



OMHRS

# Ontario Mental Health Reporting System Resource Manual

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Canadian Institute  
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# Introduction

## About CIHI

The Canadian Institute for Health Information (CIHI) is an independent, not-for-profit organization dedicated to providing essential health information to all Canadians.

CIHI works closely with federal, provincial and territorial partners and stakeholders throughout Canada to gather, package and disseminate information to inform policy, management, care and research, leading to better and more equitable health outcomes for all Canadians.

Health information has become one of society's most valuable public goods. For 25 years, CIHI has set the pace on data privacy, security, accessibility and innovation to improve Canada's health systems.

CIHI: Better data. Better decisions. Healthier Canadians.

## Privacy and confidentiality

### CIHI's Privacy Program

CIHI has a comprehensive privacy program in place to protect the confidentiality and security of our data holdings. A cornerstone of this program is a set of strict principles and policies that governs how CIHI collects, stores, analyzes and disseminates data. These are outlined in the document *Privacy and Confidentiality of Health Information at CIHI: Principles and Policies for the Protection of Personal Health Information and Policies for Institution-Identifiable Information, 3rd Edition*, available at [www.cihi.ca](http://www.cihi.ca). These policies have been reviewed to ensure they are aligned with Schedule 1 of the federal *Personal Information Protection and Electronic Documents Act* (the PIPED Act).

The Privacy Program also includes

- A Privacy Secretariat committed to developing a culture of privacy at CIHI;
- An active Privacy, Confidentiality and Security team that includes representation from across the organization;
- A Chief Privacy Advisor, who provides advice and counsel on privacy matters;
- A Privacy and Data Protection Committee — subcommittee of the CIHI Board of Directors;
- Mandatory staff training to keep health information protection matters front and centre; and
- Outreach activities to keep stakeholders advised.

## Contacting CIHI

Questions can be submitted by email to [specializedcare@cihi.ca](mailto:specializedcare@cihi.ca). Vendors should send inquiries to [help@cihi.ca](mailto:help@cihi.ca). For telephone inquiries, please call 613-241-7860 and ask for the Ontario Mental Health Reporting System.

# Ontario Mental Health Reporting System

## Introduction

The Ontario Mental Health Reporting System (OMHRS) is an important and unique project for mental health in Canada. This system, implemented by the Canadian Institute for Health Information (CIHI) on behalf of the Ontario Ministry of Health (MOH), serves to standardize the capture of mental health clinical and administrative information within a singular reporting framework. Utilizing the Resident Assessment Instrument — Mental Health (RAI-MH), stakeholders have the opportunity to facilitate data collection, inform care decisions and move towards a system of resource allocation based on discrete patient groupers.

CIHI's goals for OMHRS are to

- Provide accurate and timely administrative and clinical information to stakeholders on the utilization of adult mental health beds;
- Effectively manage and support the RAI-MH suite of products;
- Provide effective education on the coding and applications of the RAI-MH and OMHRS;
- Develop strong and supportive relationships with reporting facilities, licensed software vendors and other stakeholders; and
- Maintain the highest standards of data quality and integrity.

OMHRS stakeholders include hospitals providing mental health services, the MOH, the Ontario Hospital Association (OHA), Statistics Canada, Health Canada, interRAI, researchers, consumers of mental health services and the public.

## Development of OMHRS

The Joint Policy and Planning Committee (JPPC) was formed in 1992 out of a partnership between the OHA and the MOH. The Activity Measurement Working Group (the Hospital Funding Committee of the JPPC) examined patient classifications in psychiatry and in 1995 brought forth some key findings and recommendations:

- There was a need for a case mix system for psychiatry, and recommended that it incorporate non-diagnostic factors; and
- Any classification system developed should have clinical utility in order to facilitate good data quality.

In response, the JPPC established the Psychiatric Working Group in 1996, with the mandate to develop a classification system for hospital-based psychiatry. The working group found there was no pre-existing assessment instrument that had the capacity for clinical relevance and accountability measures. The JPPC partnered with interRAI to develop a mental health assessment called the Resident Assessment Instrument — Mental Health (RAI-MH), which includes a Minimum Data Set for Mental Health (MDS-MH)©, care-planning protocols, outcome measures, quality indicators and Case Mix Groups.

The RAI-MH version 1.0 was piloted in more than 30 hospitals in Ontario, as well as 2 in Alberta and 1 in Manitoba. Criterion validity was assessed through comparisons of sub-scales against gold standards, e.g., the Mini-Mental State Examination and the Cognitive Performance Scale. Research also began on development of the Mental Health Assessment Protocols (which were further developed to become the Mental Health Clinical Assessment Protocols, released in 2011) and the case mix system. International efforts were also launched with pilot studies in the U.S. (Illinois), Iceland, Sweden, Germany and Spain.

In March 2003, the JPPC Psychiatric Working Group submitted the completed RAI-MH instrument to the joint owners of the instrument in Canada — the MOH and the OHA — with some recommendations, including the following:

- That the RAI-MH be mandated in Ontario;
- That the mandate incorporate case mix funding based on the RAI-MH; and
- That the ministry support ongoing research to refine the instrument.

Following this transition, the MOH and OHA entered into a licence agreement with CIHI to develop and administer the Ontario Mental Health Reporting System utilizing data derived from the RAI-MH. Under the terms of the licence agreement, CIHI is responsible for the development, implementation, distribution, promotion and maintenance of the Mental Health Reporting System in Canada. interRAI continues to research and develop the RAI-MH in Canada and internationally. Ongoing enhancements to the RAI-MH and any subsequent versions may be incorporated in the Mental Health Reporting System in the future.

## Scope of OMHRS

The current project scope of OMHRS, as defined in the mandate, is the collection, analysis and reporting of data collected from the MDS-MH in all facilities in the province of Ontario with designated inpatient mental health beds. This includes all general and specialty psychiatric facilities in the province, numbering approximately 5,000 inpatient mental health beds.

# Basic principles of the RAI-MH

## What Is the RAI–Mental Health Assessment?

The RAI-MH is a comprehensive, standardized instrument for evaluating the needs, strengths and preferences of adults in inpatient mental health settings. The RAI-MH has been designed to be compatible with other internationally used interRAI instruments for long-term care, home care, community care, acute care and post-acute care. Compatibility of assessment elements improves continuity of care through a seamless health care assessment system across multiple care settings and promotes a person-centred approach to assessment.

## How does the RAI-MH work?

The MDS-MH form is designed for use by mental health professionals (e.g., nurses, social workers, psychiatrists, family physicians, recreational and occupational therapists) as a clinical assessment.

The assessment requires direct questioning of the person in care as well as the primary support person (if available), observation of the person in the mental health setting and review of available documents. Where possible, the person in care is the primary source of information. When the information gathered is of dubious validity, further in-depth assessment using professional clinical judgment may be required. It is important to note that the MDS-MH assessment seeks information *about* the person, not necessarily *of* the person.

The presence of an accurate MDS-MH assessment lays the groundwork for identifying problems, determining causes and consequences of problems, and specifying care goals and necessary approaches to care.

