the stage and number of any ulcers present. Without a full body check, an ulcer can be missed.

Pressure ulcers are staged according to the extent of damage present during the observation period.

- **For example**, if an ulcer was originally a stage 4 but has shown improvement to a partial thickness loss of skin layers, it would be coded as a stage 2.

Assessing a Stage 1 ulcer requires a specially focused assessment for residents with darker skin tones to take into account variations in ebony-coloured skin. To recognize **Stage 1 ulcers in ebony complexions**, look for:

- any change in the feel of the tissue in a high-risk area;
- any change in the appearance of the skin in high-risk areas, such as the “orange-peel” look;
- a subtle purplish hue; and
- extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break.

Coding

Record the number of ulcers at each stage on the resident’s body, in the last 7 days, regardless of the ulcer cause. If necrotic eschar is present, prohibiting accurate staging, code the ulcer as Stage “4” until the eschar has been debrided (surgically or mechanically) to allow staging. If there are no ulcers at a particular stage, record “0” (zero) in the box provided. If there are more than 9 ulcers at any one stage, enter “9” in the appropriate box.

Example

Mrs. L has end-stage metastatic cancer and weighs 75 pounds. She has a Stage 3 ulcer over her sacrum and two Stage 1 ulcers over her heels.

Stage	Code
M1a. Stage 1	2
M1b. Stage 2	0
M1c. Stage 3	1
M1d. Stage 4	0

M2 Type of Ulcers

Intent

To record the highest stage for two types of ulcers, Pressure and Stasis, that was present in the **last 7 days**.

Definition

M2a. Pressure ulcer—Any lesion caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bedsores and decubitus ulcers.

CIHI Tip
Includes any lesion caused by unrelieved pressure. Pressure ulcers usually occur over bony prominences and are staged according to the extent of tissue damage observed.

M2b. Stasis ulcer—An open lesion, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency; also referred to as a venous ulcer or ulcer related to peripheral vascular disease (PVD).

Process

Review the resident's record. Consult with the physician regarding the cause of the ulcer(s).

Coding

Using the ulcer staging scale in item M1 record the highest ulcer stage for pressure and stasis ulcers present in the last 7 days. Remember that there are other types of ulcers than the two listed in this item (e.g. ischemic ulcers). An ulcer recorded in item M1 may not necessarily be recorded in item M2.

CIHI Tip
Code other types of ulcers, for example, arterial and diabetic, in section I3 (Other Current Diagnoses and ICD-10-CA Codes).

M3 History of Resolved/Cured Ulcers

Intent

To determine if the resident previously had an ulcer that was resolved or cured during the **past 90 days**. Identification of this condition is important because it is a risk factor for development of subsequent ulcers.

CIHI Tip
This item refers to pressure ulcers only.

Process

Review clinical records, including the last assessment

Coding

0 No
1 Yes

M4 Other Skin Problems or Lesions Present

Intent

To document the presence of skin problems other than ulcers, and conditions that are risk factors for more serious problems.

Definition

M4a. Abrasions, bruises—Includes skin scrapes, ecchymoses, localized areas of swelling, tenderness and discolouration.

M4b. Burns (second or third degree)—Burns (second or third degree). Includes burns from any cause (e.g. heat, chemicals) in any stage of healing. This category does not include first-degree burns (changes in skin colour only).

> **CIHI Tip**
> All 2nd/3rd degree burns are included, irrespective of the cause.

M4c. Open Lesions other than ulcers, rashes or cuts (e.g. cancer lesions)—These open lesions may develop because of injury or in association with other diseases such as syphilis or cancer.

M4d. Rashes (e.g. intertrigo, eczema, drug/heat rash, herpes)—Includes inflammation or eruption of the skin that may include change in colour, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (e.g. heat, drugs, bacteria, viruses, contact with irritating substances such as urine or detergents, allergies, etc.). Intertrigo refers to rashes (dermatitis) within skin folds.

M4e. Skin desensitized to pain or pressure—The resident is unable to perceive sensations of pain or pressure.

Review the resident's record for documentation of impairment of this type. An obvious example of a resident with this problem is someone who is comatose. Other residents at high risk include those with quadriplegia, paraplegia, hemiplegia or hemiparesis, peripheral vascular disease and neurological disorders. In the absence of documentation in the clinical record, sensation can be tested in the following way:

- To test for pain, use a new, disposable safety pin or wooden "orange stick" (usually used for nail care). Always dispose of the pin or stick after each use to prevent contamination.
- Ask the resident to close his or her eyes. If the resident cannot keep his or her eyes closed or cannot follow directions to close eyes, block what you are doing (in local areas of legs and feet) from view with a cupped hand or towel.
- Lightly press the pointed end of the pin or stick against the resident's skin. Do not press hard enough to cause pain, injury, or break in the skin. Use the pointed and blunt ends of the pin or stick alternately to test sensations on the resident's arms, trunk, and legs. Ask the resident to report if the sensation is "sharp" or "dull."
- Compare the sensations in symmetrical areas on both sides of the body.
- If the resident is unable to feel the sensation, or cannot differentiate sharp from dull, the area is considered desensitized to pain sensation.
- For residents who are unable to make themselves understood or who have difficulty understanding your directions, rely on their facial expressions (e.g. wincing, grimacing, surprise), body motions (e.g. pulling the limb away, pushing the examiner) or sounds (e.g. "Ouch!") to determine if they can feel pain.
- Do not use pins with agitated or restless residents. Abrupt movements can cause injury.

M4f. Skin tears or cuts (other than surgery)—Any traumatic break in the skin penetrating to subcutaneous tissue. Examples include skin tears, lacerations, etc.

M4g. Surgical wounds—Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include healed surgical sites or stomas.

M4h. *NONE OF ABOVE*

Process

Ask the resident if he or she has any problem areas. Examine the resident. Ask nurse assistant. Review the resident's record.

Coding

Check all that apply. If there is no evidence of such problems in the **last seven days**, check *M4h. NONE OF ABOVE.*

M5 Skin Treatments

Intent

To document any specific or generic skin treatments the resident has received in the **past seven days**.

Definition

M5a. Pressure relieving device(s) for chair—Includes gel, air (e.g. Roho), or other cushioning placed on a chair or wheelchair. Do not include egg crate cushions in this category.

M5b. Pressure relieving device(s) for bed—Includes air fluidized, low airloss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Do not include egg crate mattresses in this category.

M5c. Turning or repositioning program—Includes a continuous, consistent program for changing the resident's position and realigning the body.

M5d. Nutrition or hydration intervention to manage skin problems—Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions—e.g. wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing.

M5e. Ulcer care—Includes any intervention for treating an ulcer at any ulcer stage. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.

> **CIHI Tip**
>
> Any ulcer care, including the application of medications to an ulcer, is captured in section M5e. Do not include care specific to ulcers in other M5 items.

M5f. Surgical wound care—Includes any intervention for treating or protecting any type of surgical wound. Examples of care include topical cleansing, wound irrigation, application of antimicrobial ointments, dressings of any type, suture removal, and warm soaks or heat application.

M5g. Application of dressings (with or without topical medications) other than to feet—Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

M5h. Application of ointments or medications (except to feet)—Includes ointments or medications used to treat a skin condition (e.g. cortisone, antifungal preparations, chemotherapeutic agents, etc.). This definition does not include ointments used to treat non-skin conditions (e.g. nitropaste for chest pain).

M5i. Other preventative or protective skin care (except to feet)—Includes application of creams or bath soaks to prevent dryness, scaling; application of protective elbow pads (e.g. down, sheepskin, padded, quilted).

M5j. *NONE OF ABOVE*

Process

Review the resident's records. Ask the resident and nurse assistant.

Coding

Check all that apply. If none apply in the **past seven days**, check M5J. *NONE OF ABOVE.*

M6 Foot Problems and Care

Intent

To document the presence of foot problems and care to the feet during the **last seven days**.

> **CIHI Tip**
> Care for foot problems applies to the area below the level of the malleoli (ankle bone) and is captured in section M6.

Definition

M6a. Resident has one or more foot problems (e.g. corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems)

M6b. Infection of the foot (e.g. cellulitis, purulent drainage)

M6c. Open lesions on the foot—Includes cuts, ulcers, fissures

M6d. Nails or callouses trimmed during last 90 days—Pertains to care of the feet. Includes trimming by nurse or any health professional, including a podiatrist.

CIHI Tip

Nail care provided by members of the health care team, for example a health care aide who has been trained and is supervised by a regulated health professional, can be captured in M6d (Nails or callouses trimmed).

M6e. Received preventative or protective foot care (e.g. used special shoes, inserts, pads, toe separators)—Includes any care given for the purpose of preventing skin problems on the feet, such as diabetic foot care, foot soaks, protective booties (e.g. down, sheepskin, padded, quilted), special shoes, orthotics, application of toe pads, toe separators, etc.

M6f. Application of dressings (with or without topical meds)—Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

M6g. *NONE OF ABOVE*

Process

Ask the resident and nurse assistant. Inspect the resident's feet. Review the resident's clinical records.

Coding

Check all that apply. If none apply in the **past seven days**, check *M6g. NONE OF ABOVE*

Section N—Activity Pursuit Patterns

Intent

To record the amount and types of interests and activities that the resident currently pursues, as well as activities the resident would like to pursue that are not currently available at the facility.

Definition

Activity pursuits—Refers to any activity other than ADLs that a resident pursues in order to enhance a sense of well-being. These include activities that provide increased self-esteem, pleasure, comfort, education, creativity, success, and financial or emotional independence.

N1 Time Awake

Intent

To identify those periods of a typical day (over the **last seven days**) when the resident was awake all or most of the time (i.e. no more than one-hour nap during any such period).

For **care planning purposes** this information can be used in at least two ways:

- The resident who is awake most of the time could be encouraged to become more mentally, physically, and/or socially involved in activities (solitary or group).
- The resident who naps a lot may be bored or depressed and could possibly benefit from greater activity involvement.

Process

Consult with direct care staff, the resident, and the resident's family.

Coding

Check all periods when resident was awake all or most of the time.

N1a. **Morning**—7 a.m. (or when resident wakes up, if earlier or later than 7 a.m.) until noon.

N1b. **Afternoon**—noon to 5 p.m.

N1c. **Evening**—5 p.m. to 10 p.m. (or bedtime, if earlier).

N1d. **NONE OF ABOVE**—If resident is comatose, this is the only Section N item to code, skip all other Section N items and go to Section O.

N2 Average Time Involved in Activities

Intent

To determine the proportion of available time that the resident was actually involved in activity pursuits as an indication of his or her overall activity-involvement pattern. This time refers to free time when the resident was awake and was not involved in receiving nursing care, treatments, or engaged in ADL activities and could have been involved in activity pursuits and Therapeutic Recreation.

CIHI Tip

Observation period: last 7 days

Process

Consult with direct care staff, activities staff members, the resident, and the resident's family. Ask about time involved in different activity pursuits.

Coding

In coding this item, **exclude** time spent in receiving treatments, for example:

- medications,
- heat treatments,
- bandage changes,
- rehabilitation therapies, or
- ADLs.

Include time spent in pursuing:

- independent activities, for example, watering plants, reading, letter-writing;
- social contacts, for example, visits or phone calls with family, other residents, staff, and volunteers;
- recreational pursuits in a group, one-on-one or an individual basis; and
- involvement in Therapeutic Recreation.

Codes

0 Most-more than 2/3 of the time

1 Some-from 1/3 to 2/3 of time

2 Little-less than 1/3 of time

3 None

N3 Preferred Activity Settings

Intent

To determine activity circumstances/settings that the resident prefers, including (though not limited to) circumstances in which the resident is at ease.

CIHI Tip

Observation period: last 7 days

Process

Ask the resident, family, direct care staff, and activities staff about the resident's preferences. Staff's knowledge of observed behaviour can be helpful, but only provides part of the answer. Do not limit preference list to areas to which the resident now has access, but try to expand the range of possibilities for the resident.

Example

Ask the resident, "Do you like to go outdoors? Outside the facility (to a mall)? To events downstairs?" Ask staff members to identify settings that resident frequents or where he or she appears to be most at ease.

Coding

Check all responses that apply. If the resident does not wish to be in any of these settings, check *N3e. NONE OF ABOVE*.

N3a. Own room

N3b. Day or activity room

N3c. Inside facility/off unit

N3d. Outside facility

N3e. ***NONE OF ABOVE***

N4 General Activity Preferences (Adapted to Resident's Current Abilities)

Intent

Determine which activities of those listed the resident would prefer to participate in (independently or with others). Choice should not be limited by whether or not the activity is currently available to the resident, or whether the resident currently engages in the activity.

> **CIHI Tip**
>
> Observation period: last 7 days

Definition

N4a. Cards, other games—Includes games played with cards such as bridge, gin rummy; other types of games such as chess, checkers, dominoes; board games (e.g., Monopoly); and puzzles.

N4b. Crafts/Arts—Includes painting, drawing, sketching, needlework, woodwork, sewing and other types of crafts and arts.

N4c. Exercise/sports—Includes any type of physical activity such as dancing, weight training, yoga, walking, sports (e.g. bowling, croquet, golf, or watching sports).

N4d. Music—Includes listening to music or being involved in making music (singing, playing piano, etc.).

N4e. Reading/writing—Reading can be independent or done in a group setting where a leader reads aloud to the group or the group listens to "talking books." Writing can be solitary (e.g. letter-writing or poetry writing) or done as part of a group program (e.g. recording oral histories). Or a volunteer can record the thoughts of a blind, hemiplegic, or apraxic resident in a letter or journal.

N4f. Spiritual/religious activities—Includes participating in religious services as well as watching them on television or listening to them on the radio.

N4g. Trips or shopping—Outings that occur away from the facility such as trips to concerts, a mall, restaurants. Also includes shopping for personal items or gifts.

N4h. Walk/wheeling outdoors—Walking outdoors either alone or with others. This item also includes persons who wheel themselves while outdoors.

N4i. Watching TV—Includes watching live television programs or recorded programs.

N4j. Gardening or plants—Includes tending one's own or other plants, participating in garden club activities, regularly watching a television program or video about gardening.

N4k. Talking or conversing—Includes talking and listening to social conversations and discussions with family, friends, other residents, or staff. May occur individually, in groups, or on the telephone; may occur informally or in structured situations.

N4l. Helping others—Includes helping other residents or staff, being a good listener, assisting with unit routines, etc.

N4m. ***NONE OF ABOVE***

Process

Consult with the resident, the resident's family, activities staff members, and nurse assistants. Explain to the resident that you are interested in hearing about what he or she likes to do or would be interested in trying. Remind the resident that a discussion of his or her likes and dislikes should not be limited by perception of current abilities or disabilities. Explain that many activity pursuits are adaptable to the resident's capabilities.

For example, if a resident says that he used to love to read and misses it now that he is unable to see small print, explain about the availability of taped books or large print editions.

For residents with dementia or aphasia, ask family members about resident's former interests. A former love of music can be incorporated into the care plan (e.g. bedside audiotapes, sing-a-longs). Also observe the resident in current activities. If the resident appears content during an activity (e.g. smiling, clapping during a music program) check the item on the form.

Coding

Check each activity preferred. If none are preferred, check *N4m. NONE OF ABOVE.*

N5 Prefers Change in Daily Routine

Intent

To determine if the resident has an interest in pursuing activities not offered at the facility (or on the nursing unit), or not made available to the resident. This includes situations in which an activity is provided but the resident would like to have other choices in carrying out the activity (e.g. the resident would like to watch the news on TV rather than the game shows and soap operas preferred by the majority of residents; or the resident would like a Methodist service rather than the Baptist service provided for the majority of residents). Residents who resist attendance/involvement in activities offered at the facility are also included in this category in order to determine possible reasons for their lack of involvement.

Process

Review how the resident spends the day. Ask the resident if there are things he or she would enjoy doing (or used to enjoy doing) that are not currently available or, if available, are not "right" for him or her in their current format. If the resident is unable to answer, ask the same question of a close family member, friend, activity professional, or nurse assistant. Would the resident prefer slight or major changes in daily routines, or is everything OK?

Coding

For each of the items, code for the resident's preferences in daily routines using the codes provided.

0 No change—Resident is content with current activity routines.

1 Slight change—Resident is content overall but would prefer minor changes in routine (e.g. a new activity, modification of a current activity).

2 Major change—Resident feels bored, restless, isolated, or discontent with daily activities or resident feels too involved in certain activities, and would prefer a significant change in routine.

Example

Mrs. B is regularly involved in several small group activities. She also has expressed a preference for music. However, she has consistently refused to go to group sing-alongs when the activity staff offer to bring her. She says she doesn't like big groups and prefers to relax and listen to classical music in her room. She wishes she had a radio or tape player to do this.

Code

N5a. Type of activities in which resident is currently involved	1 (Slight change)
N5b. Extent of resident involvement in activities.	1 (Slight change)

Section O—Medications

O1 Number of Medications

Intent

To determine the number of different medications (over-the-counter and prescription drugs) the resident has received in the **past seven days**.

Process

Count the number of different medications (not the number of doses or different dosages) administered by any route (e.g. oral, IV, injections, patch) at any time during the last seven days.

Include any routine, prn, and stat doses given. "Medications" can also include topical preparations, ointments, creams used in wound care (e.g. Elase), eyedrops, vitamins, and suppositories.

Include any medication that the resident administers to self, if known.

If the resident takes both the generic and brand name of a single drug, count as only one medication.

If the resident received a long-acting antipsychotic medication prior to the assessment period (e.g. if a fluphenazine deconoate or haloperidol deconoate is given once a month) count as one drug.

CIHI Tips

- Medications that have been given beyond the last seven days that are expected to continue to have a therapeutic effect, based on current knowledge, (for example, Haldol LA, Vitamin B12 and chemotherapeutic agents) may be counted in section O1 (Number of Medications).
- Combination medication, for example Tylenol #3, would be counted as one medication.
- Sustained release medications and regular preparations are captured separately and counted as two medications (for example, if a resident received Tylenol and Tylenol Rapid Release in the past seven days, both types of Tylenol would be included in the count).
- Antigens and vaccines administered during the 7 day observation period are counted.

Coding

Write the appropriate number in the answer box. Count only those medications actually administered and received by the resident over the last seven days. **Do not count medications ordered but not given**.

> **Example**
> Resident was given Digoxin 0.25 mg po on Tuesday and Thursday and Digoxin 0.125 mg po on Monday, Wednesday, and Friday. Although the dosage is different for different days of the week, the medication is the same. Code "1" (one medication received).

O2 New Medications

Intent

To record whether the resident is currently receiving medications that were initiated in the **last 90 days**.

Coding

0 If the resident did not receive any new medications in the past 90 days. If the resident received new medication(s) in the last 90 days but they were discontinued prior to this assessment, code "0" (no new medication).