## OMHRS episodes of care and assessments

The episode of care in OMHRS begins at the decision to admit to a mental health bed. Time spent in the emergency area after the decision to admit has been made is included in the OMHRS episode. Mental health personnel should conduct Full Admission Assessments after the person has reached the inpatient unit. However, if the wait for a bed is substantial, assessments may be required before the person has reached the mental health unit. For pre-arranged or expected admissions, or admissions to facilities where there is no emergency department, the episode begins upon arrival.

Following are the circumstances indicating when each assessment type is required for OMHRS reporting:

<b>Full Admission</b>	<p>This assessment is completed when the net length of stay is greater than 72 hours (3 days).</p> <p>A Full Admission Assessment is required if (X80 Discharge Date – CC1 Date Stay Began – X130 Total Days Away From Bed) is greater than 3 days.</p>
<b>Short Stay</b>	<p>This assessment is completed whenever the net length of stay is less than or equal to 72 hours (3 days) and includes discharge information. Information for optional items may be collected if available. When calculating the length of stay for a Short-Stay Assessment, count the admission date as day 1 and do not include days away from the mental health bed. For example, if, during a longer length of stay, an interruption in service occurs such that the person is in the mental health bed for less than or equal to 3 days, a Short-Stay Assessment is required.</p> <p>A Short-Stay Assessment is required if (X80 Discharge Date – CC1 Date Stay Began – X130 Total Days Away From Bed) is less than or equal to 3 days.</p>
<b>Change in Status</b>	<p>This assessment is completed at any time during a single episode of care for people who experience a significant, unexpected change in their clinical status.</p>
<b>Quarterly</b>	<p>This assessment is completed every quarter for all longer-stay people within a maximum of 92 days following the last Full Admission, Quarterly or Change in Status assessment. This is of particular importance for quarter 1 (April 1 to June 30) and quarter 4 (January 1 to March 31), both of which are shorter than 92 days.</p>
<b>Discharge (Full)</b>	<p>This assessment is completed for all planned discharges where the net length of stay is greater than 6 days and when there is no indication that the person will be returning to continue this episode of care. A Full Discharge Assessment is required if (X80 Discharge Date – CC1 Date Stay Began – X130 Total Days Away From Bed) is greater than 6 days and the discharge is planned (X90 Reason for Discharge = 1).</p> <p>When a person is discharged, the Assessment Reference Date (A1) should reflect the day the person left the inpatient bed and did not return. The Discharge Date (X80) will be the actual date of discharge from the facility. This is true for all types of discharge assessments.</p>
<b>Discharge (Short)</b>	<p>Under specific circumstances, it is acceptable to complete a Short Discharge Assessment. This assessment is completed when 1 of the following 2 scenarios applies:</p> <ul style="list-style-type: none"> <li>• The discharge is unplanned and the net length of stay is greater than or equal to 4 days: those occasions when a person is unexpectedly discharged from leave, is discharged while absent without leave (AWOL), leaves against medical advice (AMA), dies or leaves the unit under urgent conditions and does not return. A situation in which a person is discharged on short notice is not considered an unplanned discharge if the person was on the unit for the 72 hours between the decision to discharge being made and the actual day of discharge.</li> </ul> <p>That is, the discharge is unplanned (X90 Reason for Discharge DOES NOT = 1) and the net length of stay is greater than or equal to 4 days.</p> <ul style="list-style-type: none"> <li>• The discharge is planned or unplanned, and the net length of stay is greater than or equal to 4 days and less than or equal to 6 days. This assessment has a smaller set of mandatory items but should include the clinical items that are available.</li> </ul> <p>That is, a Short Discharge Assessment is required if (X80 Discharge Date – CC1 Date Stay Began – X130 Total Days Away From Bed) is greater than or equal to 4 days and less than or equal to 6 days, whether the discharge is planned or unplanned.</p> <p>When a person is discharged, the Assessment Reference Date (A1) should reflect the day he or she left the inpatient bed and did not return. The Discharge Date (X80) will be the actual date of discharge from the facility. This is true for all types of discharge assessments.</p>



## Data elements (by type of assessment)

The following table charts each of the data elements contained in the MDS-MH by type of OMHRS assessment. The legend for the table is as follows:

- M** Mandatory
- O** Optional — although an element is optional it is recommended to complete all elements
- \*** Optional status is dependent on an associated data element or coding within a data element
- Blank** This element is not applicable to the assessment

Element ID	Element name	Admission	Short stay	Change in status	Quarterly	Discharge (full)	Discharge (short)
<b>X10</b>	Country of Residence	M	M				
<b>X20</b>	Province/Territory Issuing Health Card Number	M	M				
<b>X4</b>	Health Card Number Status	M	M				
<b>AA2</b>	Health Card Number	O*0	O*0				
<b>X30</b>	Chart Number	M	M	M	M	M	M
<b>AA3</b>	Case Record Number	M	M	M	M	M	M
<b>AA4</b>	Facility Number	M	M	M	M	M	M
<b>AA5</b>	Unit Identifier	M	M	M	M	M	M
<b>BB1</b>	Sex	M	M				
<b>BB2</b>	Birthdate	M	M				
<b>X40</b>	Estimated Birthdate	M	M				
<b>BB3</b>	Marital Status	M	O				
<b>BB4</b>	Language	M	O				
<b>BB5</b>	Education	M	O				
<b>BB6a–g</b>	Income	M	O*1				
<b>X50a–i</b>	Responsibility for Payment	M	M				
<b>BB7a–c</b>	Aboriginal Origin	M	O				
<b>CC1</b>	Date Stay Began (Admission Date)	M	M				
<b>CC2a–h</b>	Reasons for Admission	M	M				

Element ID	Element name	Admission	Short stay	Change in status	Quarterly	Discharge (full)	Discharge (short)
<b>X60</b>	Postal Code of Person's Residence	M	M				
<b>CC3</b>	Who Lived With at Admission	M	O				
<b>CC4a–b</b>	Admitted From and Usual Residential Status	M	M				
<b>X65</b>	Referred From Facility Number	O*2	O*2				
<b>CC5</b>	Residential Stability	M	O				
<b>DD1</b>	Number of Psychiatric Admissions (Recent)	M	O*3				
<b>DD2</b>	Number of Psychiatric Admissions (Lifetime)	M	O*4				
<b>DD3</b>	Time Since Last Discharge	M	O*5				
<b>DD4</b>	Amount of Time Hospitalized	M	O*6				
<b>DD5</b>	Contact With Community Mental Health	M	O				
<b>DD6</b>	Age at First Hospitalization	M	O				
<b>A1</b>	Assessment Reference Date	M	M	M	M	M	M
<b>A2</b>	Reason for Assessment	M		M	M	M	O
<b>A3a</b>	Status at Time of Admission	M	M				
<b>A3b</b>	Status at Time of Assessment	M	M	M	M	M	M
<b>X9a</b>	Forensic Status at Time of Admission	O*7	O*7				
<b>X9b</b>	Forensic Status at Time of Assessment	O*7	O*7	O*7	O*7	O*7	O*7
<b>A4a–d</b>	Capacity/Competency	M	O	M	M	M	O
<b>A5a–b</b>	Police Intervention	M	M	M	M	M	M
<b>B1a–gg</b>	Mental State Indicators	M	M	M	M	M	M
<b>B2</b>	Insight Into Mental Health	M	M	M	M	M	M
<b>C1</b>	Alcohol	M	M	M	M	M	M
<b>C2a–f</b>	Substance Use	M	M	M	M	M	M
<b>C3</b>	Withdrawal Symptoms	M	M	M	M	M	M
<b>C4a–d</b>	Patterns of Drinking or Other Substance Use	M	O	M	M	M	O

Element ID	Element name	Admission	Short stay	Change in status	Quarterly	Discharge (full)	Discharge (short)
C5	Smoking	M	O	M	M	M	O
C6	Gambling	M	O	M	M	M	O
D1a–d	Self-Injury	M	M	M	M	M	M
D2a–c	Violence	M	M	M	M	M	M
D3	History of Sexual Violence or Assault as Perpetrator	M	M	M	M	M	M
E1a–g	Behavioural Symptoms	M	M	M	M	M	M
E2	Extreme Behaviour Disturbance	M	M	M	M	M	M
F1a–b	Memory/Recall Ability	M	M	M	M	M	M
F2	Cognitive Skills for Daily Decision-Making	M	M	M	M	M	M
F3a–f	Indicators of Delirium	M	O	M	M	M	M
F4	Cognitive Decline	M	O	M	M	M	O
G1a–e	ADL	M	M	M	M	M	M
G2a–e	IADL	M	M	M	M	M	M
G3	Stamina	M	O	M	M	M	O
G4	ADL Decline	M	O	M	M	M	O
H1	Hearing	M	O	M	M	M	O
H2	Vision	M	O	M	M	M	O
H3	Making Self Understood	M	M	M	M	M	M
I1a–q	Health Conditions — Signs and Symptoms	M	O	M	M	M	O
I2a–g	Extra-Pyramidal Signs and Symptoms	M	O	M	M	M	O
I3	Sexual Functioning	M	O	M	M	M	O
I4	Self-Reported Health	M	O	M	M	M	O
I5	Chewing/Swallowing	M	O	M	M	M	O
I6aa–ab	Skin Problems	M	O	M	M	M	O
I6b	Foot Problems	M	O	M	M	M	O
I7a	Falls	M	O	M	M	M	O
I7b	Recent Falls			O		O	O
I8a–b	Pain Frequency/ Intensity	M	O*8	M	M	M	O*8
I9	Bladder Continence	M	O	M	M	M	O
I10	Bowel Continence	M	O	M	M	M	O

<b>Element ID</b>	<b>Element name</b>	<b>Admission</b>	<b>Short stay</b>	<b>Change in status</b>	<b>Quarterly</b>	<b>Discharge (full)</b>	<b>Discharge (short)</b>
<b>I11a–g</b>	Medical Diagnoses	M	M	M	M	M	M
<b>I11h–m</b>	Other Medical Diagnoses (ICD-10-CA Code)	O*9	O*9	O*9	O*9	O*9	O*9
<b>J1a–l</b>	Life Events	M	O	M	M	M	M
<b>J1m–p</b>	Life Events	M	M	M	M	M	M
<b>J2</b>	Life Event (J1) Causes Sense of Horror or Intense Fear	M	O*10	M	M	M	O*10
<b>J3a–b</b>	Other Indicators	M	O	M	M	M	O
<b>K1</b>	History of Medication Adherence	M	O				
<b>K2</b>	Medication Refusal	M	O	M	M	M	M
<b>K3</b>	Stopped Taking Psychotropic Medication	M	O	M	M	M	M
<b>K4</b>	Intentional Misuse of Medication	M	M	M	M	M	M
<b>K5</b>	Acute Control Medications	M	O	M	M	M	O
<b>K6</b>	Allergy to Drugs	M	O	M	M	M	O
<b>L1a–h</b>	Service Utilization — Formal Care	M	O	M	M	M	O
<b>L2a–d</b>	Nursing Interventions	M	O	M	M	M	O
<b>L3a–d</b>	Treatment Modalities	M	O	M	M	M	O
<b>L4a–l</b>	Focus of Intervention	M	O	M	M	M	O
<b>L5</b>	Adherence to Treatments, Therapies, Programs	M	O	M	M	M	O
<b>L6</b>	ECT	M	O	M	M	M	O
<b>X6</b>	Number of ECTs Since Last Assessment	O*11	O*11	M	M	M	M
<b>M1a–f</b>	Control Interventions	M	O	M	M	M	O
<b>M2a–d</b>	Observation Levels	M	O	M	M	M	O
<b>M3</b>	Psychiatric Intensive Care	M	O	M	M	M	O
<b>M4a–b</b>	Authorized Activities Outside Facility	M	O	M	M	M	O
<b>N1a–b</b>	Height and Weight	M	O	M	M	M	O
<b>N2a–d</b>	Nutritional Problems	M	O	M	M	M	O
<b>N3a–c</b>	Eating Disorder Indicators	M	O	M	M	M	O
<b>N4</b>	Polydipsia	M	O	M	M	M	O

Element ID	Element name	Admission	Short stay	Change in status	Quarterly	Discharge (full)	Discharge (short)
O1	Family Roles	M	O	M	M	M	O
O2a–g	Social Relations and Interpersonal Conflict	M	O	M	M	M	M
O3	Employment Status	M	M	M	M	M	O
O4a–d	Risk of Unemployment/ Disrupted Education	M	O	M	M	M	O
O5	Trade-Offs	M	M	M	M	M	O
O6a–c	Social Relationship	M	O	M	M	M	O
P1a–d	Available Social Supports	M	O	M	M	M	M
P2a–b	Discharge Readiness	M	O	M	M	M	O
P3	Projected Time to Planned Discharge	M	O	M	M	O	O
P4	Overall Change in Care Needs	M	O	M	M	M	O
P5	Discharged To		M			M	M
X140	Discharged to Facility Number		O*12			O*12	O*12
X141	Discharged With Support/ Referral for Home Care Services		O*13			O*13	O*13
Q1a–v	DSM-5-TR Provisional Diagnostic Category	M	M	M	M	M	M
Q2a–f	DSM-5-TR Code	O*14	O*14	O*14	O*14	M	O*14
Q3	Intellectual Disability	M	O	M	M	M	O
Q4	GAF Score	O	O	O	O	O	O
Q5	Patient Type	M	M	M	M	M	M
X160	Schizophrenia Primary Diagnosis		M			O	M
X161	Long-Acting Injectable Medication		O*19			O*19	O*19
X162	Treatment Resistant		O*19			O*19	O*19
X163	Treatment With Clozapine		O*19			O*19	O*19
X164	Care Plan Sent		O*19			O*19	O*19
R1	Prescribed Medications	M	O	M	M	M	M
X8A	Admitted Through Emergency Department		M			M	M
X8B	Arrived on Inpatient Unit		O*15			O*15	O*15
X8C	Date Arrived on Inpatient Unit		O*16			O*16	O*16