1 If the resident received (and continues to receive) new medications in the last 90 days.

9 If unknown on admission only.

> **CIHI Tip**
> Currently received medications include PRN and regularly administered medications that the resident is still receiving at time of completed assessment. Do not include "stat" medications given once or dose changes.

O3 Injections

Intent

To determine the number of days during the **past seven days** that the resident received any type of medication, antigen, vaccine, by subcutaneous, intramuscular or intradermal injection. Although antigens and vaccines are considered "biologicals" and not medication per se, it is important to track when they are given to monitor for localized or systemic reactions.

This category does not include intravenous (IV) fluids or medications. If the resident received IV fluids, record in Item K5a, Parenteral/IV. If IV medications were given, record "c" in Item P1a, IV medications.

Coding

Record the number of DAYS in the answer box.

Example

During the last seven days, Mr. T received a flu shot on Monday, a PPD test (for tuberculosis) on Tuesday, a Vitamin B12 injection on Wednesday.

Code "3" for Resident received injections on three days during the last seven days.

O4 Days Received the Following Medication

Intent

To record the number of days that the resident received each type of medication listed (antipsychotics, antianxiety, antidepressants, hypnotics, diuretics, analgesics) in the **past seven days**.

See the ***CCRS Medication List Used in Continuing Care*** for a list of drugs by classification. Includes any of these medications given to the resident by any route (PO, IM, or IV) in any setting (e.g. at the facility, in a hospital emergency room).

CIHI Tips

Fentanyl and Duragesic patches would be captured as analgesics; count the number of days that the nurse applied the patch.

Medications are coded according to the pharmacological classification, not their use. For example, if a resident is given ASA 81mg to prevent clot formation, the ASA would be captured as an analgesic in O4f.

Process

Review the resident's clinical record for documentation that a medication was received by the resident during the past seven days. In the case of a new admission, review transmittal records.

Coding

Enter the number of days each of the listed types of medications was received by the resident during the **past seven days**.

In the case of a **new admission**, if it is clearly documented that the resident received any type of medication (listed in this item) at the sending facility, record the number of days each listed medication was received during the **past seven days**. If transmittal records are not clear or do not reference that the resident received one of these medications, record "0" (not used) in the corresponding box.

Codes

0 If the resident did not use any medications from a drug category.

1 If the resident uses long-lasting drugs that are taken less often than weekly [e.g. Prolixin (Fluphenazine deconoate) or Haldol (Haloperidol deconoate) given every few weeks or monthly].

Examples

Medication Record for Mrs. P

- Haldol 0.5 mg po BID p.r.n.: Received once a day on Monday, Wednesday, and Thursday [Note: Haldol =Antipsychotic drug]
- Ativan 1 mg po q.a.m.: Received every day [Note: Ativan = Antianxiety drug]
- Restoril 15 mg po QHS p.r.n.: Received at H.S. on Tuesday and Wednesday only [Note: Restoril =Hypnotic]
- Mrs. P became severely short of breath in the middle of the night during the last seven days. She was transferred (but not admitted) to the emergency room (ER) at the local hospital. Upon her return to the facility the ER transmittal record stated that she had received 1 dose of IV Lasix [Note: Lasix =Diuretic].

Coding

Medication	No. of days received
O4a. Antipsychotic	3 (days)
O4b. Antianxiety	7 (days)
O4c. Antidepressant	0 (days)
O4d. Hypnotic	2 (days)
O4e. Diuretic	1 (days)
O4f. Analgesic	0 (days)

Medication Record for Mr. S

- Mr. S was admitted to the facility on 04/09/12 (Date of Entry) from an acute care hospital. The clinical staff established that 04/09/17 would be the RAI-MDS 2.0 assessment reference date (last day of RAI-MDS 2.0 observation period). By establishing 04/09/17 as the reference date, the observation period of 7 days extended back to 04/09/10 when Mr. S was still in the hospital.
- His hospital discharge summary mentioned that Mr. S was started on a daily dose of Prozac (an antidepressant) on 8/20.
- The hospital discharge summary was too sketchy to accurately determine if Mr. S received other medications during his hospital stay.
- Since admission to the facility Mr. S continues to receive the same dose of Prozac.

Coding

Medication	No. of days received
O4a. Antipsychotic	0 (days)
O4b. Antianxiety	0 (days)
O4c. Antidepressant	7 (days)
O4d. Hypnotic	0 (days)
O4e. Diuretic	0 (days)
O4f. Analgesic	0 (days)

Section P—Special Treatments and Procedures

P1 Special Treatments, Procedures, and Programs

Intent

To identify any special treatments, therapies, or programs that the resident received in the specified time period.

P1a Special Care

Treatments. The following treatments may be received by a resident either at the facility, as a hospital outpatient, or in-patient basis, etc. Check the appropriate RAI-MDS 2.0 item regardless of where the resident received the treatment.

Definition

P1aa. Chemotherapy—Includes any type of chemotherapy (anticancer drug) given by any route.

CIHI Tip

The intent of P1aa is to identify residents receiving chemotherapy for the treatment of cancer. Therefore, any chemotherapeutic agent that is used in the treatment of cancer can be captured in P1aa, including adjuvent therapies such as tamoxifen, and hormonal therapies such as herceptin. Chemotherapy for the treatment of any disease other than cancer would not be included in P1aa (e.g. Megace as an appetite stimulant, Methotrexate for the treatment of rheumatoid arthritis).

P1ab. Renal Dialysis— Including peritoneal or hemodialysis that occurs in the nursing facility or another facility.

P1ac. IV Medication—Includes any drug or biological (e.g. contrast material) given by intravenous push or drip through a central or peripheral port. Also includes infusion pumps (e.g CADD). Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication.

CIHI Tip

IV medication administered prior to admission or solely during a surgical procedure and in the immediate post-operative period (for example, in recovery room) is not captured in the RAI-MDS 2.0 assessment.

P1ad. Intake/output—The measurement and evaluation of all fluids the resident received and/or excreted for at least three consecutive shifts (i.e. 24 hours).

P1ae. Monitoring acute medical condition—Includes observation by a licensed nurse for ANY acute physical or psychiatric illness.

P1af. Ostomy care—This item refers only to care that requires nursing assistance. Do not include tracheostomy care. Code tracheostomy care by checking item P1j.

P1ag. Oxygen therapy—Includes continuous or intermittent oxygen via mask, cannula, etc.

P1ah. Radiation—Includes radiation therapy or having a radiation implant.

P1ai. Suctioning—Includes oropharyngeal, nasopharyngeal and tracheal aspiration.

P1aj. Tracheostomy care—Includes cleansing of tracheostomy and cannula.

P1ak. Transfusions—Includes transfusions of blood or any blood products (e.g. platelets).

P1al. Ventilator or respirator—Assures adequate ventilation in residents who are, or who may become, unable to support their own respiration. Includes any type of electrically or pneumatically powered closed system mechanical ventilatory support devices. Any resident who was in the process of being weaned off of the ventilator or respirator in the last 14 days should be coded under this definition.

Programs. The following programs refer to those received within the facility ONLY.

P1am. Alcohol/drug treatment program—A comprehensive interdisciplinary program within an entire or contiguous unit, wing, or floor where interventions are designed specifically for the treatment of alcohol or drug addictions.

P1an. Alzheimer's/dementia special care unit—Any identifiable part of the facility, such as an entire or a contiguous unit, wing, or floor where staffing patterns and resident care interventions are designed specifically for cognitively impaired residents who may or may not have a specific diagnosis of Alzheimer's disease.

P1ao. Hospice care—The resident is identified as being in a program for terminally ill persons where services are necessary for the palliation and management of terminal illness and related conditions.

P1ap. Pediatric unit—Any identifiable part of the facility, such as an entire or contiguous unit or wing where staffing patterns and resident care interventions are designed specifically for persons aged 22 or younger.

P1aq. Respite care—Resident's care program involves a short-term stay in the facility for the purpose of providing relief to a facility-eligible resident's primary home based caregiver(s). Following this planned short stay, it is anticipated that the resident will return to his or her home in the community.

P1ar. Training in skills required to return to the community—Resident is regularly involved in individual or group activities with a licensed skilled professional to attain goals necessary for community living (e.g. medication management, housework, shopping, using transportation, activities of daily living).

P1as. ***NONE OF ABOVE***

Process

Review the residents' clinical record.

Coding

Check all treatments and procedures that were received during the **last 14 days**.

If no items apply in the **last 14 days**, check *P1as. NONE OF ABOVE*.

P1b Therapies

Therapies that occurred after admission to the facility, were ordered by a physician, and were performed by a qualified therapist (i.e. one who meets provincial/territorial credentialing requirements or in some instances, under such a persons direct supervision).

CIHI Tips

- Therapies listed in P1b only 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 RAI-MDS 2.0 Form.
- Documentation, including evidence of therapy goals, progress and periodic evaluation are required in the clinical record. Note that Recreation Therapy must be "beyond the usual activities" program in an organization.

The therapy treatment may occur either inside or outside the facility. Includes **only** therapies based on a therapist's assessment and treatment plan that is documented in the resident's clinical record.

Intent

To record the (A) number of days administered (for at least 15 minutes a day) and (B) total number of minutes each of the following therapies was administered in the last 7 days.

Definition

P1ba. Speech-language pathology, audiology services—Services that are provided by a qualified speech-language pathologist.

P1bb. Occupational therapy—Therapy services that are provided or directly supervised by a qualified occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the facility only if he or she is under the direction of a qualified occupational therapist.

P1bc. Physical therapy—Therapy services that are provided or directly supervised by a qualified physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include service provided by a qualified physical therapy assistant who is employed by (or under contract to) the facility only if he or she is under the direction of a qualified physical therapist.

P1bd. Respiratory therapy—Included are coughing, deep breathing, heated nebulizers, aerosol treatments, and mechanical ventilation, etc., which must be provided by a qualified professional (i.e. trained nurse, respiratory therapist). Does not include hand held medication dispensers. Count only the time that the qualified professional spends with the resident.

P1be. Psychological therapy—Mental health therapy given by any licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or social worker.

P1bf. Recreation Therapy—Therapy that provides therapeutic stimulation beyond the general activity program in a facility. Documentation must include a statement of frequency, duration and scope of the treatment. Such therapy must be provided by a Provincial/Territorial licensed or nationally certified Therapeutic Recreation Specialist or Therapeutic Recreation Assistant. The Therapeutic Recreation Assistant must work under the direction of a Therapeutic Recreation Specialist. Art therapists and music therapists, who meet these criteria, are included in this category and can code therapy time in P1bf (Recreation Therapy).

Process

Review the residents' clinical record and consult with each of the qualified therapists.

CIHI Tip

All recorded time must be time spent directly with the resident; documentation is not included.

Coding

Box A

- In the first column, enter the number (#) of days the therapy was administered for 15 minutes or more in the **last seven calendar days.**
- Enter “0” if none.

Box B

- In the second column, enter the total number (#) of minutes the particular therapy was provided in the **last seven days** even if you entered “0” in Box A (e.g. less than 15 minutes of therapy provided). Count only the time that the qualified professional spends with the resident. The time should include only the actual treatment time (not time waiting or writing reports).
- Enter ”0” if none.

CIHI Tips

Group therapy ratios:

P1ba. Speech-language pathology, audiology services 4:1

P1bb. Occupational therapy 4:1

P1bc. Physical therapy 4 :1

P1bd. Respiratory therapy 4:1

P1be. Psychological therapy 8:1

P1bf. Recreation therapy 8:1

If the ratio of groups is larger than the therapeutic maximums the therapist’s time is divided by the number of residents. For example, 4 residents attend an exercise class with 1 occupational therapist for 30 minutes; each resident would receive 30 minutes of therapy. If the ratio of residents is greater than 4:1, the total time is divided by the total number of residents in the group. For example, 6 residents attending a therapy session for 30 minutes would each receive 5 minutes of therapy.

Example

Following a stroke Mrs. F was admitted to the facility in stable condition for rehabilitation therapies. Since admission she has been receiving speech therapy twice weekly for 30-minute sessions, occupational therapy twice weekly for 30-minute sessions, and physical therapy twice a day (30 minute sessions) for 5 days and respiratory therapy for 10 minutes per day on each of the last 7 days. During the last seven days Mrs. F has participated in all of her scheduled sessions.

Coding	A	B
a. Speech-language pathology, audiology services	2	60
b. Occupational therapy	2	60
c. Physical therapy	5	300
d. Respiratory therapy	0	70
e. Psychological therapy	0	0
f. Recreation therapy	0	0

P2 Intervention Programs for Mood, Behaviour, Cognitive Loss

CIHI Tip

Observation period: last 7 days

Definition

P2a. Special behaviour symptom evaluation program—A program of ongoing, comprehensive, interdisciplinary evaluation of behavioural symptoms (such as the symptoms described in item E4). The purpose of such a program is to attempt to understand the "meaning" behind the resident's behavioural symptoms in relation to the resident's health and functional status, and social and physical environment. The ultimate goal of the evaluation is to develop and implement a plan of care that serves to reduce distressing symptoms.

P2b. Evaluation by a licensed mental health specialist in the last 90 days—An assessment of a mood, behaviour disorder, or other mental health problem by a qualified clinical professional such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker, depending on provincial/territorial practice acts. Do not check this item for routine visits by the facility social worker. Evaluation may take place at the facility, private office, clinic, community mental health center, etc.

P2c. Group therapy—Resident regularly attends sessions at least weekly. Therapy is aimed at helping to reduce loneliness, isolation, and the sense that one's problems are unique and difficult to solve. The session may take place either at the facility (e.g. support group run by the facility's social worker) or outside the facility (e.g. group program at community mental health center, Alcoholics Anonymous meeting at a local church, Parkinson's Disease support group at local hospital). This item does not include group recreational or leisure activities.

P2d. Resident-specific deliberate changes in the environment to address mood/behaviour/cognitive patterns—Adaptation of the milieu focused on the resident's individual mood/behaviour/cognitive pattern. Examples include placing a banner labeled "wet paint" across a closet door to keep the resident from repetitively emptying all the clothes out of the closet, or placing a bureau of old clothes in an alcove along a corridor to provide diversionary "props" for a resident who frequently stops wandering to rummage. The latter diverts the resident from rummaging through belongings in other residents' rooms along the way.

CIHI Tip

Alarm systems (such as sensor mats or wrist bracelets) that are resident specific can be included in P2d.

P2e. Reorientation—Individual or group sessions that aim to reduce disorientation in confused residents. Includes environmental cueing in which all staff involved with the resident provide orienting information and reminders.

P2f. *NONE OF ABOVE*

Process

Review the resident's clinical record for documentation of intervention programs. These interventions also should be documented in the care plan.

Coding

Check all that apply. If none apply, check *P2f. NONE OF ABOVE*.

P3 Nursing Rehabilitation/Restorative Care

Intent

To determine the extent to which the resident receives nursing rehabilitation or restorative services from other than specialized therapy staff (e.g. occupational therapist, physical therapist, etc.). Rehabilitative or restorative care refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as is possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

Skill practice in such activities as walking and mobility, dressing and grooming, eating and swallowing, transferring, amputation care, and communication can improve or maintain function in physical abilities and ADLs and prevent further impairment.

Definition

Rehabilitation/restorative care—Included are nursing interventions that assist or promote the resident's ability to attain his or her maximum functional potential. This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in item P1b.

In addition, to be included in this section, a rehabilitation or restorative practice must meet all of the following additional criteria:

- Measurable objectives and interventions must be documented in the care plan and in the clinical record.
- Evidence of periodic evaluation by licensed nurse must be present in the clinical record.
- Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity.
- These activities are carried out or supervised by members of the staff.
- This category does not include exercise groups with more than four residents per supervising helper or caregiver.

P3a. Range of motion (passive)—The extent to which, or the limits between which, a part of the body can be moved around a fixed point, or joint. Range of motion exercise is a program of passive or active movements to maintain flexibility and functional movement in the joints of the body.

P3b. Range of motion (active)—Exercises performed by a resident, with cueing or supervision by staff, that are planned, scheduled, and documented in the clinical record.

P3c. Splint or brace assistance—Assistance can be of 2 types: 1) where staff provide verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint, or 2) where staff have a scheduled program of applying and removing a splint or brace, assess the resident's skin and circulation under the device, and reposition the limb in correct alignment. These sessions are planned, scheduled, and documented in the clinical record.

Training and skill practice in the following activities (including repetition, physical or verbal cueing, and task segmentation) provided by any staff member under the supervision of a licensed nurse.

P3d. Bed mobility—Activities used to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side, and positioning him or herself in bed.

P3e. Transfer—Activities used to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.

P3f. Walking—Activities used to improve or maintain the resident's self-performance in walking, with or without assistive devices.

P3g. Dressing or grooming—Activities used to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

P3h. Eating or swallowing—Activities used to improve or maintain the resident's self-performance in feeding one's self food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

CIHI Tip

The management of gastrostomy feedings to maintain independence would be included in P3h.

P3i. Amputation or prosthesis care—Activities used to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g. leg stump or eye socket).

P3j. Communication—Activities used to improve or maintain the resident's self-performance in using newly acquired functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

P3k. Other—Any other activities used to improve or maintain the resident's self-performance in functioning. This includes, but is not limited to, teaching self-care for diabetic management, self-administration of medications, ostomy care, and cardiac rehabilitation.

Process

Review the clinical record and the current care plan. Consult with facility staff. Look for rehabilitation, restorative care schedule, assignment, and implementation record sheet on the nursing unit.

Coding

For the **last seven days**, enter the number of days on which the technique, procedure, or activity was practiced for a total of at least 15 minutes during the 24-hour period. The 15 minutes does not have to occur all at once. Remember that persons with dementia learn skills best through repetition that occurs multiple times per day. Review for each activity throughout the 24-hour period. Enter zero "0" if none.