Element ID	Element name	Admission	Short stay	Change in status	Quarterly	Discharge (full)	Discharge (short)
<b>X75</b>	Days in Alternate Level of Care Since Last Assessment or Admission	O	O	M	M	M	M
<b>X80</b>	Discharge Date		M			M	M
<b>X90</b>	Discharge Reason		M			M	M
<b>X130</b>	Total Days Away From Bed	M	M	M	M	M	M
<b>X131</b>	Total Days Away From Bed in Previous Fiscal Year	O*17	O*17	O*17	O*17	O*17	O*17
<b>X200 A, B</b>	Project Code	O*18	O*18	O*18	O*18	O*18	O*18
<b>X210 A, B</b>	Project Data	O	O	O	O	O	O
<b>X70</b>	Drug Identification Number (DIN)	O	O	O	O	O	O
<b>R2b–f</b>	Medication Dose/ Form/Frequency/ PRN/Discontinued	O	O	O	O	O	O

The following table lists the conditions causing specific optional data elements to become mandatory for some assessment types:

<b>O*0</b>	If X4 Health Card Number Status = 1, then AA2 Health Card Number must not be blank.
<b>O*1</b>	If BB6g No Income = 1, then BB6a must = 0. If BB6g No Income = 1, then BB6b must = 0. If BB6g No Income = 1, then BB6c must = 0. If BB6g No Income = 1, then BB6d must = 0. If BB6g No Income = 1, then BB6e must = 0. If BB6g No Income = 1, then BB6f must = 0. If any of BB6a–BB6f = 1, then BB6g No Income must = 0. If all of BB6a–BB6f = 0, then BB6g must = 1.
<b>O*2</b>	If CC4a Admitted From = any of 7, 9, 10 or 12, then X65 Referred From Facility Number must not be blank.
<b>O*3</b>	If DD2 Number of Psychiatric Admissions (Lifetime) = 0, then DD1 Number of Psychiatric Admissions (Recent) must = 0. If DD3 Time Since Last Discharge = 8, then DD1 Number of Psychiatric Admissions (Recent) must = 0. If DD4 Amount of Time Hospitalized = 0, then DD1 Number of Psychiatric Admissions (Recent) must = 0.
<b>O*4</b>	If DD3 Time Since Last Discharge = 8, then DD2 Number of Psychiatric Admissions (Lifetime) must = 0.
<b>O*5</b>	If DD2 Number of Psychiatric Admissions (Lifetime) = 0, then DD3 Time Since Last Discharge must = 8.

<b>O*6</b>	<p>If DD1 Number of Psychiatric Admissions (Recent) = 0, then DD4 Amount of Time Hospitalized must = 0.</p> <p>If DD1 Number of Psychiatric Admissions (Recent) does not = 0, then DD4 Amount of Time Hospitalized must not = 0.</p> <p>If DD3 Time Since Last Discharge = 8, then DD4 Amount of Time Hospitalized must = 0.</p>
<b>O*7</b>	If A3a or A3b = 5 (Forensic), then corresponding X9a or X9b must not be blank.
<b>O*8</b>	<p>If I8a Pain Frequency = 0, then I8b Pain Intensity must = 0.</p> <p>If I8b Pain Intensity = 0, then I8a Pain Frequency must = 0.</p>
<b>O*9</b>	If Q1v Psychiatric Diagnostic Category Not Applicable = 1 and CC2h Reason for Admission — Forensic Assessment does not = 1, then 1 of I11a–g Medical Diagnoses must = 1 or 1 of I11h–m Other Medical Diagnoses must not be blank.
<b>O*10</b>	If all of J1a–p = 0, then J2 Life Event Causes Sense of Horror or Intense Fear must = 0.
<b>O*11</b>	If L6 ECT = 0, then X6 Number of ECTs Since Last Assessment must = 0.
<b>O*12</b>	If Z1 Record Type = 5 (Discharge) or 7 (Short stay) and P5 Discharged To = any of 7, 9, 10 or 12, then X140 Discharged to Facility Number must not be blank.
<b>O*13</b>	<p>If P5 Discharged To is not equal to 15 and A1 Assessment Reference Date is greater than or equal to April 1, 2020, then X141 Discharged With Support/Referral for Home Care Services must be coded.</p> <p>If P5 Discharged To equals 15, then X141 Discharged With Support/Referral for Home Care Services must be blank.</p>
<b>O*14</b>	A DSM-5-TR code must be completed if a specific psychiatric diagnosis has been determined by a psychiatrist.
<b>O*15</b>	If X8A Admitted via ED = 1, then X8B Arrived on Inpatient Unit From ED must not be blank.
<b>O*16</b>	If X8B Arrived on Inpatient Unit From ED = 1, then X8C Date Arrived on Inpatient Unit From ED must not be blank.
<b>O*17</b>	<p>If Z1 Record Type = 3 (Full Admission) or 7 (Short Stay), X130 &gt;0, and A1 Assessment Reference Date and CC1 Date Stay Began occur in different fiscal years, then X131 cannot be blank.</p> <p>If Z1 Record Type = 4 (Quarterly), 5 (Discharge) or 6 (Change in Status), X130 &gt;0, and A1 Assessment Reference Date of current assessment and A1 Assessment Reference Date of most recent previous Admission, Change in Status or Quarterly Assessment occur in different fiscal years, then X131 cannot be blank.</p>
<b>O*18</b>	<p>If X210a Project Data does not equal blank, then X200a Project Code must not be blank.</p> <p>If X210b Project Data does not equal blank, then X200b Project Code must not be blank.</p>
<b>O*19</b>	<p>If Q2a = F20.9, F25.0 or F25.1, then X161–X164 cannot be blank.</p> <p>If X160 = 1, then X161–X164 cannot be blank.</p>

# Guidelines for coding and interpretation

## Introduction

To facilitate completion of the MDS-MH assessment and to ensure consistent interpretation of items, this section presents the following types of information for the data elements (not all data elements will have all of the following):

### Intent

Reason(s) for including the item (or set of items) in the MDS-MH, to provide context and to assist with coding accuracy. Also includes discussions of how the information will be used by clinical staff to identify problems and develop a plan of care.

### Definition

Explanation of key terms.

### Process

Sources of information and methods for determining the correct response for an item.

Sources include

- Interview with and observation of the person;
- Discussion with the person's family/caregivers and members of the health care team; and
- Review of any clinical records or other administrative documentation.

### Coding

Proper method of recording each response, with explanations of individual response categories.

### Validation

The validation tables indicate the rules for coding. They include information such as allowed spacing, valid coding, interdependent/mutually exclusive elements and specific rules.



## CIHI elements

A number of elements were added to the MDS-MH by the OMHRS program at CIHI to capture important information about each episode of care. These mostly administrative elements all begin with the letter X.

## Person-specific data elements

### Section AA — Name and identification numbers

This section provides key information to uniquely identify each person and the facility/unit in which he or she is receiving mental health care.

#### AA1. Name

##### Intent

To record the person’s legal name.

##### Process

Using existing records or an interview, determine the person’s legal name.

##### Coding

Enter in the following order: a. Last/Family Name; b. First Name; c. Middle Name/Initial. If the person has no middle name or initial, leave item “c” blank. If completing a paper form, please print.

This item will not be collected by CIHI but may be used for internal hospital purposes.

#### X10. Country of Residence

##### Intent

To identify the country in which the person resides.

##### Process

Using existing records or an interview, determine the country where the person currently resides.

## **Coding**

Enter the 1-digit value that corresponds with the country of residence.

**Code “1”** for Canada.

**Code “2”** for U.S.A.

**Code “3”** for Other.

**Code “4”** for Unknown.

## **X20. Province or Territory Issuing Health Card Number**

### **Intent**

To identify the provincial or territorial government from which the health card number was issued.

### **Process**

Take the information directly from the card, if possible. If there is no card available, ask the person or a responsible family member.

### **Coding**

Enter the 2-letter code that represents the province or territory that issued the health card number. Enter the letter codes in the first 2 spaces. See below for the codes.

<b>NL</b>	<b>Newfoundland and Labrador</b>
<b>PE</b>	<b>Prince Edward Island</b>
<b>NS</b>	<b>Nova Scotia</b>
<b>NB</b>	<b>New Brunswick</b>
<b>QC</b>	<b>Quebec</b>
<b>ON</b>	<b>Ontario</b>
<b>MB</b>	<b>Manitoba</b>
<b>SK</b>	<b>Saskatchewan</b>
<b>AB</b>	<b>Alberta</b>
<b>BC</b>	<b>British Columbia</b>
<b>YT</b>	<b>Yukon</b>
<b>NT</b>	<b>Northwest Territories</b>
<b>NU</b>	<b>Nunavut</b>
<b>-70</b>	<b>Unknown</b>
<b>-90</b>	<b>Not Applicable</b>

**Code “-70”** for Unknown if the province issuing the health card number is not known.

**Code “-90”** for Not Applicable if the person is a resident of the U.S.A. or another country, or if the person has a health card issued by the federal government (such as military personnel).

## **X4. Health Card Number Status**

### **Intent**

To indicate the person’s health card number status.

### **Process**

Ask the person or primary support person for the health card number status or check existing records.

### **Coding**

**Code “1”** for health card number known.

**Code “8”** for health card number unknown.

**Code “9”** for health card number not applicable.

For persons who have health cards issued by the federal government (such as military personnel), code Health Card Number Status as “9” (not applicable).

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#### **Validation**

If X20 Province/Territory Issuing Health Card Number = -90, then X4 Health Card Number Status must = 9.

If X20 Province/Territory Issuing Health Card Number = -70, then X4 Health Card Number Status must = 8.

---

## **AA2. Health Card Number**

### **Intent**

To record the person’s health card number.

### **Process**

Ask the person or primary support person for the health card number or check existing records.

### **Coding**

Begin writing 1 number per box, starting with the first box on the left. Recheck the number to be sure you have written the digits correctly. Include the version code if available.

**Leave blank** for Unknown if the health card number is not known, if X20 Province or Territory Issuing Health Card Number is coded as “-70” (Unknown) or if X4 Health Card Number Status is coded as “8” (Unknown).

**Leave blank** for Not Applicable if X20 Province or Territory Issuing Health Card Number is coded as “-90” (Not Applicable) or if X4 Health Card Number Status is coded as “9” (Not Applicable).

<b>Validation</b>
If X4 Health Card Number Status = 1, then AA2 Health Card Number must not be blank.
If X4 Health Card Number Status = 8 or 9, then AA2 Health Card Number must be blank.
Alpha characters must be upper case.
If X20 Province/Territory Issuing Health Card Number is not coded as -70 (Unknown) or -90 (Not Applicable), then AA2 Health Card Number must adhere to the validations for the province/territory issuing the health card number.
If X20 Province/Territory Issuing Health Card Number = NT, then AA2 Health Card Number must be 1 alpha (N, M, T, D or H) plus 7 numeric characters and adhere to mod 10 check digit validations OR be blank.
If X20 Province/Territory Issuing Health Card Number = ON, then AA2 Health Card Number must be 10 numeric characters plus 1 or 2 alpha or numeric version code characters and adhere to mod 10 check digit validations or be 10 numeric characters and adhere to mod 10 check digit validations or be blank.
If X20 Province/Territory Issuing Health Card Number = BC, then AA2 Health Card Number must be 10 numeric characters and adhere to the following validations or be blank.  The validation is done using the first 10 digits only, with the 10th digit as the check digit.  Perform the following calculation:  2nd digit of HCN × 2 + 3rd digit of HCN × 4 + 4th digit of HCN × 8 + 5th digit of HCN × 5 + 6th digit of HCN × 10 + 7th digit of HCN × 9 + 8th digit of HCN × 7 + 9th digit of HCN × 3  Divide the total by 11, giving a remainder.  The 10th digit of HCN must = 11 – remainder.

---

**Validation**


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If X20 Province/Territory Issuing Health Card Number = AB, then AA2 Health Card Number must be 9 numeric characters and adhere to the following validations or be blank.

The Alberta HCN is 9 numeric digits; the 5th digit is the check digit. The algorithm for validating the HCN involves 2 tables: Table A and Table B.

Table A is 0246813579.

Table B is 0987654321.

Perform the following calculation:

1st digit of HCN +

3rd digit of HCN +

6th digit of HCN +

8th digit of HCN +

Table A value at position (value of 2nd digit of HCN + 1) +

Table A value at position (value of 4th digit of HCN + 1) +

Table A value at position (value of 7th digit of HCN + 1) +

Table A value at position (value of 9th digit of HCN + 1).

Divide that total by 10, giving a remainder.

The 5th digit of HCN must = Table B value at position (remainder + 1).

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If X20 Province/Territory Issuing Health Card Number = SK, then AA2 Health Card Number must be 9 numeric characters or be blank.

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If X20 Province/Territory Issuing Health Card Number = YT, then AA2 Health Card Number must be 9 numeric characters and adhere to mod 10 check digit validations or be blank.

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If X20 Province/Territory Issuing Health Card Number = QC, then AA2 Health Card Number must be 4 alpha plus 8 numeric characters or be blank.

---

If X20 Province/Territory Issuing Health Card Number = NB, then AA2 Health Card Number must be 9 numeric characters and adhere to mod 10 calculation to the first 8 digits, using the 9th digit as the check digit, or be blank.

---

If X20 Province/Territory Issuing Health Card Number = NS, then AA2 Health Card Number must be 10 numeric characters and adhere to mod 10 check digit validations or be blank.

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If X20 Province/Territory Issuing Health Card Number = PE, then AA2 Health Card Number must be 8 numeric characters and adhere to mod 10 check digit validations or be blank.

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If X20 Province/Territory Issuing Health Card Number = NL, then AA2 Health Card Number must be 12 numeric characters and adhere to mod 10 check digit validations or be blank.