Examples of Nursing Rehabilitation/Restoration

- Mr. V has lost range of motion (ROM) in his right arm, wrist and hand due to a CVA experienced several years ago. He has moderate to severe loss of cognitive decision-making skills and memory. To avoid further ROM loss and contractures to his right arm, the occupational therapist fabricated a right resting handsplint and instructions for its application and removal. The nursing coordinator developed instructions for providing passive range of motion exercises to his right arm, wrist and hand 3 times per day. The nursing assistants have been instructed on how and when to apply and remove the handsplint and how to do the passive ROM exercises. These plans are documented on Mr. V's care plan. The total amount of time involved each day in removing and applying the handsplint and completing the ROM exercises is 30 minutes. The nursing assistants report that there is less resistance in Mr. V's affected extremity when bathing and dressing him. For both Splint or Brace assistance and Range of Motion (passive). **Enter "7" as the number of days these nursing rehabilitative techniques were provided.**
- Mrs. K was admitted to the facility 7 days ago following repair to a fractured hip. Physical therapy was delayed due to complications and a weakened condition. Upon admission, she had difficulty moving herself in bed and required total assistance for transfers. To prevent further deterioration and increase her independence, the staff implemented a plan on the second day following admission to teach her how to move herself in bed and transfer from bed to chair using a trapeze, the bedrails, and a transfer board. The plan was documented in Mrs. K's clinical record and communicated to all staff at the change of shift. The charge nurse documented in the nurses notes that in the five days Mrs. K has been receiving training and skill practice for bed mobility and transferring, her endurance and strength are improving, and she requires only extensive assistance for transferring. Each day the amount of time to provide this nursing rehabilitation intervention has been decreasing so that for the past five days, the average time is 45 minutes. **Enter "5" as the number of days training and skill practice for bed mobility and transfer was provided.**

- Mrs. J had a CVA less than a year ago resulting in left-sided hemiplegia. Mrs. J has a strong desire to participate in her own care. Although she cannot dress herself independently, she is capable of participating in this activity of daily living. Mrs. J's overall care plan goal is to maximize her independence in ADL's. A plan, documented on the care plan, has been developed to teach Mrs. J how to put on and take off her blouse with no physical assistance from the staff. All of her blouses have been adapted for front closure with velcro. The nursing assistants have been instructed in how to verbally guide Mrs. J as she puts on and takes off her blouse. It takes approximately 20 minutes per day for Mrs. J to complete this task (dressing and undressing). **Enter "7" as the number of days training and skill practice for dressing and grooming was provided.**

Examples of Nursing Rehabilitation/Restoration (cont'd)

- Using a quad cane and a short leg brace, Mrs. D is receiving training and skill practice in walking. Together, Mrs. D and the staff have set progressive walking distance goals. The staff have received instruction on how to provide Mrs. D with the instruction and guidance she needs to achieve the goals. She has three scheduled times each day where she learns how to apply her short leg brace followed by walking. Each teaching and practice episode for brace application and walking, supervised by a nursing assistant, takes approximately 15 minutes. **Enter "7" as the number of days for splint and brace assistance and training and skill practice in walking were provided**.
- Experiencing a slow recovery from Guillain Barre syndrome, Mr. B is receiving daily training and skill practice in swallowing. Along with specially designed cups and appropriate food consistency, the documented plan of care to improve his ability to swallow involves proper body positioning, consistent verbal instructions, and jaw control techniques. Mr. B requires close monitoring when given food and fluids as he is at risk for choking and aspiration. Therefore, only licensed nurses provide this nursing rehabilitative intervention. It takes approximately 35 minutes each meal for Mr. B to finish his food and liquids. He receives supplements via a gastrostomy tube if he does not achieve the prescribed fluid and caloric intake by mouth. **Enter "7" as the number of days training and skill practice in swallowing was provided.**
- Mr. W's cognitive status has been deteriorating progressively over the past several months. Despite deliberate nursing restoration, attempts to promote his independence in feeding himself, he will not eat unless he is fed. Because Mr. W did not receive nursing rehabilitation/ restoration for eating in the last 7 days. **Enter "0" as the number of days training and skill practice for eating was provided.**
- Mrs. E has amyotrophic lateral sclerosis. She no longer has the ability to speak or even to nod her head "yes" and "no". Her cognitive skills remain intact, she can spell, and she can move her eyes in all directions. The speech language pathologist taught both Mrs. E and the staff to use a communication board so that Mrs. E. could communicate with staff. The communication board has proven very successful and all are reminded by a sign over Mrs. E's bed that they are to provide her with the board to enable her to communicate with them. This is also documented in Mrs. E's care plan. Because the teaching and practice in using the communication board had been completed two weeks ago and Mrs. E is able to use the board to communicate successfully, she no longer receives skill and practice training in communication. **Enter "0" as the number of days training and skill practice in communication was provided.**

P4 Devices and Restraints

Intent

To record the frequency, over the **last seven days**, with which the resident was restrained by any of the devices listed below at any time during the day or night.

Definition

A physical restraint is any manual method, or any physical or mechanical device, material, or equipment that is attached or adjacent to the resident's body, that the resident cannot remove easily, and that restricts the resident' s freedom of movement or normal access to his or her body. It is the effect the device has on the resident that classifies it into the category of restraint, not the name or label given to the device, nor the purpose or intent of the device.

P4a. **Full bed rails on all open sides of bed**—Full rails may be one or more rails along both sides of the resident's bed that block three-quarters to the whole length of the mattress from top to bottom. **This definition also includes beds with one side placed against the wall (prohibiting the resident from entering and exiting on that side) and the other side blocked by a full rail (one or more rails).** A veil screen (used in pediatric units) is included in this category.

P4b. **Other types of bed rails used** (e.g. half rail, one side)

P4c. **Trunk restraint**—Includes any device or equipment or material that the resident cannot easily remove (e.g. vest or waist restraint).

P4d. **Limb restraint**—Includes any device or equipment or material that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e. hand, arm) or lower extremity (i.e. foot, leg).

P4e. **Chair prevents rising**—Any type of chair with locked lap board or chair that places resident in a recumbent position that restricts rising or a chair that is soft and low to the floor (e.g. bean bag chair). Includes "comfort cushions" (e.g. lap buddy), "merry walkers."

Process

Check the resident's clinical records and restraint flow sheets. Consult staff. Observe the resident. If the resident has no voluntary movement, specifically is comatose, or he or she is quadriplegic, code P4c (Trunk restraint), P4d (Limb restraint), and P4e (Chair prevents rising) as "0" (Not used).

P4e (Chair prevents rising) would be coded "0" (Not used) if the resident does not have the physical ability or cognitive capacity to rise from ANY chair. If a resident who could get out of an upright, non-restricting chair is placed in a chair that prevents him or her from rising (for example, in a recumbent position, in a chair with a locked lap board, or one that is soft and low to the floor), P4e should be coded as 1 (Used, less than daily) or 2 (Used daily).

Coding

For the last seven days enter the frequency each device type is used:

0 Not used

1 Used, less than daily

2 Used daily

P5 Hospital Stay(s)

Intent

To record how many times the resident was admitted to the hospital with an overnight stay in the **last 90 days** or since the last assessment if less than 90 days (regardless of payment status for these days either by the hospital or by the facility). If the resident is a new admission to the facility, this item includes admissions during the period prior to admission.

Definition

The resident was formally admitted by a physician as an in-patient with the expectation that he or she will stay overnight. It does not include day surgery, outpatient services, etc.

Process

Review the resident's record. If the resident is a new admission, ask the resident and resident's family. Sometimes transmittal records from recent hospital admissions are not readily available during a facility admission from the community.

Coding

Enter the number of hospital admissions in the box. Enter "0" if no hospital admissions.

Examples

- Mrs. D, an insulin-dependent diabetic, was admitted to the facility yesterday from her own home. At home she had been having a lot of difficulty with insulin regulation since developing an ulcer on her left foot six weeks ago. During the last 90 days prior to admission, Mrs. D had two hospitalizations, for 3 and 5 days respectively. **Code "2" for two hospital admissions in the last 90 days.**
- Mr. W has been a resident of the facility for two years. He has a blood dyscrasia and receives transfusions at the local emergency room twice monthly. In the last month Mr. W was admitted to the hospital for 2 days after developing a fever during his blood transfusion. **Code "1" for one hospital admission in the last 90 days.**

P6 Emergency Room (ER) Visit(s)

Intent

To record if during the **last 90 days** the resident visited a hospital emergency room (e.g. for treatment or evaluation) but **was not admitted** to the hospital for an overnight stay at that time. If the resident is a new admission to the facility, this item includes emergency room visits during the period prior to admission.

Definition

Emergency room visit—A visit to an emergency room not accompanied by an overnight hospital stay. Exclude prior scheduled visits for physician evaluation, transfusions, chemotherapy, etc.

Process

Review the resident's clinical record. For new admissions, ask the resident and the resident's family and review the transmittal record.

Coding

Enter the number of ER visits in the **last 90 days** (or since last assessment if less than 90 days). Enter "0" if no ER visits.

Examples

- One evening, Mr. X complained of chest pain and shortness of breath. He was transferred to the local emergency room for evaluation. In the emergency room Mr. X was given IV Lasix, nitrates, and oxygen. By the time he stabilized, it was late in the evening and he was admitted to the hospital for observation. He was transferred back to the facility the next afternoon. **Code "0" for No ER visits.** *The rationale for this coding is that although Mr. X was transferred to the emergency room, he was admitted to the hospital overnight. An overnight stay is not part of the definition of this item.*
- During the night shift, Mrs. F slipped and fell on her way to the bathroom. She complained of pain in her right hip and was transferred to the local emergency room for x-rays. The x-rays were negative for a fracture and Mrs. F was transferred back to the facility within several hours. **Code "1" for 1 ER visit.**
- Once during the last 90 days, Mr. P's gastrostomy tube became dislodged and facility staff were unsuccessful in reinserting it after multiple attempts. Mr. P was then transferred to the local emergency room where the on-call physician reinserted the tube. **Code "1" for ER visit.**

P7 Physician Visits

Intent

To record the **number of days during the last 14-day period** a physician has examined the resident (or since admission if less than 14 days ago). Examination can occur in the facility or in the physician's office. In some cases the frequency of physician's visits is indicative of clinical complexity.

Definition

Physician—Includes MD, osteopath, podiatrist, or dentist who is either the primary physician or consultant. Also include an authorized physician assistant, or nurse practitioner working in collaboration with the physician.

CIHI Tip

The following disciplines can be included in item P7: Osteopath, Podiatrist, Optometrist, Ophthalmologist, Nurse Practitioner, Physician Assistant, Dentist and Dental Surgeon, any consultant (for example, a cardiologist) and Naturopathic Physician/Doctor of Naturopathy/ Doctor of Naturopathic.

Do NOT include: Chiropodist, Orthotist/Pedorthist, Chiropractor, Optician, Denturist, Psychologist, and Clinical Nurse Specialist.

Physician exam—May be a partial or full exam at the facility or in the physician's office. This does not include exams conducted in an emergency room. If the resident was examined by a physician during an unscheduled emergency room visit, record the number of times this happened in the last 90 days in Item P6, "Emergency Room (Visits)".

Coding

Enter the number of days the physician examined the resident.

If none, enter "0".

P8 Physician Orders

Intent

To record the **number of days during the last 14-day period** (or since admission, if less than 14 days ago) in which a physician has changed the resident's orders. In some cases the frequency of physician's order changes is indicative of clinical complexity.

Definition

Physician—Includes MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or a consultant. Also includes authorized physician assistant or nurse practitioner working in collaboration with the physician.

Physician orders—Includes written, telephone, fax, or consultation orders for new or altered treatment. Does **NOT** include admission orders, return admission orders, or renewal orders without changes.

> **CIHI Tips**
>
> 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.

Coding

Enter the number of days on which physician orders were changed. Do not include order renewals without change.

If no order changes, enter “0”.

P9 Abnormal Lab Values

Intent

To document whether the resident had any abnormal laboratory values during the **last 90 days**. This item refers only to laboratory tests performed after admission to the facility. “Abnormal” refers to laboratory values that are abnormal when compared to standard values, not abnormal for the particular resident. The laboratory values referred to here are for blood tests and tests of other human tissue samples or substances, which are tested in the laboratory.

> **Example**
>
> An elevated prothrombin time in a resident receiving coumadin therapy is coded “1” for Yes (Abnormal) even though this may be the desired effect.

Process

Check medical records, especially laboratory reports.

Coding

0 If no abnormal value was noted in the record.
1 If the resident has had at least one abnormal laboratory value.

Section Q—Discharge Potential and Overall Status

Q1 Discharge Potential

Intent

To identify residents who are potential candidates for discharge within the **next three months**. Some residents will meet the "potential discharge" profile at admission; others will move into this status as they continue to improve during the first few months of residency.

Definition

Discharge—Can be to home, another community setting, another care facility, or a residential setting. A prognosis of death should not be considered as an expected discharge.

Support person—Can be a spouse, family member, or significant other.

Process

For **new and recent admissions**, ask the resident directly. The longer the resident lives at the facility, the tougher it is to ask about preferences to return to the community.

After one year of residency, many persons feel settled into the new lifestyle at the facility. Creating unrealistic expectations for a resident can be cruel. Use careful judgement. Listen to what the resident brings up (e.g. Calls out, "I want to go home"). Ask indirect questions that will give you a better feel for the resident's preferences. **For example**, say, "It's been about 1 year that we've known each other. How are things going for you here at (facility).

Consult with primary care and social service staff, the resident's family, and significant others. Review clinical records. Discharge plans are often recorded in social service notes, nursing notes, or medical progress notes.

Coding

Q1a. Resident expresses/indicates preference to return to the community.

0 No

1 Yes

Q1b. Resident has a support person who is positive towards discharge

0 No

1 Yes

Q1c. Stay projected to be of a short duration—Discharge projected within 90 days (do not include expected discharge due to death).

0 No

1 Within 30 days

2 Within 31–90 days

3 Discharge status uncertain

Examples

- Mrs. F is a 65 year old married woman who sustained a CVA two months ago. She was admitted to the facility one week ago from a rehabilitation facility for further rehab, particularly for transfer, gait training, and wheelchair mobility. Mrs. F is extremely motivated to return home. Her husband is supportive and has been busy making their home "user friendly" to promote her independence. Their goal is to be ready for discharge within 2 months.

Discharge Potential	Coding
Q1a. Resident expresses/indicates preference to return to the community.	1 (Yes)
Q1b. Resident has a support person who is positive towards discharge.	1 (Yes)
Q1c. Stay projected to be of a short duration—discharge projected within 90 days (do not include expected discharge due to death.	2 (Within 31–90 days)

Examples (cont'd)

- Mrs. D is a 67-year-old widow with end-stage metastatic cancer to bone with pathological fractures. Currently her major problems are pain control and confusion secondary to narcotics. Mrs. D periodically calls out for someone to take her home to her own bed. Her daughter is unwilling and unable to manage her hospice care at home. Because of the fractures, Mrs. D is totally dependent in all ADLs except eating (she can hold a straw).

Rationale for coding:

Although Mrs. D is near death, you should apply a code of "0" (No). This RAI-MDS 2.0 item instructs you "do not include expected discharge due to death."

Discharge Potential	Coding
Q1a. Resident expresses/indicates preference to return to the community.	1 (Yes)
Q1b. Resident has a support person who is positive towards discharge.	0 (No)
Q1c. Stay projected to be of a short duration—discharge projected within 90 days (do not include expected discharge due to death.	0 (No)

- Mr. S is a 70 year-old married gentleman who was admitted to the facility two weeks ago from the hospital following surgical repair of a left hip fracture. Mr. S has a long history of alcoholism and cirrhosis of the liver. His daughter reports that when he is drinking he is abusive towards his wife of 40 years. Though he has a strong wish to return home, his wife states she can't take it anymore and doesn't want him to return home. He has basically worn out all his family options. Other social support options are being explored. At this time plans for discharge remain uncertain.

Discharge Potential	Coding
Q1a. Resident expresses/indicates preference to return to the community.	1 (Yes)
Q1b. Resident has a support person who is positive towards discharge.	0 (No)
Q1c. Stay projected to be of a short duration—discharge projected within 90 days (do not include expected discharge due to death.	3 (Uncertain)

Q2 Overall Change in Care Needs

Intent

To monitor the resident's overall progress at the facility over time. Document changes **as compared to his or her status of 90 days ago** (or since last assessment if less than 90 days ago). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Definition

Overall self-sufficiency—Includes self-care performance and support, continence patterns, involvement patterns, use of treatments, etc.

Process

Review clinical record, transmittal records (if new admission or readmission), previous RAI-MDS 2.0 assessments (including quarterly assessments), and care plan. Discuss with direct caregivers.

Coding

Record the number corresponding to the most correct response.

0 No change

1 Improved (receives fewer supports, needs less restrictive level of care)

2 Deteriorated (receives more support).

Examples

- Mr. R is a 90 year-old comatose gentleman admitted to the facility from a six months' stay at another facility to be closer to his wife's residence. His condition has remained unchanged for approximately six months. **Code "0" for No change**.
- Mrs. T has a several year history of Alzheimer's disease. In the past four months her overall condition has generally improved. Although her cognitive function has remained unchanged, her mood is improved. She seems happier, less agitated, sleeps more soundly at night, and is more socially involved in daily activity programming. **Code "1" for Improved**.
- Mr. D also has a several year history of Alzheimer's disease. Although for the past year he was quite dependent on others in most areas, he was able to eat and walk with supervision until recently. In the past 90 days he has become more dependent. He no longer feeds himself. Additionally, he fell two weeks ago and has been unable to learn how to use a walker. He requires a two-person assist for walking even short distances. **Code "2" for Deteriorated**.

Section R—Assessment Information

R1 Participation in Assessment

Intent

To record the participation of the resident, family and/or significant others in the assessment, and to indicate the reason if the resident's assessment is incomplete.

> **CIHI Tip**
>
> Participation in assessment would include the resident actively participating by responding to questions or providing information into his or her health status and functioning.

Definition

Family—A spousal, kin (e.g. sibling, child, parent, nephew), or in-law relationship.

Significant other—May include close friend, lover, housemate, legal guardian, trust officer, or attorney. Significant other does not, however, include staff at the facility.

Process

Preparing residents and family members to participate in the care-planning process begins with assessment. When staff members explain the assessment process to a resident, they should also explain that the outcome of assessment is care delivery guided by a care plan. Every assessment team member can establish an expectation of resident participation by asking for and respecting the resident's perspective during assessment.

Asking family members about their expectations of the facility and their concerns during the assessment process can prove beneficial. Relatives may need to talk to a staff member or they may need information. Some family concerns and expectations can be appropriately addressed in the care-planning conference. Discussing these matters with the family during the assessment process can assist in maintaining a focus on the resident during the care-planning meeting.

Staff should consider some important aspects of resident and/or family participation in assessment and care planning. Attention to seating arrangements that will facilitate communication is necessary for several reasons:

- To keep the resident from feeling intimidated and/or powerless in front of professionals.
- To accommodate any communication impairments.
- To minimize any tendencies for family members to dominate the resident in the conference yet encourage them to support the resident if that is needed.
- To facilitate non-verbal support of the resident by staff with whom the resident is close.

Verbal communication should be directed to the resident, even when the resident is cognitively impaired. The terms used should be tailored to facilitate understanding by the resident. The resident's opinions, questions, and responses to the developing care plan should be solicited if they are not forthcoming.

Coding

R1a. **Resident**—Enter "0" for No or "1" for Yes to indicate whether the resident participated in the assessment. This item should be completed last.

R1b. **Family**—Enter "0" for No or "1" for Yes to indicate whether the family participated; enter "2" for No family.

R1c. **Significant other**—Enter "0" for No or "1" for Yes to indicate whether a significant other participated; enter "2" for None if there is no significant other.

R2 Signatures of Persons Completing the Assessment

Intent

Refer to provincial/territorial and facility policies regarding requirements for the Assessment Co-ordinator to sign, date and certify that the assessment is complete.

Process

Each staff member who completes any portion of the RAI-MDS 2.0 must sign and date the RAI-MDS 2.0 and indicate beside their signature which portions they completed. Two or more staff members can complete items within the same section of the RAI-MDS 2.0. The Assessment Co-ordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the RAI-MDS 2.0. The Assessment Co-ordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.

Coding

All persons completing part of this assessment, including the Assessment Co-ordinator, must sign their names in the appropriate locations. To the right of the name, enter title and the letters that correspond to sections of the RAI-MDS 2.0 for which the assessor was responsible, and also enter the date on which the form is signed.

R3a Discharged to Facility/Level of Care

Intent

This section identifies the facility/level of care to which the resident is discharged, or that the discharge is due to death (code 11).

Definition

R3a Discharged to	Facility/Level of Care	Setting	Services/ Programs
00	Ambulatory Health Service	• Associated with a hospital service, or • Other community/ primary care setting	• Ambulatory care encompasses all health services that are provided to clients who are not residing in health care institutions at the time the care is given • May include emergency services, day/night care, specialty or non-specialty clinics, day surgery, private medical practice
01	Inpatient Acute Care Service	• Free-standing acute care hospital, or • Acute care nursing unit in a hospital offering multiple levels of care	• Provides diagnosis and short-term treatment of patients with a wide variety of diseases or injuries • 24 hour coverage by professional nursing staff and on-call physicians

R3a Discharged to	Facility/Level of Care	Setting	Services/ Programs
02	Inpatient Rehabilitation Service (General)	• Rehabilitation unit within a hospital offering multiple levels of care • Includes general rehabilitation unit within a free-standing rehabilitation hospital	• Provides rehabilitation to a broad range of client groups • Generally includes nursing, PT, OT and may include other professional services
03	Inpatient Continuing Care Service	• Free-standing hospital (e.g. chronic, complex continuing care, extended care, auxiliary hospital), or • Continuing care nursing unit within an acute care hospital, or facility/ program offering multiple levels of continuing care services (including ALC and assessment units)	• Provides care to persons who, because of chronic illness and marked functional disability, require hospitalization, but do not need acute care services • Provide assessment services to facilitate placement and/or service planning • 24 hour coverage by professional nursing staff and on-call physicians
04	Residential Care Service (24-hour nursing care)	• Free-standing residential care facility, or • Residential unit within a facility/program offering multiple levels of continuing care services	• Provides care for clients who cannot safely live at home • Provide medication supervision, 24 hour professional nursing care, assisted meal service, etc.
05	Inpatient Psychiatry Service	• Free-standing psychiatric hospital, or • Psychiatry nursing unit within a hospital offering multiple levels of care	• Provides for the diagnosis and short-term treatment and continuing assessment and long-term treatment of inpatients with psychiatric disorders
06	Other/ Unclassified Service		

R3a Discharged to	Facility/Level of Care	Setting	Services/ Programs
07	Inpatient Rehabilitation Service (Specialized)	• Free-standing rehabilitation hospital, or • Rehabilitation unit within a hospital offering multiple levels of care	• Provides specialized programs (e.g. acquired brain injury, stroke, neurological conditions, spinal cord dysfunction, amputation, major multiple trauma, orthopedic conditions, etc.) • Includes a comprehensive range of professional services including medical/ surgical specialists, physiotherapists, occupational therapists, speech language pathologists, psychologists, recreational therapists , orthotists and prosthetists
08	Home Care Service	• Private home or apartment with home health and/or home support services	• Provides an array of health and support services that enable individuals, incapacitated in whole or in part to live at home
09	Residential Care Service (board and care)	• Free-standing residential care facility, or • Residential unit within a facility/program offering multiple levels of continuing care services	• Provides support for activities of daily living • Professional and nursing services may be accessed through home care or other community-based service
10	Private Home (no home care)	• Any house, condominium or apartment in the community, whether owned by the client or another person	• No formal home health or home support services are provided
11	Deceased		

R3b Discharged to Facility Number

Intent

To identify the specific facility/level of care to which the resident is discharged.

Definition

The facility number is assigned by the provincial/territorial government. This number must contain a total of five (5) characters. The first character, a letter or number is designated by CIHI and, indicates the province/territory in which the facility is located.

Process

For provinces/territories submitting RAI-MDS 2.0 data to CCRS, this information will be contained in a provincial/territorial specific appendix of the CCRS Specifications Manual.

Coding

Begin writing in the left-hand box. Enter one digit per box. The first character indicates the province/territory in which the facility is located (see Item AA6).

If R3a (Discharged to Facility/Level of Care) is coded 09 (Residential care service—board and care), or 10 (Private home with home care service) or 11 (Deceased), R3b must be coded with spaces.

Section U—Medication List

Facility residents are highly susceptible to adverse drug reactions and drug interactions. It is estimated that approximately 30% of all geriatric hospital admissions are due to drug-related problems. Polypharmacy is the use of two or more medications for no apparent reasons or for the same purpose. Polypharmacy also occurs when a medication is used to treat an adverse reaction from another medication. Polypharmacy can occur in facilities when there is no regular and careful monitoring of residents' prescribed medications.

Intent

This section will assist staff in identifying potential problems related to polypharmacy, drug reactions and interactions. Further, this section can also help staff to identify potential physical and emotional problems a resident may be experiencing.

For example, reviewing and documenting the frequency a resident uses a PRN pain medication, sleeping medication, or laxative may lead the interdisciplinary team to do further assessment related to underlying causes associated with the use of PRN medications. Many of the CAPs/RAPs and Triggers refer to assessment of medications in which this section would be very helpful.

In addition to using the medication information collected in Section U for resident care planning purposes, this section can be integrated into a facility's quality assurance program to monitor for quality care issues such as polypharmacy, overuse of different medications, and medication administration errors and omissions.

Definitions

Amount Administered—the number of tablets, capsules, suppositories, or amount of liquid (cc's, mls, units) **per dose** that is administered to a resident.

DIN—The Drug Information Number for each medication given. The DIN must match the drug dispensed by the pharmacy.

Medication Administration Record (MAR)—The part of the resident's clinical record that is used by the nurse administering medications to record the medication administered. The MAR typically is the form or document used specifying the medication, dose, frequency, and route for each medication that a resident is to receive on a scheduled or PRN basis.

Process

Recording all of the information required in this section can be done efficiently by having the following information:

1. current physician order sheets;
2. current Medication Administration Record (MAR),
3. DIN codes.

Use the Medication Administration Record (MAR) as your primary document for identifying all medications administered in the **last seven days**. Check the physician's order sheet to determine if any medications had recently been ordered.

In some facilities, the pharmacist may complete some portions of Section U, particularly the DIN codes and the amount administered. The pharmacy may also be able to supply you with the DIN codes for the medications ordered for each resident. Talk to the pharmacist for your facility and engage their participation in assisting with the completion of this section. If the pharmacist does not complete any portions of the medication section of the RAI-MDS 2.0, you may be able to obtain a list of DIN codes from your pharmacy

Take special care to ensure that you have identified and recorded all medications that were administered in the last 7 days. Often residents can have several MAR pages, especially if medications have been discontinued and new ones ordered or if there are a lot of PRN medications ordered. Recheck the MAR at least twice to avoid missing any medications administered in the last seven days. Make sure you count medications that may have been discontinued, but were administered in the last seven days.

To accurately complete the DIN codes and amount administered, it will be necessary to look at the actual medications that are given to the resident. For example, some injectable medications can be provided in vials, ampules, or premeasured syringes.

If Section U is completed by the pharmacist or other facility personnel, these persons must certify its accuracy with their signature in section R. The Assessment Co-ordinator must review Section U to ensure that it is complete.

Coding

The coding instructions are extensive. Review them carefully. Study the examples. Complete the coding exercises at the end of this section.

U1 Medication Name and Dose Ordered

Identify and record all medications that the resident **received** in the **last seven days**. Also identify and record any medications that may not have been given in the last seven days, but are part of the resident's regular medication regimen (e.g. monthly B-12 injections). Do **not** record PRN medications that were **not** administered in the last seven days.

Record the name of the medication and dose that was ordered by the physician in **column 1**. Write the name of the medication and dose ordered *EXACTLY* as it appears on the MAR.

Occasionally, dosages of medications may be changed during the seven day assessment period. The medication with dosage changes should be recorded separately.

Example for Medication Name and Dose Ordered

Medications as listed on MAR for assessment period of 2010/08/11-2010/08/17

a. Lasix 40 mg. daily p.o.

b. Acetaminophen 325 mg. 2 tabs q3-4 hrs PRN p.o. (given 3 times in last seven days)

c. Vitamin B12 1cc qmonth IM (given 2010/08/08)

d. Isopto Carbachol 1.5% 2 drops OD TID

e. Robitussin-DM 5cc HS PRN p.o. (not given in last 7 days)

f. Motrin 300 mg. QID p.o. (discontinued 2010/08/15)

g. Dilantin 300 mg. HS p.o. (ordered 2010/08/15)

h. Theo-Dur 200 mg. BID p.o. (given 2010/08/11–2010/08/15 and then order discontinued)

i. Theo-Dur 200 mg TID p.o. (given 2010/08/14–2010/08/15 and then order discontinued)

J. Theo-Dur 400 mg BID p.o. (given 2010/08/15)

1. Medication Name and Dose Ordered	2. RA	3. Frequency	4. Amount Administered	5. PRN-Number of Doses	6. DIN Number							
Lasix 40 mg.												
Acetaminophen 325 mg. 2 tabs												
B-12 1cc												
Isopto Carbachol 1.5% 2 drops												
Motrin 300 mg.												
Dilantin 300 mg.												
Theo-Dur 200 mg.												
Theo-Dur 200 mg.												
Theo-Dur 400 mg.												

***** Note that Robitussin-DM was not recorded because it was not given in the last 7 days.

U2 Route of Administration (RA)

Determine the Route of Administration (RA) used to administer each medication. The MAR and the physician's orders should identify the RA for each medication. Record the RA in **column 2** using the following codes:

01 = by mouth (PO)
02 = sublingual (SL)
03 = intramuscular (IM)
04 = intravenous (IV)
05 = subcutaneous (SQ)
06 = rectal (R)
07 = topical
08 = inhalation
09 = enteral tube
10 = other

CIHI Tip

Eye drops, ear drops, and transdermal applications such as Transderm Nitro should be coded "10" (Other). Creams (for example, Hydrocortisone Cream, Canesten Cream) that only affect an area of skin to which they are applied would be coded as "7" (Topical).

Example for Route of Administration

Medications as listed on MAR for assessment period of 2010/08/11-2010/08/17

a. Mylanta 15 cc after meals p.o.
b. Zantac 150mg q12h
c. Transderm nitro patch 2.5mg, 1 patch daily
d. Humulin N 15 U before breakfast daily SQ
e. Lasix 80 mg. IV STAT
g. Acetaminophen suppository 650 mg. q 4 hrs. PRN (given on 2 occasions in last 7 days)

1. Medication Name and Dose Ordered	2. RA	3. Frequency	4. Amount Administered	5. PRN-Number of Doses	6. DIN Number							
Mylanta 15cc	1											
Zantac 150 mg.	9											
Transderm nitro patch 2.5 1 patch	10											
Humulin N 15 U	5											
Lasix 80 mg.	4											
Acetaminophen suppository 650 mg.	6											

U3 Frequency

Determine the number of times per day, week, or month that each medication is given. Record the frequency in **column 3** using the following codes:

Prn = as necessary	tid = three times daily
q1h = every hour	qid = four times daily
q2h = every two hours	eod = every other day
q3h = every three hours	1wk = once a week
q4h = every four hours	2wk = twice a week
q6h = every six hours	3wk = three times a week
q8h = every eight hours	4wk = four times a week
od = once daily	5wk = five times a week
hs = at bedtime	1mo = once a month
bid = two times daily (includes every 12 hrs)	2mo = twice a month
	cont = continuous
	othr = other

Be careful to differentiate between similar frequencies. For example, some facilities have a policy that antibiotics are to be administered around the clock. Therefore, if an antibiotic is ordered as T.I.D., the medication may actually be given every 8 hours. There is a different frequency code for T.I.D. (tid) and every 8 hrs (q8h). In this case, the frequency code would be “q8h”.

If insulin is given on a sliding scale, each different dose of insulin given is entered as a PRN medication.

Example for Frequency

Medications as listed on MAR for assessment period of 2010/08/11–2010/08/17

a. Ampicillin 250 mg. q 6 hrs x 10 days p.o. (8/10–8/20)

b. Beconase nasal inhaler 1 puff BID

c. Compazine suppository 5 mg. STAT

d. Lanoxin 0.25 mg. p.o. every other day. On alternate days, give Lanoxin 0.125 mg. p.o.

e. Peri-colace 2 capsules HS p.o.

f. Humulin N 15 U before breakfast daily SQ

g. Check blood sugar daily at 4 p.m. Sliding scale insulin: Humulin R 5 units if blood sugar 200–300; 10 units if over 300. (5 units given on 2010/08/11 for BS of 255; 5 units given on 2010/08/13 for BS of 233; 10 units given on 2010/08/17 for BS of 305)

1. Medication Name and Dose Ordered	2. RA	3. Frequency	4. Amount Administered	5. PRN-Number of Doses	6. DIN Number							
Ampicillin 250 mg.	1	q6h										
Beconase nasal inhaler 1 puff	8	bid										
Compazine suppository 5 mg.	6	prn										
Lanoxin 0.25 mg.	1	eod										
Lanoxin 0.125 mg.	1	eod										
Peri-colase 2 capsules	1	hs										
Humulin N 15 U	5	od										
Humulin R 5U	5	prn										
Humulin R 10 U	5	prn										

U4 Amount Administered

Determine the amount of medication administered each time the medication was given. Amount administered **is not always** the dose. Rather, it is the number of tablets, capsules, suppositories, or amount of liquid (cc's, mls, units) **per dose** that is administered to a resident.

- For **tablets, capsules or suppositories**, enter the ***number*** of tablets or capsules that were given for each *administration* in column 4 (e.g. 1, 2, 1.5).
- For **liquids**, enter the ***number*** of cc's, mls, or units that were given for each *administration* in column 4 (e.g. 0.5ml, 2.5cc, 10 units).
- For topical medications (e.g. creams, ointments, eye drops), inhalation medications, and oral medications that are dissolved in water, enter the numeric code 999 in column 4.
- If a half of tablet or half of cc is administered, enter it as a decimal (0.5) rather than a fraction.

Example for Amount Administered

Medications as listed on MAR for assessment period of 2010/08/11–2010/08/17

a. Lanoxin 0.125 mg. daily p.o.

b. Haldol 1 mg. liquid q8 hrs PRN p.o. (received 2 times in last 7 days)

c. Ampicillin 250 mg. q 6 hrs liquid p.o.

d. Acetaminophen 650 mg. QID p.o. (pharmacy supplies two 325 mg. tablets)

e. Acetaminophen 325 mg. 3 tabs q3-4 hrs PRN for pain p.o. (received 5 times in last 7 days)

f. Humulin N 15 U before breakfast daily SQ

g. Check blood sugar daily at 4 p.m. Sliding scale insulin: Humulin R 5 units if blood sugar 200–300; 10 units if over 300. (5 units given on 2010/08/11 for BS of 255; 5 units given on 2010/08/13 for BS of 233; 10 units given on 2010/08/11 for BS of 305)

h. Elase ointment to necrotic tissue on left heel TID

i. Diazepam 3 mg. HS p.o.

j. Dilantin 300 mg. HS p.o.

k. Metamucil powder 1 tbsp. in a.m. p.o.

1. Medication Name and Dose Ordered	2. RA	3. Frequency	4. Amount Administered	5. PRN-Number of Doses	6. DIN Number							
Lanoxin 0.125 mg.	1	od	1									
Haldol 1 mg.	1	prn	.5cc									
Ampicillin 250 mg.	1	q6h	5ml									
Acetaminophen 650 mg.	1	qid	2									
Acetaminophen 325 mg. 3 tabs	1	prn	3									
Humulin N 15 U	5	od	15U									
Humulin R 5 U	5	prn	5U									
Humulin R 10 U	5	prn	10U									
Elase ointment	7	tid	999									
Diazepam 3 mg.	1	od	1.5									
Dilantin 300 mg.	1	od	3									
Metamucil powder 1 tbsp.	1	od	999									

U5 PRN-Number of Doses

This column is only completed for medications that have a frequency of administration coded as PRN. Record the **number of times** in the past seven days that each medication coded as PRN was given. STAT medications are recorded in the **PRN column** using code "99".

Remember, if a PRN medication was **not** given in the **past seven days**, it should **not** be listed in Section U.

Example For PRN—Number of Doses

Medications as listed on MAR for assessment period of 2010/08/11-2010/08/17.

a. Mylanta 15 cc after meals PRN p.o. (administered 12 times in last 7 days)

b. Haldol 1 mg. liquid q8 hrs PRN p.o. (administered 2 times in last 7 days)

c. Hydrocortisone cream 1% PRN to back and chest (administered 5 times in last 7 days)

d. Lasix 80 mg. IV STAT

e. Check blood sugar daily at 4 p.m. Sliding scale insulin: Humulin R 5 units if blood sugar 200–300; 10 units if over 300. (5 units given on 2010/08/11 for BS of 255; 5 units given on 2010/08/13 for BS of 233; 10 units given on 2010/08/17 for BS of 305

f. Nitroglycerin 0.3 mg 1 tab SL for chest pain; repeat 2 times at 5 minute intervals if pain is not relieved (given on 2010/08/12 once and another five minutes following)

1. Medication Name and Dose Ordered	2. RA	3. Frequency	4. Amount Administered	5. PRN-Number of Doses	6. DIN Number							
Mylanta 15 cc	1	prn	15cc	12								
Haldol 1 mg	1	prn	0.5cc	2								
Hydrocortisone cream 1%	7	prn	999	5								
Lasix 80 mg.	4	prn	8cc	99								
Humulin R 5 Units	5	prn	5U	2								
Humulin R 10 Units	5	prn	10U	1								
Nitroglycerin 0.3 mg.	2	prn	1	2								

U6 Drug Identification Number (DIN)

The drug identification number (DIN) uniquely identifies a specific drug product based on the chemical, the brand name, the strength, the dosage, and the form. The DIN is an 8-digit number that is located on the manufacturer's label of the prescription or over-the-counter product. It is very important that the DIN is accurate as it provides important details about the medication being administered. A pharmacist should be consulted to provide and/or confirm correct DIN codes.

If a patient is taking one drug for which there are different strengths, please ensure that you record all DINs accordingly. For example, if a patient is taking 60mg of Lasix in the form of a 20mg tablet and a 40mg tablet then the DINs for both strengths should be recorded. If however the patient takes 3 tablets of the 20mg strength then only the DIN for the 20mg strength should be recorded with the "amount administered" adjusted accordingly.

Code investigational drugs as 99999999. Code compounds (topical mixtures prepared by the pharmacist) as 88888888.