---

If X20 Province/Territory Issuing Health Card Number = NU, then AA2 Health Card Number must be 9 numeric characters AND adhere to the following validations OR be blank.

The first digit of a Nunavut HCN must be "1"; the second through eighth digits must be validated using a MOD 10 check digit number; the ninth digit must be a value within the range of 3 to 8.

---

If X20 Province/Territory Issuing Health Card Number = MB, then AA2 Health Card Number must be 9 numeric characters or be blank.

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## **X30. Chart Number**

### **Intent**

To record the chart number.

### **Process**

This number is assigned to the person at the time of her or his first admission to the facility. It is important to distinguish this element from AA3 Case Record Number, which follows.

### **Definition**

The chart number is unique to a person within a facility. A person with multiple episodes (admissions/discharges) within a facility will have the same chart number for all episodes.

### **Coding**

Enter the chart number in the boxes provided, beginning with the first box on the left. All letters must be upper case.

---

**Validation**

Alpha characters must be upper case.

---

## **AA3. Case Record Number**

### **Intent**

To record the case record number.

### **Definition**

The case record number is the hospital registration number assigned for each admission to the facility.

### **Process**

Review the documentation to determine the case record number assigned to this person for this episode of care.

### **Coding**

Place the person's hospital registration number in the boxes provided, starting with the first box on the left.

---

**Validation**

Alpha characters must be upper case.

---

## AA4. Facility Number

### Intent

To record the facility number for the purposes of reporting aggregate data.

### Process

The facility number is a 1-character provincial/territorial code plus a 4-digit mental health master number. This number (including the provincial/territorial character) must contain a total of 5 characters. The provincial/territorial government assigns the 4-digit mental health master numbers (MH numbers in Ontario).

### Coding

The first character, a letter or number, indicates the province/territory in which the facility is located. The CIHI-assigned provincial/territorial characters are as follows:

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
Y	Yukon
N	Northwest Territories
V	Nunavut
Z	Outside of Canada

### Validation

AA4 Facility Number must match the facility number of the submission file name.

The 4-digit provincial/territorial facility number must be in the range of 0001 to 9999.

The first character of AA4 Facility Number must be a valid provincial/territorial code (0–9, N, Y, V or Z).

If Z is coded, then the remaining 4 digits must be 9999.

### Example

The facility number assigned by the Ontario government for the mental health beds in Facility A is 1234.

Facility A's facility number is recorded as

5	1	2	3	4
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## AA5. Unit Identifier

### Intent

To identify the specific unit type the person is on at the time of assessment.

### Definitions

Unit Identifier — refers to the ministry designation for functional centre/unit type.

**25 Mental Health — Acute:** Designated for the provision of short-term assessment and treatment.

**45 Mental Health — Addictions:** Designated for the provision of services related to substance abuse problems.

**50 Mental Health — Child/Adolescent:** Designated for the provision of assessment, treatment and psychosocial rehabilitation for persons younger than 18 years of age.

**55 Mental Health — Forensic:** Designated for the provision of assessment, treatment and psychosocial rehabilitation for persons referred by the criminal justice system.

**90 Mental Health — Psychiatric Crisis:** Designated for the provision of services for persons requiring constant supervision and care.

**20 Mental Health — Longer Term Dual Diagnosis:** Designated for the provision of longer term assessment, treatment and psychosocial rehabilitation for persons with both mental illness and intellectual disability.

**30 Mental Health — Longer Term Combined:** Designated for the provision of longer term assessment, treatment and psychosocial rehabilitation for persons with dual diagnoses, rehabilitation and/or problems related to aging.

**81 Mental Health — Longer Term Rehabilitation:** Designated for the provision of longer term assessment, treatment and psychosocial rehabilitation for persons with a persistent impairment and disability resulting from a serious mental illness.



**96 Mental Health — Longer Term Geriatrics:** Designated for the provision of longer term assessment, treatment and psychosocial rehabilitation for persons older than 65 years of age with dementia.

**99 Mental Health — Other Longer Term:** Designated for the provision of longer term assessment, treatment and psychosocial rehabilitation for persons not falling into any of the above categories.

### Process

When choosing a unit identifier, do not consider length of stay, patient type, diagnosis or treatment; unit identifiers refer to the unit only. If there are questions regarding a facility's designations, it is recommended that the ministry be contacted for clarification.

### Coding

Enter the 2-digit unit identifier in the spaces provided.

## Section BB — Personal items

These items capture basic demographic information about the person. Complete this section only at the initial assessment.

### BB1. Sex

#### Intent

To record the person's sex.

#### Process

Code this item consistently with the anatomy of the patient. Gender (social sexual identity) may be reported by the patient to be different from his or her sex, but this is not captured in the RAI-MH; however, clinicians may wish to include this information in the care plan.

#### Coding

**Code “M”** for Male.

**Code “F”** for Female.

**Code “O”** for Other.

## BB2. Birthdate

### Intent

To record the person’s actual or estimated birthdate.

### Process

Review the clinical record or ask the person. If the birthdate is unknown, it may be estimated.

### Coding

For the month and day of birth, enter 2 digits each, using a leading “0” as filler if needed. Use 4 digits for the year. For estimated year of birth, assign the month/day as 01/01.

### Example

January 2, 1968

1	9	6	8	0	1	0	2
Year				Month		Day	

---

#### Validation

BB2 Birthdate must be less than or equal to CC1 Date Stay Began.

Record will be flagged as suspicious if calculated age at Date Stay Began is less than 14 years or greater than 115 years.

---

## X40. Estimated Birthdate

### Intent

To track those persons for whom a date of birth cannot be verified by documents or from the informant’s memory.

### Process

Indicate if the person or family is unsure about the exact date of birth and there is no definitive evidence to support an exact date.

### Coding

**Code “0”** if the birthdate entered in BB2 is known.

**Code “1”** if the birthdate entered in BB2 is estimated.

## BB3. Marital Status

### Intent

To record the person’s marital status.

### Process

Ask the person or check with the family to determine the person’s current marital status.

### Coding

Enter the code that describes the person’s current marital status.

**Code “1”** if the person has never been married.

**Code “2”** if the person is married or in a common-law relationship. If the person is in a live-in relationship that he or she does not define as common-law, code as partner/significant other (“3”).

**Code “3”** if the person is living with a partner or significant other.

**Code “4”** if the person is widowed.

**Code “5”** if the person is separated.

**Code “6”** if the person is divorced.

## BB4. Language

### Intent

To monitor the service utilization for French, English and other languages and to have information about the person’s language in order to provide interpretation services, if necessary.

### Definition

The language the person generally prefers to use for day-to-day communication.

### Process

Ask the person or check with the family if the person is uncommunicative. Enter “eng” if the language is identified as English. Enter “fra” if the language is identified as French.

For most other languages, refer to the CIHI Standard Language Pick-List, which is a subset of ISO 639-3 language codes. The pick-list may be available through your vendor software, or you can email [specializedcare@cihi.ca](mailto:specializedcare@cihi.ca) for a copy. Enter the 3-letter code that corresponds to the person’s language in the set of boxes provided.