Record the DIN code in **column 6.** Begin writing in the left hand box entering one digit per box. There should be 8 numbers in the DIN code recorded in column 6. Recheck the number to be sure you have entered the digits correctly.

Example for DIN Codes

Medications as listed on MAR for assessment period of 2010/08/11-2010/08/17

a. Lanoxin 0.125 mg. daily p.o.

b. Apo Haloperidol 1 mg. liquid q8 hrs PRN p.o. (administered 2 times in last 7 days)

c. Apo-Ampi Susp 250 mg. q 6 hrs. liquid p.o.

d. Acetaminophen 650 mg. QID p.o. (pharmacy supplies two 325 mg. tablets)

f. Humulin N 15 U before breakfast daily SQ

g. Check blood sugar daily at 4 p.m. Sliding scale insulin: Humulin R 5 units if blood sugar 200–300; 10 units if over 300. (5 units given on 2010/08/11 for BS of 255; 5 units given on 2010/08/13 for BS of 233; 10 units given on 2010/08/17 for BS of 305).

h. Transderm Nitro 1 Patch QD

i. Furosemide 80 mg. IV STAT

j. Apodiazepam 3 mg. HS p.o.

k. Dilantin 300 mg. HS p.o.

1. Medication Name and Dose Ordered	2. RA	3. Frequency	4. Amount Admi-nistered	5. PRN-Number of Doses	6. DIN Number							
Lanoxin 0.125 mg/tab (0.125mg)	1	od	1		0	2	2	4	2	3	2	2
Apo Haloperidol Liq. 2mg/ml—(1mg)	1	prn	.5cc	2	0	0	5	8	7	7	0	2
Apo-Ampi Susp. 250mg/5ml (250mg)	1	q6h	5ml		0	0	6	0	3	2	8	7
Acetaminophen 325mg (650 mg)	1	q4h	2		0	0	3	7	4	1	4	8
Humulin N cartridge (15 U)	5	od	15U		0	1	9	5	9	2	3	9
Humulin R inj. (5 U)	5	prn	5U	2	0	0	5	8	6	7	1	4
Humulin R inj. (10 U)	5	prn	10U	1	0	0	5	8	6	7	1	4
Transderm Nitro 0.4 mg/h (1 patch)	10	od	999		0	0	8	5	2	3	8	4
Furosemide inj. 10mg/ml (80mg)	4	prn	8cc	99	0	0	5	6	5	0	4	0
Apodiazepam tab 2mg/tab (3mg)	1	od	1.5		0	0	4	0	5	3	2	9
Dilantin 100mg/cap (300mg)	1	od	3		0	0	0	2	2	7	8	0

Coding Exercises for Section U

Complete Section U for the following medications during a 7 day period (2010/09/01–2010/09/07):

1. Inderal 40 mg. BID p.o.
2. Sinemet 100/10 TID p.o.
3. Artificial Tears 1.4% 1 drop OU QID
4. Anusol HC 10mg, suppository, PRN (given 1 time in last seven days)
5. Amoxil 500 mg q 6 hrs per tube
6. Benylin DM cough syrup 2 tbs. PRN p.o. (given 10 times in last seven days)
7. Heparin lock flush 10 U daily
8. Ditropan syrup 2.5 mg daily p.o.
9. Transderm Nitropatch 0.4 mg 1 patch daily
10. Novolin GE NPH Inj. Sus. 24 U before breakfast SQ
11. Check blood sugar before breakfast. Sliding scale insulin: Novolin GE Toronto R 10 units if blood sugar over 200. (10 units given on 2 days in last 7 days)
12. Questran 1 packet with each meal p.o.
13. Quinine Sulfate 300 mg. HS
14. Coumadin 2.5 mg daily p.o. (discontinued 2010/09/03)
15. Coumadin 5mg. daily p.o. (ordered to start on 2010/09/03)
16. Maalox 15 cc PRN for indigestion p.o. (not administered in last 7 days)

1. Medication Name and Dose Ordered	2. RA	3. Frequency	4. Amount Administered	5. PRN-Number of Doses	6. DIN Number							

Compare your responses to the coding exercises with the responses on the next page

1. Medication Name and Dose Ordered	2. RA	3. Frequency	4. Amount Administered	5. PRN-Number of Doses	6. DIN Number
Inderal 40 mg/tab (40mg)	1	bid	1		02042207
Sinemet 100/10tab (100/10)	1	tid	1		00355658
Artificial Tears 1.4% (1 drop)	10	qid	999		02229570
Anusol HC suppository 10mg (1)	6	prn	1	1	00476276
Amoxil susp 250mg/ 5ml (500mg)	9	q6h	10 ml		02042594
Benylin DM cough syrup 15mg/ml (2 Tbs.)	1	prn	30 cc	10	01944738
Heparin Lock Flush Inj. 10U/ml (10U)	4	od	1 ml		00725327
Ditropan syrup 1mg/ml (2.5mg)	1	od	2.5ml		01947547
Transderm Nitropatch 0.4mg/h (1 patch)	10	od	999		00852384
Novolin GE NPH Inj. Sus. 100U/ml (24U)	5	od	24 U		02242754
Novolin GE Toronto R inj. 100U/mL (10U)	5	prn	10 U	2	02243343
Questran 4GM/pack (1 packet)	1	tid	999		01918966
Quinine Sulphate 300mg (300mg)	1	od	1		00093755
Coumadin 2.5 mg (2.5mg)	1	od	1		01918346
Coumadin 5 mg (5mg)	1	od	1		01918354

Chapter 3: RAI-MDS 2.0 Assessment Forms

Full Assessment

Quarterly Assessment Pubs

Minimum Data Set (MDS) 2.0© Canadian Version

FULL ASSESSMENT

**** Status in last 7 days, unless other time frame indicated.***

Addressograph

SECTION AA and A: IDENTIFICATION INFORMATION

AA1	**UNIQUE REGISTRATION IDENTIFIER**	
A1	**RESIDENT NAME**	
A2	**ROOM NUMBER**	a. Unit ☐☐☐☐☐ b. Room #
AA2	**SEX**	M. Male F. Female O. Other ☐
A3	**ASSESSMENT REFERENCE DATE**	☐☐☐☐ Year ☐☐ Month ☐☐ Day
AA3a	**BIRTH DATE**	☐☐☐☐ Year ☐☐ Month ☐☐ Day
AA3b	**ESTIMATED BIRTH DATE**	Birth date is estimated 0. No 1. Yes ☐
AA4	**ABORIGINAL IDENTITY**	Person identifies self as First Nations, Métis or Inuit ■ 0. No 1. Yes a. First Nations ☐ b. Métis ☐ c. Inuit ☐
A5	**MARITAL STATUS**	1. Never married 4. Separated ■ 2. Married 5. Divorced 3. Widowed 9. Unknown ☐
AA6	**FACILITY NUMBER**	☐☐ Prov./Terr. ☐☐☐☐ Facility Number (See manual for province/territory codes)
AA5a	**HEALTH CARD NUMBER**	a. Enter the resident's health card number, or enter "0" if unknown or "1" if not applicable. ☐☐☐☐☐☐☐☐☐☐☐☐
AA5b	**PROVINCE/ TERRITORY OF ISSUE**	b. Enter the Province/Territory code issuing health card number. (See CCRS manual for province/territory codes.) ☐☐
A6a	**HEALTH RECORD NUMBER**	☐☐☐☐☐☐☐☐☐☐☐☐
A6b	**HEALTH REGISTER NUMBER**	☐☐☐☐☐

A7	**RESPONSIBILITY FOR PAYMENT**	(*Check all that apply in LAST 30 DAYS.*)	■
		a. Provincial/territory government plan (for resident of province/territory)	a
		b. Other province/territory (resident of Canada)	b
		c. Federal government—Veterans Affairs Canada	c
		d. Federal government—First Nations and Inuit Health Branch (FNIHB)	d
		e. Federal government—other (RCMP, Canadian Forces, federal penitentiary inmate, refugee)	e
		f. Worker's compensation board (WCB/WSIB)	f
		g. Canadian resident, private insurance pay	g
		h. Canadian resident, public trustee pay	h
		i. Canadian resident, self pay	i
		j. Other country resident, self pay	j
		k. Responsibility for payment unknown/unavailable	k
AA8	**REASON FOR ASSESSMENT**	Primary reason for assessment 01. Admission assessment (before day 14) 02. Full annual assessment 03. Significant change in status assessment 04. Significant correction of prior full assessment	■ ☐☐
A11	**DECISION-MAKER FOR PERSONAL CARE AND PROPERTY**	1. Person 2. Other a. Personal Care b. Property	■ ☐ ☐
A12	**ADVANCE DIRECTIVES**	0. Not in Place 1. In Place a. Advance Directives for Not Resuscitating b. Advance Directives for Not Hospitalizing	■ ☐ ☐

☐ = when box blank, must enter number or letter a = when letter in box, or when instructed to do so, check if condition applies

SECTION AB: DEMOGRAPHIC INFORMATION

AB1	ADMISSION/ RE-ENTRY DATE		Year	Month	Day

SECTION B: COGNITIVE PATTERNS

B1	COMATOSE	*(Persistent vegetative state or no discernible consciousness)* 0. No 1. Yes (Skip to item G1)	
B2	MEMORY	*(Recall of what was learned or known)* a. Short-term memory OK—seems or appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK—seems or appears to recall long past 0. Memory OK 1. Memory problem	
B3	MEMORY/ RECALL ABILITY	*(Check all that resident was normally able to recall during the LAST 7 DAYS.)* a. Current season b. Location of own room c. Staff names/faces d. That he/she is in a facility e. *NONE OF ABOVE* are recalled	a b c d e
B4	COGNITIVE SKILLS FOR DAILY DECISION MAKING	*(Made decisions regarding tasks of daily life.)* 0. INDEPENDENT–decisions consistent and reasonable 1. MODIFIED INDEPENDENCE–some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues or supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions	
B5	INDICATORS OF DELIRIUM-PERIODIC DISORDERED THINKING/ AWARENESS	*(Code for behaviour in LAST 7 DAYS.) Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behaviour over this time.* 0. Behaviour not present 1. Behaviour present, not of recent onset 2. Behaviour present, over last 7 days appears different from resident's usual functioning (e.g. new onset or worsening)	
		a. EASILY DISTRACTED (e.g. difficulty paying attention, gets sidetracked)	
		b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS (e.g. moves lips or talks to someone not present; believes he or she is somewhere else; confuses night and day)	
		c. EPISODES OF DISORGANIZED SPEECH (e.g. speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)	
		d. PERIODS OF RESTLESSNESS (e.g. fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out)	
		e. PERIODS OF LETHARGY (e.g. sluggishness; staring into space; difficult to arouse; little bodily movement)	
		f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY (e.g. sometimes better, sometimes worse; behaviours sometimes present, sometimes not)	
B6	CHANGE IN COGNITIVE STATUS	Resident's cognitive status, skills or abilities have changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No change 1. Improved 2. Deteriorated	

SECTION C: COMMUNICATION/HEARING PATTERNS

C1	HEARING	*(With hearing appliance, if used)* 0. HEARS ADEQUATELY—normal talk, TV, phone 1. MINIMAL DIFFICULTY—when not in quiet setting 2. HEARS IN SPECIAL SITUATION ONLY—speaker has to adjust tonal quality and speak distinctly 3. HIGHLY IMPAIRED or absence of useful hearing	
C2	COMMUNI-CATION DEVICES/ TECHNIQUES	*(Check all that apply during LAST 7 DAYS.)* a. Hearing aid, present and used regularly b. Hearing aid, present and not used regularly c. Other receptive communication techniques used (e.g. lip reading) d. *NONE OF ABOVE*	a b c d
C3	MODES OF EXPRESSION	*(Check all used by resident to make needs known.)* a. Speech b. Writing messages to express or clarify needs c. American sign language or Braille d. Signs or gestures or sounds e. Communication board f. Other g. *NONE OF ABOVE*	a b c d e f g
C4	MAKING SELF UNDERSTOOD	*(Expressing information content—however able)* 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY OR NEVER UNDERSTOOD	
C5	SPEECH CLARITY	*(Code for speech in LAST 7 DAYS.)* 0. CLEAR SPEECH—distinct, intelligible words 1. UNCLEAR SPEECH—slurred, mumbled words 2. NO SPEECH—absence of spoken words	
C6	ABILITY TO UNDERSTAND OTHERS	*(Understanding verbal information content—however able)* 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part or intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY OR NEVER UNDERSTANDS	
C7	CHANGE IN COMMUNI-CATION/ HEARING	Resident's ability to express, understand, or hear information has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No Change 1. Improved 2. Deteriorated	

SECTION D: VISION PATTERNS

D1	VISION	*(Able to see in adequate light and with glasses, if used)* 0. ADEQUATE—sees fine detail, including regular print in newspapers or books 1. IMPAIRED—sees large print, but not regular print in newspapers or books 2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects 4. SEVERELY IMPAIRED—no vision or sees only light, colours or shapes; eyes do not appear to follow objects	
D2	VISUAL LIMITATIONS/ DIFFICULTIES	a. Side vision problems—decreased peripheral vision (e.g. leaves food on one side of tray, difficulty travelling, bumps into people and objects, misjudges placement of chair when seating self) 0. No 1. Yes b. Experiences any of the following: sees halos or rings around lights, sees flashes of light, sees "curtains" over eyes 0. No 1. Yes	
D3	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

SECTION E: MOOD AND BEHAVIOUR PATTERNS

E1	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	*(Code for indicators observed in LAST 30 DAYS, irrespective of the assumed cause.)* 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to 5 days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days)	
		VERBAL EXPRESSIONS OF DISTRESS	
		a. Resident made negative statements (e.g. "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die.")	
		b. Repetitive questions: (e.g. "Where do I go? What do I do?"	
		c. Repetitive verbalizations (e.g. Calling out for help; "God help me.")	
		d. Persistent anger with self or others (e.g. easily annoyed, anger at placement in facility; anger at care received)	
		e. Self deprecation (e.g. "I am nothing, of no use to anyone.")	
		f. Expressions of what appear to be unrealistic fears (e.g. fear of being abandoned, left alone, being with others)	
		g. Recurrent statements that something terrible is about to happen (e.g. believes is about to die, have a heart attack)	
		h. Repetitive health complaints (e.g. persistently seeks medical attention, obsessive concern with body functions)	
		i. Repetitive anxious complaints or concerns—non-health (e.g. persistently seeks attention or reassurance regarding schedules, meals, laundry or clothing, relationship issues)	
		SLEEP-CYCLE ISSUES	
		j. Unpleasant mood in morning	
		k. Insomnia or change in usual sleep pattern	
		SAD, APATHETIC, ANXIOUS APPEARANCE	
		l. Sad, pained, worried facial expressions (e.g. furrowed brows)	
		m. Crying, tearfulness	
		n. Repetitive physical movements (e.g. pacing, hand wringing, restlessness, fidgeting, picking)	
		LOSS OF INTEREST	
		o. Withdrawal from activities of interest (e.g. no interest in longstanding activities or being with family, friends)	
		p. Reduced social interaction	
E2	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident in LAST 7 DAYS. 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	
E3	CHANGE IN MOOD	Resident's mood status has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No change 1. Improved 2. Deteriorated	
E4	BEHAVIOURAL SYMPTOMS	*(Code for behaviour in LAST 7 DAYS.)* A. Behavioural symptom frequency in last 7 days 0. Behaviour not exhibited in last 7 days 1. Behaviour of this type occurred on 1 to 3 days in last 7 days 2. Behaviour of this type occurred 4 to 6 days, but less than daily 3. Behaviour of this type occurred daily B. Behavioural symptom alterability in last 7 days 0. Behaviour not present—OR—behaviour was easily altered 1. Behaviour was not easily altered	A / B
		a. **WANDERING** (moved with no rational purpose, seemingly oblivious to needs or safety)	
		b. **VERBALLY ABUSIVE BEHAVIOURAL SYMPTOMS** (others were threatened, screamed at, cursed at)	
		c. **PHYSICALLY ABUSIVE BEHAVIOURAL SYMPTOMS** (others were hit, shoved, scratched, sexually abused)	
		d. **SOCIALLY INAPPROPRIATE or DISRUPTIVE BEHAVIOURAL SYMPTOMS** (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behaviour or disrobing in public, smeared or threw food or feces, hoarding, rummaged in others' belongings)	
		e. **RESISTS CARE** (resisted taking meds or injections, ADL assistance, or eating)	
E5	CHANGE IN BEHAVIOURAL SYMPTOMS	Resident's behavioural status has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No change 1. Improved 2. Deteriorated	

SECTION F: PSYCHOSOCIAL WELL-BEING

F1	SENSE OF INITIATIVE/ INVOLVEMENT	a. At ease interacting with others	a
		b. At ease doing planned or structured activities	b
		c. At ease doing self-initiated activities	c
		d. Establishes own goals	d
		e. Pursues involvement in life of facility (e.g. makes and keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e
		f. Accepts invitations into most group activities	f
		g. *NONE OF ABOVE*	g
F2	UNSETTLED RELATIONSHIPS	a. Covert/open conflict with or repeated criticism of staff	a
		b. Unhappy with roommate	b
		c. Unhappy with residents other than roommate	c
		d. Openly expresses conflict/anger with family/friends	d
		e. Absence of personal contact with family or friends	e
		f. Recent loss of close family member or friend	f
		g. Does not adjust easily to change in routines	g
		h. *NONE OF ABOVE*	h
F3	PAST ROLES	a. Strong identification with past roles and life status 0. No 1. Yes 9. Unknown (admission only)	
		b. Expresses sadness, anger or empty feeling over lost roles or status 0. No 1. Yes 9. Unknown (admission only)	
		c. Resident perceives that daily life (customary routine, activities) is very different from prior pattern in the community 0. No 1. Yes 9. Unknown (admission only)	

SECTION G: PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

G1

A. ADL SELF-PERFORMANCE *(Code for resident's **PERFORMANCE OVER ALL SHIFTS** during LAST 7 DAYS, not including setup)*

0. **INDEPENDENT**. No help or oversight–OR–help/oversight provided only 1 or 2 times during last 7 days.

1. **SUPERVISION.** Oversight, encouragement or cueing provided 3 or more times during last 7 days–OR–Supervision plus physical assistance provided only 1 or 2 times during last 7 days.

2. **LIMITED ASSISTANCE**. Resident highly involved in activity; received physical help in guided maneuvering of limbs, or other non-weight-bearing assistance 3 or more times–OR–More help provided only 1 or 2 times during last 7 days.

3. **EXTENSIVE ASSISTANCE**. Although resident performed part of activity, over last 7-day period, help of the following type(s) was provided 3 or more times:

- weight-bearing support
- full staff performance during part (but not all) of last 7 days.

4. **TOTAL DEPENDENCE**. Full staff performance of activity during entire 7 days.