## Coding

Refer to the CIHI Standard Language Pick-List. If unable to determine the correct Language Code or First Nations' Language, contact CIHI at [specializedcare@cihi.ca](mailto:specializedcare@cihi.ca).

## BB5. Education

### Intent

To record the highest level of education that the person has attained or in which the person has participated.

### Definitions

1. **No schooling** — The person received no formal schooling at all.
2. **8 grades or less** — The person attended 8 grades or less of school. This includes persons with an intellectual disability diagnosis who have received special education services.
3. **9–11 grades** — The person left school having completed 9 to 11 grades.
4. **High school** — The person obtained a high school diploma and completed school through the 12th grade or through an adult education program.
5. **Technical or trade school** — The person received a non-degree certificate in any technical occupation or trade (e.g., carpentry, plumbing, acupuncture, baking, secretarial, practical/vocational nursing, computer programming).
6. **Some college or university** — The person completed some college courses at a (community) college, an associate's degree or an incomplete bachelor's degree.
7. **Diploma or bachelor's degree** — The person completed an undergraduate bachelor's degree or college diploma.
8. **Graduate degree** — The person completed a master's degree or higher (MSc, PhD, MD, etc.).
9. **Unknown** — To be used **only** when the assessor has been unsuccessful in determining the person's educational level.

### Process

Ask the person directly. If the person is unable to provide the information, check with the family or other sources who may know the person (e.g., a community support worker). Accept the response provided; it is not necessary to have proof of attendance or completion.

## Coding

Enter the number assigned to the most appropriate response.

## BB6. Sources of Income

### Intent

To identify the person's source(s) of income.

### Definitions

- a. **Employment** — Includes full-time or part-time paid employment, either self-employed or as an employee.
- b. **Employment insurance** — The person is presently receiving employment insurance.
- c. **Pension** — Includes disability, old age, Canada Pension Plan (CPP), Ontario Disability Support Program (ODSP) and workplace pensions.
- d. **Social assistance** — Includes welfare, the Guaranteed Annual Income System Source (G.A.I.N.S.), a training program and public insurance.
- e. **Disability insurance** — Private insurance to cover disabilities.
- f. **Other** — Includes investment income, inheritance income, workplace safety and insurance benefits, student loans and sheltered workshops. Include here income from illicit sources (e.g., dealing in street drugs, prostitution).
- g. **No income** — The person is receiving no benefits or assistance and is unemployed.

### Process

Ask the person directly. If the person is unable to provide the information, check with the family or other sources who may know the person (e.g., an outpatient therapist, a community support worker).

### Coding

Specify a code for each source-of-income option presented.

**Code “1”** for all sources of income available now.

**Code “0”** if income is not received from the identified source.

---

#### Validation

All elements BB6a to BB6f must be coded as 0 (No) when BB6g No Income is coded as 1 (Yes).

BB6g No Income must be coded as 0 (No) when any of BB6a to BB6f is coded as 1 (Yes).

BB6g No Income must be coded as 1 (Yes) when all of BB6a to BB6f are coded as 0 (No).

---

## X50. Responsibility for Payment

### Intent

To capture the agency or agencies responsible for the method of payment being used for this episode of care.

### Definitions

- a. **Provincial/territorial responsibility**
- b. **Workers' compensation — from the Workers' Compensation Board (WCB) or the Workplace Safety and Insurance Board (WSIB)**
- c. **Other province/territory (if resident of Canada)**
- d. **Veterans Affairs Canada (VAC)**
- e. **First Nations and Inuit Health Branch (FNIHB) — formerly called the Medical Services Branch (MSB)**
- f. **Other federal government — Canadian Forces, federal penitentiary, department responsible for refugee claims**
- g. **Self-pay — Canadian resident — includes private insurance**
- h. **Self-pay — Other country**
- i. **Unknown**

### Process

Determine who will be making the payments for this admission. Use the interview and available documents. There may be multiple entries.

### Coding

Record an answer for each of the options presented.

**Code “1”** for the agency or agencies responsible for payment of the person's episode of care.

**Code “0”** if the agency is not responsible for payment for the person's episode of care.

---

#### Validation

---

If all of X50a–h are coded as 0 (No), then X50i Responsibility for Payment — Unknown must = 1 (Yes).

---

Elements X50a–h must be coded as 0 (No) when X50i Responsibility for Payment — Unknown is coded as 1 (Yes).

---

X50i Responsibility for Payment — Unknown must be coded as 0 (No) when any of X50a–h is coded as 1 (Yes).

---

## BB7. Aboriginal Origin

### Intent

To document self-identification as a member of an Aboriginal community, including Inuit, Métis or First Nations, when applicable.

### Definitions

- a. First Nations — Person self-identifies as a member of a First Nation.
- b. Métis — Person self-identifies as Métis.
- c. Inuit — Person self-identifies as Inuit.

### Process

Ask the person or family members, or check medical records if available. This element is based on self-identification and does not require proof (i.e., a status card) to report in the positive.

### Coding

Record an answer for each of BB7a, b and c.

**Code “0”** if the person does not self-identify as a member of the named Aboriginal community.

**Code “1”** if the person does self-identify as a member of the named Aboriginal community.

## Section CC — Referral items

This section identifies circumstances surrounding the initial referral. Complete this section at intake/on admission only.

### CC1. Date Stay Began

#### Intent

To record the date the person was admitted as a mental health patient in your facility.

#### Process

Review the clinical record. If the person was transferred from another institution, CC1 is the date the person was transferred into a mental health bed on an inpatient unit in your facility.

If the person was admitted through your facility’s emergency department, CC1 is **the date the decision was made** by the emergency department physician or consulting psychiatrist to admit the person to a mental health inpatient unit in your facility.

### Coding

Enter the date on which the person’s stay began in your facility. 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 with a “0.”

For example, if the person was admitted on March 20, 2018, the date should be entered as

2	0	1	8		0	3		2	0
Year					Month			Day	

---

### Validation

CC1 Date Stay Began must be greater than or equal to October 1, 2005 (start of Ontario mandate).

CC1 Date Stay Began must be prior to or the same date as A1 Assessment Reference Date.

---

## CC2. Reasons for Admission

### Intent

To identify problems that contributed to the person’s present admission. Persons admitted to mental health inpatient units may have many problems contributing to their present situation. When developing a care plan for each person and when planning discharge, it is important for the treatment team to address significant problems beyond the primary reason for admission.

### Definitions

- a. **Threat or danger to self** — The person may have stated intentions to hurt himself or herself or actually done so; or others have expressed a concern that the person is a danger to himself or herself.
- b. **Threat or danger to others** — The person may have stated intentions to hurt someone else, have actually hurt someone or made an attempt to hurt someone; or others have expressed a concern that the person is a danger to others.
- c. **Inability to care for self due to mental illness** — The person’s current behaviour shows a lack of competence to care for himself or herself that is likely to lead to imminent harm to self.
- d. **Problem with addiction/dependency** — There is a concern about substance use/abuse (e.g., alcohol, drugs) or non-substance addiction (e.g., gambling, shopping).