8. **ACTIVITY DID NOT OCCUR** during entire 7 days.

B. ADL SUPPORT PROVIDED (*Code for **MOST SUPPORT PROVIDED OVER ALL SHIFTS** during LAST 7 DAYS; code regardless of resident's self-performance classification.)*

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist
8. ADL activity did not occur during entire 7 days

			A SELF -PERFORMANCE	B SUPPORT PROVIDED
G1a	BED MOBILITY	How resident moves to and from lying position, turns from side to side, and positions body while in bed		
G1b	TRANSFER	How resident moves between surfaces–to and from: bed, chair, wheelchair, standing position (EXCLUDE to and from bath and toilet)		
G1c	WALK IN ROOM	How resident walks between locations in own room		
G1d	WALK IN CORRIDOR	How resident walks in corridor on unit		
G1e	LOCOMOTION ON UNIT	How resident moves between locations in own room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
G1f	LOCOMOTION OFF UNIT	How resident moves to and returns from off-unit locations (e.g. areas set aside for dining, activities or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
G1g	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning and removing prosthesis		
G1h	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition)		
G1i	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
G1j	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair; brushing teeth; shaving; applying makeup; washing and drying face, hands, and perineum (EXCLUDE baths and showers)		

SECTION G: PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS (cont'd)

G2 BATHING

How resident takes full-body bath or shower, sponge bath, and transfers in and out of tub or shower (EXCLUDE washing of back and hair). (*Code for most dependent in self-performance and support.)*

Bathing self-performance codes are:

0. Independent–No help provided
1. Supervision–Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence
8. Bathing did not occur during the entire 7 days

(Bathing support codes are as defined in item G1aB, "support provided" above)

	A SELF-PERFORMANCE	B SUPPORT PROVIDED

G3 TEST FOR BALANCE

(Code for ability during test in the LAST 7 DAYS.)

0. Maintained position as required in test
1. Unsteady, but able to rebalance self without physical support
2. Partial physical support during test or doesn't follow directions
3. Not able to attempt test without physical help

a. Balance while standing	
b. Balance while sitting–position, trunk control	

G4 FUNCTIONAL LIMITATION IN RANGE OF MOTION

(Code for limitations during LAST 7 DAYS that interfered with daily functions or put resident at risk of injury.)

A. RANGE OF MOTION
0. No limitation
1. Limitation on 1 side
2. Limitation on both sides

B. VOLUNTARY MOVEMENT
0. No loss
1. Partial loss
2. Full loss

	A	B
a. Neck		
b. Arm—including shoulder or elbow		
c. Hand—including wrist or fingers		
d. Leg—including hip or knee		
e. Foot—including ankle or toes		
f. Other limitation or loss		

G5 MODES OF LOCOMOTION

(Check all that apply during LAST 7 DAYS.)

a. Cane, walker, or crutch	a
b. Wheeled self	b
c. Other person wheeled	c
d. Wheelchair primary mode of locomotion	d
e. *NONE OF ABOVE*	e

G6 MODES OF TRANSFER

(Check all that apply during LAST 7 DAYS.)

a. Bedfast all or most of the time	a
b. Bed rails used for bed mobility or transfer	b
c. Lifted manually	c
d. Lifted mechanically	d
e. Transfer aid (e.g. slide board, trapeze, cane, walker, brace)	e
f. *NONE OF ABOVE*	f

G7 TASK SEGMENTATION

Some or all of ADL activities were broken into sub-tasks during LAST 7 DAYS so that resident could perform them.

0. No 1. Yes

G8 ADL FUNCTIONAL REHAB. POTENTIAL

(Check all that apply during LAST 7 DAYS.)

a. Resident believes self to be capable of increased independence in at least some ADLs	a
b. Direct care staff believe resident is capable of increased independence in at least some ADLs	b
c. Resident able to perform tasks/activity but is very slow	c
d. Difference in ADL self-performance or ADL support, comparing mornings to evenings	d
e. *NONE OF ABOVE*	e

G9 CHANGE IN ADL FUNCTION

Resident's ADL Self-Performance status has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days).

0. No change 1. Improved 2. Deteriorated

SECTION H: CONTINENCE IN LAST 14 DAYS

H1 CONTINENCE SELF-CONTROL CATEGORIES *(Code for performance over all shifts.)*

0. CONTINENT–Complete control
1. USUALLY CONTINENT–BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. OCCASIONALLY INCONTINENT– BLADDER, 2+ times a week but not daily; BOWEL, once a week
3. FREQUENTLY INCONTINENT–BLADDER, tended to be incontinent daily, but some control present (e.g. on day shift); BOWEL, 2 or 3 times a week
4. INCONTINENT–Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

H1a BOWEL CONTINENCE

Control of bowel movement, with appliance or bowel continence programs, if used

H1b BLADDER CONTINENCE

Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g. foley) or continence programs, if used

H2 BOWEL ELIMINATION PATTERN

(Check all that apply in LAST 14 DAYS.)

a. Bowel elimination pattern regular—at least 1 movement every 3 days	a
b. Constipation	b
c. Diarrhea	c
d. Fecal impaction	d
e. *NONE OF ABOVE*	e

H3 APPLIANCES AND PROGRAMS

(Check all that apply in LAST 14 DAYS.)

a. Any scheduled toileting plan	a
b. Bladder retraining program	b
c. External (condom) catheter	c
d. Indwelling catheter	d
e. Intermittent catheter	e
f. Did not use toilet, commode, urinal	f
g. Pads or briefs used	g
h. Enemas, irrigation	h
i. Ostomy present	i
j. *NONE OF ABOVE*	j

H4 CHANGE IN URINARY CONTINENCE

Resident's urinary continence has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days).

0. No change 1. Improved 2. Deteriorated

SECTION I: DISEASE DIAGNOSES

(Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behaviour status, medical treatments, nurse monitoring, or risk of death. Do not list inactive diagnoses.)

I1 DISEASES — *(If none of I1a–I1uu apply, CHECK item I1vv)*

ENDOCRINE/METABOLIC/NUTRITIONAL
- a. Diabetes mellitus — a
- b. Hyperthyroidism — b
- c. Hypothyroidism — c

HEART/CIRCULATION
- d. Arteriosclerotic heart disease (ASHD) — d
- e. Cardiac dysrhythmia — e
- f. Congestive heart failure — f
- g. Deep vein thrombosis — g
- h. Hypertension — h
- i. Hypotension — i
- j. Peripheral vascular disease — j
- k. Other cardiovascular disease — k

MUSCULOSKELETAL
- l. Arthritis — l
- m. Hip fracture — m
- n. Missing limb (e.g. amputation) — n
- o. Osteoporosis — o
- p. Pathological bone fracture — p

NEUROLOGICAL
- q. Amyotrophic lateral sclerosis (ALS) — q
- r. Alzheimer's disease — r
- s. Aphasia — s
- t. Cerebral palsy — t
- u. Cerebrovascular accident (stroke) — u
- v. Dementia other than Alzheimer's disease — v
- w. Hemiplegia/hemiparesis — w
- x. Huntington's chorea — x
- y. Multiple sclerosis — y
- z. Paraplegia — z
- aa. Parkinson's disease — aa
- bb. Quadriplegia — bb
- cc. Seizure disorder — cc
- dd. Transient ischemic attack (TIA) — dd
- ee. Traumatic brain injury — ee

PSYCHIATRIC/MOOD
- ff. Anxiety disorder — ff
- gg. Depression — gg
- hh. Bipolar Disorder — hh
- ii. Schizophrenia — ii

PULMONARY
- jj. Asthma — jj
- kk. Emphysema/ COPD — kk

SENSORY
- ll. Cataracts — ll
- mm. Diabetic retinopathy — mm
- nn. Glaucoma — nn
- oo. Macular degeneration — oo

OTHER
- pp. Allergies — pp
- qq. Anemia — qq
- rr. Cancer — rr
- ss. Gastrointestinal disease — ss
- tt. Liver disease — tt
- uu. Renal failure — uu
- vv. *NONE OF ABOVE* — vv

I2 INFECTIONS — *(If none of I2a-I2m apply, CHECK item I2n.)*
- a. Antibiotic resistant infection (e.g. Methicillin resistant staph) — a
- b. Cellulitis — b
- c. Clostridium difficile — c
- d. Conjunctivitis — d
- e. HIV infection — e
- f. Pneumonia — f
- g. Respiratory infection — g
- h. Septicemia — h
- i. Sexually transmitted diseases — i
- j. Tuberculosis (active) — j
- k. Urinary tract infection in LAST 30 DAYS — k
- l. Viral hepatitis — l
- m. Wound infection — m
- n. *NONE OF ABOVE* — n

I3 OTHER CURRENT DIAGNOSIS AND ICD-10-CA CODES

a							
b							
c							
d							
e							
f							

SECTION J: HEALTH CONDITIONS

J1 PROBLEM CONDITIONS — *(Check all problems present in LAST 7 DAYS UNLESS OTHER TIME FRAME IS INDICATED.)*

INDICATORS OF FLUID STATUS
- a. Weight gain or loss of 1.5 or more kilograms in last 7 days (3 lbs.) — a
- b. Inability to lie flat due to shortness of breath — b
- c. Dehydrated; e.g. output exceeds intake — c
- d. Insufficient fluid; did NOT consume all or almost all liquids provided during LAST 3 DAYS — d

OTHER
- e. Delusions — e
- f. Dizziness/vertigo — f
- g. Edema — g
- h. Fever — h
- i. Hallucinations — i
- j. Internal bleeding — j
- k. Recurrent lung aspirations in LAST 90 DAYS — k
- l. Shortness of breath — l
- m. Syncope (fainting) — m
- n. Unsteady gait — n
- o. Vomiting — o
- p. *NONE OF ABOVE* — p

J2 PAIN SYMPTOMS — *(Code for the highest level of pain present in LAST 7 DAYS.)*

a. FREQUENCY with which resident complains or shows evidence of pain:
0. No pain *(Skip to J4)*
1. Pain less than daily
2. Pain daily

b. INTENSITY of pain:
1. Mild pain
2. Moderate pain
3. Times when pain is horrible or excruciating

J3 PAIN SITE — *(Check all sites where pain was present in LAST 7 DAYS.)*

a. Back pain	a	f. Incisional pain	f
b. Bone pain	b	g. Joint pain (other than hip)	g
c. Chest pain during usual activities	c	h. Soft tissue pain (e.g. lesion, muscle)	h
d. Headache	d	i. Stomach pain	i
e. Hip pain	e	j. Other site	j

J4 ACCIDENTS — *(CHECK all that apply.)*
- a. Fell in PAST 30 DAYS — a
- b. Fell in PAST 31 to 180 DAYS — b
- c. Hip fracture in LAST 180 DAYS — c
- d. Other fracture in LAST 180 DAYS — d
- e. *NONE OF ABOVE* — e

SECTION J: HEALTH CONDITIONS (cont'd)

J5 STABILITY OF CONDITIONS *(Check all that apply.)*

- a. Conditions or diseases make resident's cognitive, ADL, mood, or behaviour patterns unstable (fluctuating, precarious, or deteriorating) — a
- b. Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem — b
- c. End-stage disease; 6 months or less to live — c
- d. *NONE OF ABOVE* — d

SECTION K: ORAL/NUTRITIONAL STATUS

K1 ORAL PROBLEMS *(Check all that apply in LAST 7 DAYS.)*

- a. Chewing problem — a
- b. Swallowing problem — b
- c. Mouth pain — c
- d. *NONE OF ABOVE* — d

K2 HEIGHT AND WEIGHT

a. (Record height in centimetres) a. HEIGHT (cm.)

b. (Record weight in kilograms) b. WEIGHT (kg.)

Base weight on most recent measure in LAST 30 DAYS; measure weight consistently in accord with standard facility practice (e.g. in AM after voiding, before meal, with shoes off, and in nightclothes).

K3 WEIGHT CHANGE

a. Weight loss—5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS.

0. No 1. Yes 9. Unknown (admission only)

b. Weight gain—5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS

0. No 1. Yes 9. Unknown (admission only)

K4 NUTRITIONAL PROBLEMS *(Check all that apply in LAST 7 DAYS.)*

- a. Complains about the taste of many foods — a
- b. Regular or repetitive complaints of hunger — b
- c. Leaves 25% or more of food uneaten at most meals — c
- d. *NONE OF ABOVE* — d

K5 NUTRITIONAL APPROACHES *(Check all that apply in LAST 7 DAYS.)*

- a. Parenteral/IV — a
- b. Feeding tube — b
- c. Mechanically altered diet — c
- d. Syringe (oral feeding) — d
- e. Therapeutic diet — e
- f. Dietary supplement between meals — f
- g. Plate guard, stabilized built-up utensil, etc. — g
- h. On a planned weight change program — h
- i. *NONE OF ABOVE* — i

K6 PARENTERAL OR ENTERAL INTAKE *(Skip to Section L if neither 5a nor 5b is checked.)*

a. Code the proportion of total calories the resident received through parenteral or tube feedings in the LAST 7 DAYS

0. None 1. 1% to 25% 2. 26% to 50% 3. 51% to 75% 4. 76% to 100%

b. Code the average fluid intake per day by IV or tube in the last 7 days

0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day

SECTION L: ORAL/DENTAL STATUS

L1 ORAL STATUS AND DISEASE PREVENTION *(Check all that apply in LAST 7 DAYS.)*

- a. Debris (soft, easily removable substances) present in mouth prior to going to bed at night — a
- b. Has dentures and/or removable bridge — b
- c. Some or all natural teeth lost—does not have or does not use dentures (or partial plates) — c
- d. Broken, loose, or carious teeth — d
- e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses, ulcers or rashes — e
- f. Daily cleaning of teeth or dentures, or daily mouth care—by resident or staff — f
- g. *NONE OF ABOVE* — g

SECTION M: SKIN CONDITION

M1 ULCERS (due to any cause) *(Record the **number** of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply in LAST 7 DAYS. Code 9 for 9 or more.)* **Requires a full body exam.**

- a. **Stage 1**–A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved
- b. **Stage 2**–A partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater
- c. **Stage 3**–A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue
- d. **Stage 4**–A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone

M2 TYPE OF ULCER *(For each type of ulcer, code for the **highest stage** in LAST 7 DAYS using scale in item M1—i.e., 0 = none; stages 1, 2, 3, 4.)*

- a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue
- b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities

M3 HISTORY OF RESOLVED/ CURED ULCERS

Resident has had a pressure ulcer that was resolved or cured in last 90 days.

0. No 1. Yes

M4 OTHER SKIN PROBLEMS OR LESIONS PRESENT *(Check all that apply during LAST 7 DAYS.)*

- a. Abrasions, bruises — a
- b. Burns (second or third degree) — b
- c. Open lesions other than ulcers, rashes or cuts (e.g. cancer lesions) — c
- d. Rashes (e.g. intertrigo, eczema, drug/ heat rash, herpes) — d
- e. Skin desensitized to pain or pressure — e
- f. Skin tears or cuts (other than surgery) — f
- g. Surgical wounds — g
- h. *NONE OF ABOVE* — h

M5 SKIN TREATMENTS *(Check all that apply during LAST 7 DAYS.)*

- a. Pressure relieving device(s) for chair — a
- b. Pressure relieving device(s) for bed — b
- c. Turning or repositioning program — c
- d. Nutrition or hydration intervention to manage skin problems — d
- e. Ulcer care — e
- f. Surgical wound care — f
- g. Application of dressings (with or without topical medications) other than to feet — g
- h. Application of ointments or medications (except to feet) — h
- i. Other preventative or protective skin care (except to feet) — i
- j. *NONE OF ABOVE* — j

M6 FOOT PROBLEMS AND CARE *(Check all that apply during LAST 7 DAYS.)*

- a. Resident has one or more foot problems (e.g. corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems) — a
- b. Infection of the foot (e.g. cellulitis, purulent drainage) — b
- c. Open lesions on the foot — c
- d. Nails or callouses trimmed during LAST 90 DAYS — d
- e. Received preventative or protective foot care (e.g. used special shoes, inserts, pads, toe separators) — e
- f. Application of dressings (with or without topical meds) — f
- g. *NONE OF ABOVE* — g

SECTION N: ACTIVITY PURSUIT PATTERNS

N1 TIME AWAKE

(Check appropriate time periods over LAST 7 DAYS.) Resident awake all or most of the time (i.e. naps no more than 1 hour per time period) in the:

- a. Morning [a]
- b. Afternoon [b]
- c. Evening [c]
- d. *NONE OF ABOVE* [d]

(If resident is comatose, skip to Section O.)

N2 AVERAGE TIME INVOLVED IN ACTIVITIES

(When awake and not getting treatment or ADL care)

0. Most—more than 2/3 of time
1. Some—from 1/3 to 2/3 of time
2. Little—less than 1/3 of time
3. None

N3 PREFERRED ACTIVITY SETTINGS

(Check all settings in which activities are preferred.)

- a. Own room [a]
- b. Day or activity room [b]
- c. Inside facility/off unit [c]
- d. Outside facility [d]
- e. *NONE OF ABOVE* [e]

N4 GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)

(Check all PREFERENCES whether or not activity is currently available to resident.)

- a. Cards, other games [a]
- b. Crafts or arts [b]
- c. Exercise or sports [c]
- d. Music [d]
- e. Reading, writing [e]
- f. Spiritual or religious activities [f]
- g. Trips or shopping [g]
- h. Walk/wheeling outdoors [h]
- i. Watching TV [i]
- j. Gardening or plants [j]
- k. Talking or conversing [k]
- l. Helping others [l]
- m. *NONE OF ABOVE* [m]

N5 PREFERS CHANGE IN DAILY ROUTINE

(Code for resident preferences in daily routine.)

0. No change 1. Slight change 2. Major change

- a. Type of activities in which resident is currently involved
- b. Extent of resident involvement in activities

SECTION O: MEDICATIONS

O1 NUMBER OF MEDICATIONS

(Record the NUMBER of different MEDICATIONS used in the LAST 7 DAYS. Enter "00" if none used.)

O2 NEW MEDICATIONS

Resident currently receiving medications that were initiated during the LAST 90 DAYS.

0. No 1. Yes 9. Unknown (admission only)

O3 INJECTIONS

(Record the NUMBER OF DAYS injections of any type were received during the LAST 7 DAYS. Enter "0" if none used.)

O4 DAYS RECEIVED THE FOLLOWING MEDICATION

(Record the NUMBER OF DAYS during LAST 7 DAYS; enter "0" if not used. N.B. Enter "1" for long-acting medications used less than weekly.)

- a. Antipsychotic
- b. Antianxiety
- c. Antidepressant
- d. Hypnotic
- e. Diuretic
- f. Analgesic

SECTION P: SPECIAL TREATMENTS AND PROCEDURES

P1a SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS

SPECIAL CARE*—(Check treatments or programs received in LAST 14 DAYS.)*

TREATMENTS

- a. Chemotherapy [a]
- b. Renal Dialysis [b]
- c. IV medication [c]
- d. Intake/output [d]
- e. Monitoring acute medical condition [e]
- f. Ostomy care [f]
- g. Oxygen therapy [g]
- h. Radiation [h]
- i. Suctioning [i]
- j. Trach. Care [j]
- k. Transfusions [k]
- l. Ventilator or respirator [l]

PROGRAMS

- m. Alcohol or drug treatment program [m]
- n. Alzheimer's or dementia special care unit [n]
- o. Hospice care [o]
- p. Pediatric Unit [p]
- q. Respite care [q]
- r. Training in skills required to return to the community (e.g. taking medications, housework, shopping, transportation, ADLs) [r]
- s. *NONE OF ABOVE* [s]

P1b

THERAPIES*—(Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the LAST 7 DAYS. Enter "0" if none or less than 15 minutes daily.) Note: Count only post-admission therapies.*

Box **A = # of days** administered for 15 minutes or more
Box **B = total # of minutes** provided in last 7 days

	A	B
a. Speech—language pathology, audiology service		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		
f. Recreation therapy		

P2 INTERVENTION PROGRAMS FOR MOOD, BEHAVIOUR, COGNITIVE LOSS

(Check all interventions or strategies used in the LAST 7 DAYS, no matter where received.)

- a. Special behaviour symptom evaluation program [a]
- b. Evaluation by a licensed mental health specialist in LAST 90 DAYS [b]
- c. Group therapy [c]
- d. Resident-specific deliberate changes in the environment to address mood or behaviour patterns (e.g. providing bureau in which to rummage) [d]
- e. Reorientation (e.g. cueing) [e]
- f. *NONE OF ABOVE* [f]

P3 NURSING REHABILITATION/ RESTORATIVE CARE

(Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the LAST 7 DAYS. Enter "0" if none or less than 15 minutes daily.)

- a. Range of motion (passive)
- b. Range of motion (active)
- c. Splint or brace assistance

Training and skill practice in:

- d. Bed mobility
- e. Transfer
- f. Walking
- g. Dressing or grooming
- h. Eating or swallowing
- i. Amputation or prosthesis care
- j. Communication
- k. Other

SECTION P: SPECIAL TREATMENTS AND PROCEDURES

P4	DEVICES AND RESTRAINTS	*(Use the following codes for the LAST 7 DAYS:)* 0. Not used 1. Used less than daily 2. Used daily	
		a. Full bed rails on all open sides of bed	
		b. Other types of side rails used (e.g. half rail, 1 side)	
		c. Trunk restraint	
		d. Limb restraint	
		e. Chair prevents rising	
P5	HOSPITAL STAY(s)	*Record number of times resident was admitted to hospital in the LAST 90 DAYS [or since last assessment]. Enter "00" if no admission.*	
P6	EMERGENCY ROOM (ER) VISIT(s)	*Record number of times resident visited ER in the LAST 90 DAYS [or since last assessment if less than 90 days]. Enter "00" if no ER visits.*	
P7	PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission, if less than 14 days in facility), how many days has the physician (or authorized assistant or practitioner) examined the resident? *(Enter "00" if none.)*	
P8	PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission, if less than 14 days in facility), on how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change.* *(Enter "00" if none.)*	
P9	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the LAST 90 DAYS (or since admission)? 0. No 1. Yes	

SECTION Q: DISCHARGE POTENTIAL AND OVERALL STATUS

Q1	DISCHARGE POTENTIAL	a. Resident expresses or indicates preference to return to the community. 0. No 1. Yes	
		b. Resident has a support person who is positive towards discharge. 0. No 1. Yes	
		c. Stay projected to be of a short duration—Discharge projected WITHIN 90 DAYS. *(Do not include expected discharge due to death.)* 0. No 2. Within 31–90 days 1. Within 30 days 3. Discharge status uncertain	
Q2	OVERALL CHANGE IN CARE NEEDS	Resident's overall level of self-sufficiency has changed significantly as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support	

SECTION R: ASSESSMENT INFORMATION

R1	PARTICIPATION IN ASSESSMENT	a. Resident: 0. No 1. Yes	
		b. Family: 0. No 1. Yes 2. No family	
		c. Significant other: 0. No. 1. Yes 2. None	

SECTION R: ASSESSMENT INFORMATION (cont'd)

SIGNATURES OF THOSE COMPLETING THE ASSESSMENT

	Provider Type	Assessor ID #
_____		
Signature of Assessment Coordinator (sign on above line)		
R2b. Date Assessment Coordinator signed as complete: Year ____ Month ____ Day ____		
Other Signatures / Title / Sections / Date		
_____		
_____		
_____		
_____		
_____		
_____		
_____		

SECTION U: MEDICATION LIST

List all medications that the resident received during the LAST 7 DAYS. Include scheduled medications that are used regularly, but less than weekly

1. **Medication name and dose ordered.**

2. **Route of administration (RA)**. Code the route of administration using the following codes:
   01 = by mouth (PO) 02 = sublingual (SL) 03 = intramuscular (IM) 04 =intravenous (IV) 05 = subcutaneous (SC)
   06 = rectally (PR) 07 = topical 08 = inhalation 09 = enteral tube 10 = other

3. **Frequency.** Code the number of times per day, week or month that the medication is administered using the following list:
   prn = as necessary q1h = every 1 hour q2h = every 2 hours q3h = every 3 hours q4h = every 4 hours
   q6h = every 6 hours q8h = every 8 hours od = once a day hs = at bedtime bid = two times daily
   tid = three times daily qid = four times daily eod = every other day 1wk = once a week 2wk = twice a week
   3wk = three times a week 4wk = four times a week 5wk = five times a week 6wk = six times a week 1mo = once a month 2mo = twice a month cont = continuous othr = other

4. **Amount Administered.** Record the number of tablets, capsules, suppositories, or liquid (any route) per dose administered to the resident. Code 999v9 for topicals, eyedrops, inhalants and oral medications that need to be dissolved in water.

5. **PRN—number of doses**. If the frequency code for the medication is "PRN" record the number of times during the last 7 days that each PRN medication was given. Code "99" for STAT medications given once.

6. **DIN Number—**Drug Information Number for each medication given. Be sure to enter the correct DIN for the drug name, strength and form. The DIN must match the drug dispensed by the pharmacy.

	1. Medication Name and Dose Ordered	2. RA	3. Frequency	4. Amount Administered	5. PRN Number of Doses	6. DIN Number
A						
B						
C						
D						
E						
F						
G						
H						
I						
J						
K						
L						
M						
N						
O						
P						
Q						
R						
S						
T						

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QUARTERLY ASSESSMENT

**** Status in last 7 days, unless other time frame indicated.***

Addressograph

SECTION AA and A: IDENTIFICATION INFORMATION			
AA1	**UNIQUE REGISTRATION IDENTIFIER**		
A1	**RESIDENT NAME**		
A2	**ROOM NUMBER**	a. Unit ____ b. Room # ____	
AA2	**SEX**	M. Male F. Female O. Other	
A3	**ASSESSMENT REFERENCE DATE**	Year ____ Month ____ Day ____	
AA3a	**BIRTH DATE**	Year ____ Month ____ Day ____	
AA3b	**ESTIMATED BIRTH DATE?**	Birth date is estimated 0. No 1. Yes	
AA4	**ABORIGINAL IDENTITY**	Person identifies self as First Nations, Métis or Inuit 0. No 1. Yes a. First Nations b. Métis c. Inuit	
A5	**MARITAL STATUS**	1. Never married 4. Separated 2. Married 5. Divorced 3. Widowed 9. Unknown	
AA6	**FACILITY NUMBER**	Prov./Terr. ____ Facility Number ____ (See manual for province/territory codes)	

AA5a	**HEALTH CARD NUMBER**	a. Enter the resident's health card number, or enter "0" if unknown or "1" if not applicable.	
AA5b	**PROVINCE/ TERRITORY ISSUING HEALTH CARD NUMBER**	b. Enter the Province/Territory code issuing health card number (See manual for province/ territory abbreviations)	
A6a	**HEALTH RECORD NUMBER**		
A6b	**HEALTH REGISTER NUMBER**		
AA8	**REASON FOR ASSESSMENT**	Primary reason for assessment 05. Quarterly review assessment 10. Significant correction of prior quarterly assessment	
A11	**DECISION-MAKER FOR PERSONAL CARE AND PROPERTY**	1. Person 2. Other a. Personal Care b. Property	
A12	**ADVANCE DIRECTIVES**	0. Not in Place 1. In Place a. Advance Directives for Not Resuscitating b. Advance Directives for Not Hospitalizing	

SECTION B: COGNITIVE PATTERNS

B1	**COMATOSE**	*(Persistent vegetative state or no discernible consciousness)* 0. No 1. Yes (Skip to item G1)	
B2	**MEMORY**	*(Recall of what was learned or known)* a. Short-term memory OK—seems or appears to recall after 5 minutes 0. Memory OK 1. Memory problem	
		b. Long-term memory OK—seems or appears to recall long past 0. Memory OK 1. Memory problem	
B3	**MEMORY/ RECALL ABILITY**	*(Check all that resident was normally able to recall during the LAST 7 DAYS.)*	
		a. Current season	a
		b. Location of own room	b
		c. Staff names and faces	c
		d. That he/she is in a facility	d
		e. *NONE OF ABOVE* recalled	e
B4	**COGNITIVE SKILLS FOR DAILY DECISION MAKING**	*(Made decisions regarding tasks of daily life.)* 0. INDEPENDENT—decisions consistent and reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues or supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions	
B5	**INDICATORS OF DELIRIUM-PERIODIC DISORDERED THINKING/ AWARENESS**	*(Code for behaviour in LAST 7 DAYS.) Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behaviour over this time.* 0. Behaviour not present 1. Behaviour present, not of recent onset 2. Behaviour present, over last 7 days appears different from resident's usual functioning (e.g. new onset or worsening)	
		a. EASILY DISTRACTED (e.g. difficulty paying attention, gets sidetracked)	
		b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS (e.g. moves lips or talks to someone not present; believes he or she is somewhere else; confuses night and day)	
		c. EPISODES OF DISORGANIZED SPEECH (e.g. speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)	
		d. PERIODS OF RESTLESSNESS (e.g. fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out)	
		e. PERIODS OF LETHARGY (e.g. sluggishness; staring into space; difficult to arouse; little bodily movement)	
		f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY (e.g. sometimes better, sometimes worse; behaviours sometimes present, sometimes not)	
B6	**CHANGE IN COGNITIVE STATUS**	Resident's cognitive status, skills or abilities have changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No change 1. Improved 2. Deteriorated	

SECTION C: COMMUNICATION/HEARING PATTERNS

C4	**MAKING SELF UNDERSTOOD**	*(Expressing information content—however able)* 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY OR NEVER UNDERSTOOD	
C6	**ABILITY TO UNDERSTAND OTHERS**	*(Understanding verbal information content—however able)* 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part or intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY OR NEVER UNDERSTANDS	
C7	**CHANGE IN COMMUNI-CATION/ HEARING**	Resident's ability to express, understand, or hear information has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No Change 1. Improved 2. Deteriorated	

SECTION E: MOOD AND BEHAVIOUR PATTERNS

E1	**INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD**	*(Code for indicators observed in LAST 30 DAYS, irrespective of the assumed cause.)* 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to 5 days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days)	
		VERBAL EXPRESSIONS OF DISTRESS	
		a. Resident made negative statements (e.g. "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die.")	
		b. Repetitive questions ("Where do I go? What do I do?")	
		c. Repetitive verbalizations (e.g. Calling out for help "God help me.")	
		d. Persistent anger with self or others (e.g. easily annoyed, anger at placement in facility; anger at care received)	
		e. Self deprecation (e.g. "I am nothing, of no use to anyone.")	
		f. Expressions of what appear to be unrealistic fears (e.g. fear of being abandoned, left alone, being with others)	
		g. Recurrent statements that something terrible is about to happen (e.g. believes is about to die, have a heart attack)	
		h. Repetitive health complaints (e.g. persistently seeks medical attention, obsessive concern with body functions)	
		i. Repetitive anxious complaints or concerns—non-health (e.g. persistently seeks attention or reassurance regarding schedules, meals, laundry or clothing, relationship issues)	
		SLEEP-CYCLE ISSUES	
		j. Unpleasant mood in morning	
		k. Insomnia or change in usual sleep pattern	
		SAD, APATHETIC, ANXIOUS APPEARANCE	
		l. Sad, pained, worried facial expressions (e.g. furrowed brows)	
		m. Crying, tearfulness	
		n. Repetitive physical movements (e.g. pacing, hand wringing, restlessness, fidgeting, picking)	
		LOSS OF INTEREST	
		o. Withdrawal from activities of interest (e.g. no interest in longstanding activities or being with family, friends)	
		p. Reduced social interaction	

SECTION E: MOOD AND BEHAVIOUR PATTERNS (cont'd)

E2	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident in LAST 7 DAYS. 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered		
E3	CHANGE IN MOOD	Resident's mood status has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No change 1. Improved 2. Deteriorated		
E4	BEHAVIOURAL SYMPTOMS	*(Code for behaviour in LAST 7 DAYS.)* A. Behavioural symptom frequency in last 7 days 0. Behaviour not exhibited in last 7 days 1. Behaviour of this type occurred on 1 to 3 days in last 7 days 2. Behaviour of this type occurred 4 to 6 days, but less than daily 3. Behaviour of this type occurred daily B. Behavioural symptom alterability in last 7 days 0. Behaviour not present —OR—behaviour was easily altered 1. Behaviour was not easily altered	A	B
		a. **WANDERING** (moved with no rational purpose, seemingly oblivious to needs or safety)		
		b. **VERBALLY ABUSIVE BEHAVIOURAL SYMPTOMS** (others were threatened, screamed at, cursed at)		
		c. **PHYSICALLY ABUSIVE BEHAVIOURAL SYMPTOMS** (others were hit, shoved, scratched, sexually abused)		
		d. **SOCIALLY INAPPROPRIATE or DISRUPTIVE BEHAVIOURAL SYMPTOMS** (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behaviour or disrobing in public, smeared or threw food or feces, hoarding, rummaged in others' belongings)		
		e. **RESISTS CARE** (resisted taking meds or injections, ADL assistance, or eating)		
E5	CHANGE IN BEHAVIOURAL SYMPTOMS	Resident's behavioural status has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No change 1. Improved 2. Deteriorated		

SECTION F: PSYCHOSOCIAL WELL-BEING

F1	SENSE OF INITIATIVE/ INVOLVEMENT	a. At ease interacting with others	a
		b. At ease doing planned or structured activities	b
		c. At ease doing self-initiated activities	c
		d. Establishes own goals	d
		e. Pursues involvement in life of facility (e.g. makes and keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e
		f. Accepts invitations into most group activities	f
		g. *NONE OF ABOVE*	g

SECTION G: FUNCTIONING AND STRUCTURAL PROBLEMS

G1 A. ADL SELF-PERFORMANCE *(Code for resident's **PERFORMANCE OVER ALL SHIFTS** during LAST 7 DAYS, not including setup.)*

0. INDEPENDENT. No help or oversight–OR–help/oversight provided only 1 or 2 times during last 7 days.

1. SUPERVISION. Oversight, encouragement or cueing provided 3 or more times during last 7 days–OR–Supervision plus physical assistance provided only 1 or 2 times during last 7 days.

2. LIMITED ASSISTANCE. Resident highly involved in activity; received physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3 or more times–OR–More help provided only 1 or 2 times during last 7 days.

3. EXTENSIVE ASSISTANCE. Although resident performed part of activity, over last 7-day period, help of the following type(s) was provided 3 or more times:
- weight-bearing support
- full staff performance during part (but not all) of last 7 days.

4. TOTAL DEPENDENCE. Full staff performance of activity during entire 7 days.

8. ACTIVITY DID NOT occur during entire 7 days.

B. ADL SUPPORT PROVIDED
(*Code for **MOST SUPPORT PROVIDED OVER ALL SHIFTS** during LAST 7 DAYS; code regardless of resident's self-performance classification.)*

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist
8. ADL activity did not occur during entire 7 days

			A: SELF-PERFORMANCE	B: SUPPORT PROVIDED
G1a	BED MOBILITY	How resident moves to and from lying position, turns from side to side, and positions body while in bed		
G1b	TRANSFER	How resident moves between surfaces–to and from: bed, chair, wheelchair, standing position (EXCLUDE to and from bath and toilet)		
G1c	WALK IN ROOM	How resident walks between locations in own room		
G1d	WALK IN CORRIDOR	How resident walks in corridor on unit		
G1e	LOCOMOTION ON UNIT	How resident moves between locations in own room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
G1f	LOCOMOTION OFF UNIT	How resident moves to and returns from off-unit locations (e.g. areas set aside for dining, activities or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
G1g	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning and removing prosthesis		
G1h	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition)		
G1i	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
G1j	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair; brushing teeth; shaving; applying makeup; washing and drying face, hands, and perineum (EXCLUDE baths and showers)		

SECTION G: PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS (cont'd)

			A	B
G2	BATHING	How resident takes full-body bath or shower, sponge bath, and transfers in and out of tub or shower (EXCLUDE Washing of back and hair). *Code for most dependent in self-performance.* Bathing self-performance codes are: 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Bathing did not occur during the entire 7 days	SELF-PERFORMANCE	SUPPORT PROVIDED
G3	TEST FOR BALANCE	*(Code for ability during test in the LAST 7 DAYS.)* 0. Maintained position as required in test 1. Unsteady, but able to rebalance without physical support 2. Partial physical support during test or doesn't follow directions 3. Not able to attempt test without physical help		
		a. Balance while standing		
		b. Balance while sitting–position, trunk control		
G4	FUNCTIONAL LIMITATION IN RANGE OF MOTION	*(Code for limitations during LAST 7 DAYS that interfered with daily functions or put resident at risk of injury.)* **A. RANGE OF MOTION** 0. No limitation 1. Limitation on 1 side 2. Limitation on both sides **B. VOLUNTARY MOVEMENT** 0. No loss 1. Partial loss 2. Full loss	A	B
		a. Neck		
		b. Arm—including shoulder or elbow		
		c. Hand—including wrist or fingers		
		d. Leg—including hip or knee		
		e. Foot—including ankle or toes		
		f. Other limitation or loss		
G6	MODES OF TRANSFER	*(Check all that apply during LAST 7 DAYS.)*		
		a. Bedfast all or most of the time		a
		b. Bed rails used for bed mobility or transfer		b
		f. *NONE OF ABOVE*		f
G7	TASK SEGMENTATION	Some or all of ADL activities were broken into sub-tasks during LAST 7 DAYS so that resident could perform them.		
		0. No 1. Yes		
G9	CHANGE IN ADL FUNCTION	Resident's ADL Self-Performance status has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days).		
		0. No change 1. Improved 2. Deteriorated		

SECTION H: CONTINENCE IN LAST 14 DAYS

CONTINENCE SELF-CONTROL CATEGORIES *(Code for performance over all shifts.)*

0. CONTINENT–Complete control	3. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g. on day shift); BOWEL, 2 or 3 times a week
1. USUALLY CONTINENT—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly	4. INCONTINENT—Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time
2. OCCASIONALLY INCONTINENT—BLADDER, 2+ times a week but not daily; BOWEL, once a week	

H1a	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if used	
H1b	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g. foley) or continence programs, if used	

SECTION H: CONTINENCE IN LAST 14 DAYS (cont'd)

H2	BOWEL ELIMINATION PATTERN	*(Check all that apply in LAST 14 DAYS.)*	
		c. Diarrhea	c
		d. Fecal impaction	d
		e. *NONE OF ABOVE*	e
H3	APPLIANCES AND PROGRAMS	*(Check all that apply in LAST 14 DAYS.)*	
		a. Any scheduled toileting plan	a
		b. Bladder retraining program	b
		c. External (condom) catheter	c
		d. Indwelling catheter	d
		i. Ostomy present	i
		j. *NONE OF ABOVE*	j
H4	CHANGE IN URINARY CONTINENCE	Resident's urinary continence has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No change 1. Improved 2. Deteriorated	

SECTION I: DISEASE DIAGNOSES

(Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behaviour status, medical treatments, nurse monitoring, or risk of death. Do not list inactive diagnoses.)

I1	DISEASES	*(If none of I1a–I1tt apply, CHECK item I1vv.)*	
		ENDOCRINE/METABOLIC/NUTRITIONAL	
		a. Diabetes mellitus	a
		MUSCULOSKELETAL	
		m. Hip fracture	m
		NEUROLOGICAL	
		q. Amyotrophic lateral sclerosis (ALS)	q
		s. Aphasia	s
		t. Cerebral palsy	t
		u. Cerebrovascular accident (stroke)	u
		v. Dementia other than Alzheimer's disease	v
		w. Hemiplegia/Hemiparesis	w
		x. Huntington's chorea	x
		y. Multiple sclerosis	y
		bb. Quadriplegia	bb
		PSYCHIATRIC/MOOD	
		gg. Depression	gg
		hh. Bipolar Disorder	hh
		ii. Schizophrenia	ii
		OTHER	
		ss. Gastrointestinal disease	ss
		tt. Liver disease	tt
		vv. *NONE OF THE ABOVE*	vv

SECTION I: DISEASE DIAGNOSES (cont'd)

I2	INFECTIONS	*(If none of !2a-!2m apply, CHECK item I2n.)*	
		a. Antibiotic resistant infection (e.g. Methicillin resistant staph)	a
		b. Cellulitis	b
		c. Clostridium difficile	c
		d. Conjunctivitis	d
		e. HIV infection	e
		f. Pneumonia	f
		g. Respiratory infection	g
		h. Septicemia	h
		i. Sexually transmitted diseases	i
		j. Tuberculosis (active)	j
		k. Urinary tract infection in last 30 days	k
		l. Viral hepatitis	l
		m. Wound infection	m
		n. *NONE OF ABOVE*	n
I3	OTHER CURRENT DIAGNOSIS AND ICD-10-CA CODES	a	
		b	
		c	
		d	
		e	
		f	

SECTION J: HEALTH CONDITIONS

J1	PROBLEM CONDITIONS	*(Check all problems present in last 7 days UNLESS OTHER TIME FRAME IS INDICATED.)*	
		INDICATORS OF FLUID STATUS	
		a. Weight gain or loss of 1.5 or more kilograms in last 7 days (3 lbs.)	a
		b. Inability to lie flat due to shortness of breath	b
		c. Dehydrated; e.g. output exceeds intake	c
		d. Insufficient fluid; did NOT consume all or almost all liquids provided during last 3 days	d
		OTHER	
		e. Delusions	e
		f. Dizziness/vertigo	f
		g. Edema	g
		h. Fever	h
		i. Hallucinations	i
		j. Internal bleeding	j
		k. Recurrent lung aspirations in last 90 days	k
		l. Shortness of breath	l
		m. Syncope (fainting)	m
		n. Unsteady gait	n
		o. Vomiting	o
		p. *NONE OF ABOVE*	p

SECTION J: HEALTH CONDITIONS (cont'd)

J2	PAIN SYMPTOMS	*(Code for the highest level of pain present in LAST 7 DAYS)*	
		a. FREQUENCY with which resident complains or shows evidence of pain:	
		0. No pain *(Skip to J4)* 1. Pain less than daily 2. Pain daily	
		b. INTENSITY of pain: 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating	
J4	ACCIDENTS	*(CHECK all that apply.)*	
		a. Fell in past 30 days	a
		b. Fell in past 31 to 180 days	b
		c. Hip fracture in last 180 days	c
		d. Other fracture in last 180 days	d
		e. *NONE OF ABOVE*	e
J5	STABILITY OF CONDITIONS	*(Check all that apply.)*	
		a. Conditions or diseases make resident's cognitive, ADL, mood, or behaviour patterns unstable (fluctuating, precarious, or deteriorating)	a
		b. Resident experiencing an acute episode or a flare-up of a recurrent or chronic	b
		c. End-stage disease; 6 months or less to live	c
		d. *NONE OF ABOVE*	d

SECTION K: ORAL/NUTRITIONAL STATUS

K1	ORAL PROBLEMS	*(Check all that apply in last 7 days.)*	
		a. Chewing problem	a
		b. Swallowing problem	b
		d. *NONE OF ABOVE*	d
K2	HEIGHT AND WEIGHT	*(a. Record height in centimetres)* a. HEIGHT	
		(b. Record weight in kilograms) b. WEIGHT	
		Base weight on most recent measure in LAST 30 DAYS; measure weight consistently in accord with standard facility practice (e.g. in AM after voiding, before meal, with shoes off, and in nightclothes).	
K3	WEIGHT CHANGE	**a. Weight loss**—5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS. 0. No 1. Yes	
		b. Weight gain—5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS 0. No 1. Yes	
K4	NUTRITIONAL PROBLEMS	*(Check all that apply in LAST 7 DAYS.)*	
		c. Leaves 25% or more of food uneaten at most meals	c
		d. *NONE OF ABOVE*	d
K5	NUTRITIONAL APPROACHES	*(Check all that apply in LAST 7 DAYS.)*	
		a. Parenteral/IV	a
		b. Feeding tube	b
		f. Dietary supplement between meals	f
		g. Plate guard, stabilized built-up utensil, etc.	g
		h. On a planned weight change program	h
		i. *NONE OF ABOVE*	i

SECTION K: ORAL/NUTRITIONAL STATUS (cont'd)

K6	PARENTERAL OR ENTERAL INTAKE	*(Skip to Section M if neither 5a nor 5b is checked.)* a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days 0. None 2. 26% to 50% 4. 76% to 100% 1. 1% to 25% 3. 51% to 75% b. Code the average fluid intake per day by IV or tube in the last 7 days 0. None 3. 1001 to 1500 c 1. 1 to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day	

SECTION M: SKIN CONDITION

M1	ULCERS (due to any cause)	*(Record the **number** of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply in LAST 7 DAYS. Code 9 for 9 or more.)* **Requires a full body exam.** a. **Stage 1**–A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved b. **Stage 2**–A partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater c. **Stage 3**–A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue d. **Stage 4**–A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone	
M2	TYPE OF ULCER	*(For each type of ulcer, code for the **highest stage** in LAST 7 DAYS using scale in item M1—i.e., 0 = none; stages 1, 2, 3, 4.)* a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
M4	OTHER SKIN PROBLEMS OR LESIONS PRESENT	*(Check all that apply during LAST 7 DAYS.)* a. Abrasions, bruises b. Burns (second or third degree) c. Open lesions other than ulcers, rashes or cuts (e.g. cancer lesions) d. Rashes (e.g. intertrigo, eczema, drug/heat rash, herpes) e. Skin desensitized to pain or pressure f. Skin tears or cuts (other than surgery) g. Surgical wounds h. *NONE OF ABOVE*	a b c d e f g h
M5	SKIN TREATMENTS	*(Check all that apply during LAST 7 DAYS.)* a. Pressure relieving device(s) for chair b. Pressure relieving device(s) for bed c. Turning or repositioning program d. Nutrition or hydration intervention to manage skin problems e. Ulcer care f. Surgical wound care g. Application of dressings (with or without topical medications) other than to feet h. Application of ointments or medications (except to feet) i. Other preventative or protective skin care (except to feet) j. *NONE OF ABOVE*	a b c d e f g h i j

SECTION M: SKIN CONDITION (cont'd)

M6	FOOT PROBLEMS AND CARE	*(Check all that apply during LAST 7 DAYS.)* a. Resident has one or more foot problems (e.g. corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems) b. Infection of the foot (e.g. cellulitis, purulent drainage) c. Open lesions on the foot d. Nails or callouses trimmed during LAST 90 DAYS e. Received preventative or protective foot care (e.g. used special shoes, inserts, pads, toe separators) f. Application of dressings (with or without topical meds) g. *NONE OF ABOVE*	a b c d e f g

SECTION N: ACTIVITY PURSUIT PATTERNS

N1	TIME AWAKE	*(Check appropriate time periods over LAST 7 DAYS.)* Resident awake all or most of the time (i.e. naps no more than 1 hour per time period) in the: a. Morning [a] c. Evening [c] b. Afternoon [b] d. *NONE OF ABOVE* [d]	
		(If resident is comatose, skip to Section O.)	
N2	AVERAGE TIME INVOLVED IN ACTIVITIES	*(When awake and not getting treatment or ADL care)* 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None	

SECTION O: MEDICATIONS

O1	NUMBER OF MEDICATIONS	*(Record the NUMBER of different MEDICATIONS used in the LAST 7 DAYS. Enter "00" if none used.)*	
O3	INJECTIONS	*(Record the NUMBER OF DAYS injections of any type were received during the LAST 7 DAYS. Enter "0" if none used.)*	
O4	DAYS RECEIVED THE FOLLOWING MEDICATION	*(Record the NUMBER OF DAYS during LAST 7 DAYS; enter "0" if not used. N.B. Enter "1" for long-acting meds used less than weekly.)* a. Antipsychotic b. Antianxiety c. Antidepressant d. Hypnotic e. Diuretic f. Analgesic	

SECTION P: SPECIAL TREATMENTS AND PROCEDURES

P1 SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS

a. SPECIAL CARE—*(Check treatments or programs received in LAST 14 DAYS.)*

TREATMENTS

a. Chemotherapy	a
b. Renal dialysis	b
c. IV medication	c
d. Intake/output	d
e. Monitoring acute medical condition	e
f. Ostomy care	f
g. Oxygen therapy	g
h. Radiation	h
i. Suctioning	i
j. Trach. Care	j
k. Transfusions	k
l. Ventilator or respirator	l

PROGRAMS

m. Alcohol or drug treatment program	m
n. Alzheimer's or dementia special care unit	n
o. Hospice care	o
p. Pediatric unit	p
q. Respite care	q
r. Training in skills required to return to the community (e.g. taking medications, house-work, shopping, transportation, ADLs)	r
s. *NONE OF ABOVE*	s

b. THERAPIES—*(Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the LAST 7 DAYS. Enter "0" if none or less than 15 minutes daily.) Note: Count only post-admission therapies.*

Box **A = # of days** administered for 15 minutes or more

Box **B = total # of minutes** provided in last 7 days

	A	B
a. Speech—language pathology, audiology Service		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		
f. Recreation therapy		

SECTION P: SPECIAL TREATMENTS AND

P3 NURSING REHABILITATION/ RESTORATIVE CARE

(Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the LAST 7 DAYS. Enter "0" if none or less than 15 minutes daily.)

a. Range of motion (passive)	
b. Range of motion (active)	
c. Splint or brace assistance	
Training and skill practice in:	
d. Bed mobility	
e. Transfer	
f. Walking	
g. Dressing or grooming	
h. Eating or swallowing	
i. Amputation or prosthesis care	
j. Communication	
k. Other	

P4 DEVICES AND RESTRAINTS

(Use the following codes for the LAST 7 DAYS.)

0. Not used 1. Used less than daily 2. Used daily

a. Full bed rails on all open sides of bed	
b. Other types of side rails used (e.g. half rail, 1 side)	
c. Trunk restraint	
d. Limb restraint	
e. Chair prevents rising	

P7 PHYSICIAN VISITS

In the LAST 14 DAYS (or since admission, if less than 14 days in facility), how many days has the physician (or authorized assistant or practitioner) examined the resident? *(Enter "00" if none.)*

P8 PHYSICIAN ORDERS

In the LAST 14 DAYS (or since admission, if less than 14 days in facility), on how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change. (Enter "00" if none.)*

SECTION Q: DISCHARGE POTENTIAL AND OVERALL STATUS

Q2 OVERALL CHANGE IN CARE NEEDS

Resident's overall level of self-sufficiency has changed significantly as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days ago).

0. No change
1. Improved—receives fewer supports, needs less restrictive level of care
2. Deteriorated—receives more support

SECTION R: ASSESSMENT INFORMATION

SIGNATURES OF THOSE COMPLETING THE ASSESSMENT

Provider Type | **Assessor ID #**

Signature of Assessment Coordinator (sign on above line)

R2b. Date Assessment Coordinator signed as complete

Year | Month | Day

Other Signatures	Title	Sections	Date	Provider Type	Assessor ID #

SECTION U: MEDICATION LIST

List all medications that the resident received during the LAST 7 DAYS. Include scheduled medications that are used regularly, but less than weekly

1. **Medication name and dose ordered.**

2. **Route of administration (RA)**. Code the route of administration using the following codes:
   01 = by mouth (PO) 02 = sublingual (SL) 03 = intramuscular (IM) 04 = intravenous (IV) 05 = subcutaneous (SC)
   06 = rectally (PR) 07 = topical 08 = inhalation 09 = enteral tube 10 = other

3. **Frequency.** Code the number of times per day, week or month that the medication is administered using the following list:
   prn = as necessary q1h = every 1 hour q2h = every 2 hours q3h = every 3 hours q4h = every 4 hours
   q6h = every 6 hours q8h = every 8 hours od = once a day hs = at bedtime bid = two times daily
   tid = three times daily qid = four times daily eod = every other day 1wk = once a week 2wk = twice a week
   3wk = three times a week 4wk = four times a week 5wk = five times a week 6wk = six times a week 1mo = once a month 2mo = twice a month cont = continuous othr = other

4. **Amount Administered.** Record the number of tablets, capsules, suppositories, or liquid (any route) per dose administered to the resident. Code 999v9 for topicals, eyedrops, inhalants and oral medications that need to be dissolved in water.

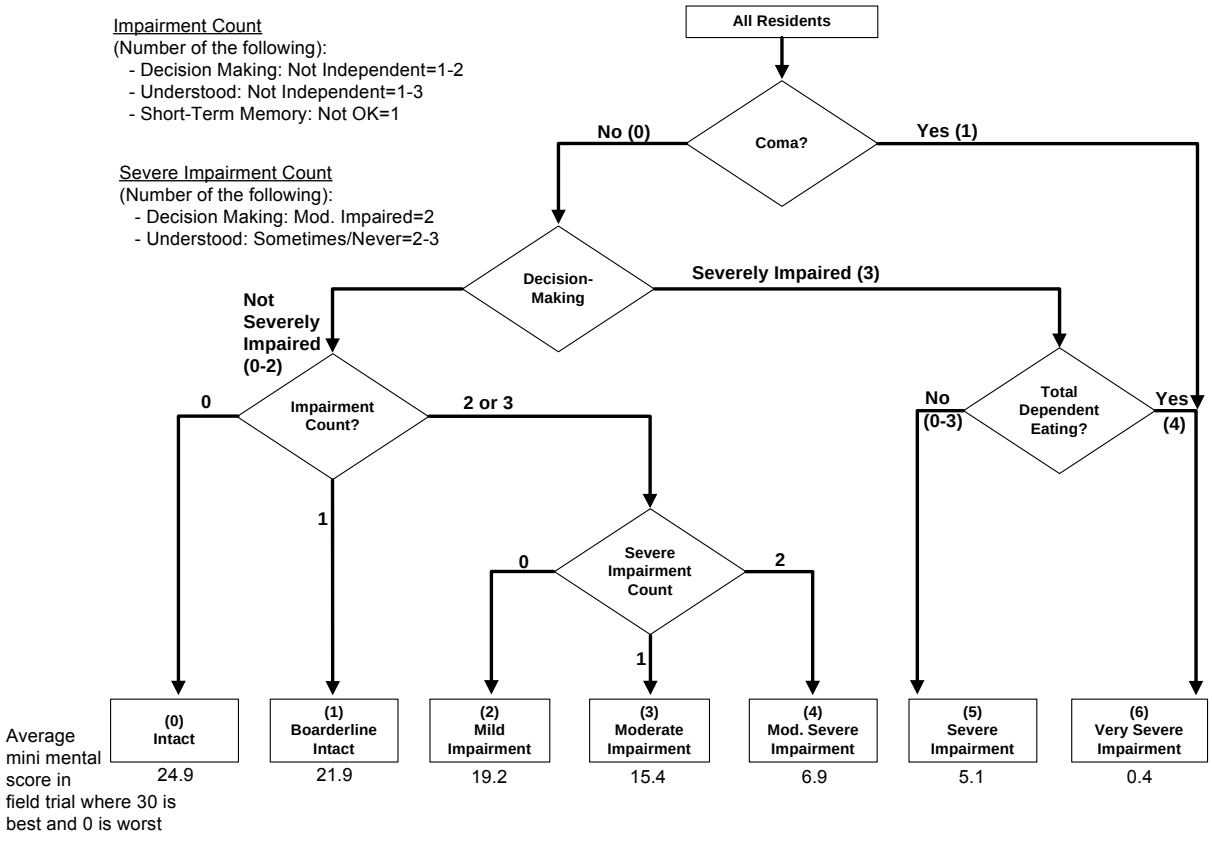
5. **PRN—number of doses**. If the frequency code for the medication is "PRN" record the number of times during the last 7 days that each PRN medication was given. Code "99" for STAT medications given once.

6. **DIN Number—**Drug Information Number for each medication given. Be sure to enter the correct DIN for the drug name, strength and form. The DIN must match the drug dispensed by the pharmacy.

	1. Medication Name and Dose Ordered	2. RA	3. Frequency	4. Amount Administered	5. PRN Number of Doses	6. DIN Number
A						
B						
C						
D						
E						
F						
G						
H						
I						
J						
K						
L						
M						
N						
O						
P						
Q						
R						
S						
T						

Appendix A—Cognitive Performance Scale (CPS) Scoring Rules

CPS SCORING RULES



Reference: Morris, JN, Fries, BF, et al MDS Performance Scale. J. Gerontology 1994; 49, m174-m182

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