- e. **Specific psychiatric symptoms** — The person exhibits symptoms such as depression, hallucinations, delusions and/or medication side effects.
- f. **Involvement with criminal justice system, forensic admission** — The person has recently had contact with the police or has been involved in or charged with criminal activity. Check this item if this is a forensic admission.
- g. **Other**
- h. **Forensic assessment** — A systematic evaluation of an issue such as fitness to stand trial or criminal responsibility has been ordered by the court.

### Process

Ask the person, family or referral source.

### Coding

Record an answer for each of the problems presented.

**Code “1”** beside all applicable problems. For example, a person may be admitted after taking an overdose. His or her situation could be that he or she has a problem with alcohol but has refused treatment and that the spouse has recently left. 2 boxes would be coded as “1”: a) Threat or danger to self; and d) Problem with addiction/dependency. If there is another reason for admission that is not listed, code “1” for “Other.”

**Code “0”** if the problem is not present.

---

#### Validation

If either of A3a Inpatient Status at Time of Admission or A3b Inpatient Status at Time of Assessment = 5, then CC2f Reason for Admission — Justice System must = 1 or CC2h Reason for Admission — Forensic Assessment must = 1.

If all of CC2a–f = 0 and CC2h = 0, then CC2g Reasons for Admission — Other must = 1.

CC2g must = 1 if all of CC2a–f = 0 and CC2h = 0.

If Q5 Current Patient Type = 4, then CC2f Reason for Admission — Justice System must = 1 or CC2h Reason for Admission — Forensic Assessment must = 1.

If CC2h Reason for Admission — Forensic Assessment = 1, then CC2f Reason for Admission — Justice System must = 1.

---

## X60. Postal Code of Person’s Residence

### Intent

To track utilization of services at provincial/territorial and regional levels.

### Definition

The 6-character Canadian postal code for the person’s current residence.

### Process

Using available information, determine the postal code of the person’s most recent residence.

### Coding

Code the 6-character Canadian postal code in the format ANANAN (where A = alpha and N = numeric). If only the forward sortation area is known, code the first 3 characters ANA.

**Code “-70”** if the postal code is unknown.

**Code “-90”** for Not Applicable.

If CC4a Admitted From = “8 homeless,” then X60 Postal Code = “-90 not applicable

---

Validation
The first character of the postal code must not be D, F, I, O, Q, U or W.
Alpha characters must be upper case.

---

## CC3. Who Lived With at Admission

### Intent

To establish with whom the person lived prior to admission to this facility. This information can help identify individuals who may potentially be available to assist the person upon discharge.

### Definitions

1. **Lived alone** — Lived with a pet only is coded as lived alone, as is living on the streets.
2. **Lived with spouse only** — Includes spouse/partner.
3. **Lived with spouse and other(s)** — Lived with spouse/partner and any other individuals, whether family or unrelated.
4. **Lived with child/children (but not spouse/partner)** — Lived with child(ren) only, or with child(ren) and other individuals, but **not** with a spouse or partner.
5. **Lived with others (not spouse or child/children)** — Includes any relative such as parent(s), a sister or a brother, but not a spouse or children.
6. **Lived in group setting with non-relative(s)** — Lived in a group setting (e.g., boarding home, long-term care home, group home, jail) or in shared accommodation with non-relatives (e.g., a roommate).

**Process**

Obtain information through person and family interviews. Medical record review may also be helpful.

**Coding**

Record the number that reflects who the person was living with at the time of admission.

**Note:** This excludes any temporary living arrangements while mental health services were being set up and can include hospital settings if the stay is of significant duration.

**CC4. Admitted From and Usual Residence****Intent**

To document the type of residence/facility from which the person was admitted and the type of residential setting where the person normally lives. This item determines whether the person was admitted from his or her normal place of residence or if he or she was admitted from a residence/facility that was temporary/transitional in nature. This information can assist with discharge planning and tracking locations of referral sources (e.g., directly from the community, from another facility).

**Definitions**

1. **Private home/apartment/rented room** — Any house, condominium or apartment in the community, whether owned or rented by the person or another party; any rented room, e.g., a resident hotel, whether rented by the person or another person. Also included in this category are retirement communities and independent housing for the elderly or disabled.
2. **Board and care** — A non-institutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home health, homemaker, personal care, meal service, transportation, etc.
3. **Assisted living or semi-independent living** — A second type of non-institutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home health, homemaker, personal care, meal service, transportation, etc. (e.g., retirement homes in Ontario).
4. **Mental health residence** (such as a psychiatric group home) — A residence where specialized care is provided to adults with mental health problems who need supervision and limited services (meals, housekeeping).
5. **Group home for persons with physical disabilities** — A setting that provides services to persons with physical disabilities. Typically, people live in group settings with 24-hour staff presence but are encouraged to be as independent and active as possible.

6. **Setting for persons with intellectual disabilities** — A setting that provides services to persons with intellectual disabilities. Typically, people live in group settings with 24-hour staff presence but are encouraged to be as independent and active as possible.
7. **Psychiatric hospital or unit** — A hospital caring for persons with a psychiatric illness that is separate from other inpatient facilities, such as an acute, rehabilitation or complex continuing care hospital. A psychiatric unit is a designated care unit located within a general hospital.
8. **Homeless (with or without shelter)** — A homeless person does not have a fixed residence: a home, apartment, room or place to stay on a regular basis. The person may live on the streets or outside in wooded or open areas. The person may sleep in cars, abandoned buildings, under bridges, etc. People who are homeless may or may not take advantage of existing homeless shelters.
9. **Long-term care facility (nursing home)** — A health care facility that provides 24-hour skilled or intermediate nursing care.
10. **Rehabilitation hospital/unit** — A rehabilitation hospital or unit provides physical and occupational rehabilitation to persons who have experienced disease or injury resulting in subsequent decline in physical function. An entire rehabilitation hospital or a specific rehabilitation unit within an acute care hospital may be dedicated to this task.
11. **Hospice facility/palliative care unit** — A hospice facility (or unit within a facility providing more general care) provides care to persons who have a terminal illness with a prognosis of less than 6 months to live, as certified by a physician. The goal of hospice care is to provide comfort and quality of life while assisting the person and family. Palliative care is the care of persons whose diseases are not responsive to curative treatments. It targets pain and symptom relief without precluding the use of life-prolonging treatments and provides support systems for the person and his or her family.
12. **Acute care unit/hospital** — An acute care hospital primarily provides the diagnosis and treatment of acute medical disorders. Examples include complex continuing care hospitals, general hospitals and specialty hospitals. Do not include psychiatric wards of a general hospital, psychiatric hospitals or rehabilitation hospitals, as they are coded separately.
13. **Correctional facility** — Any jail, penitentiary or halfway house, whether operated by the local, provincial or federal government. Correctional staff is responsible for caring for and housing persons sentenced by a criminal court to incarceration.
14. **Other** — Any other type of setting not listed above. Outpatient settings are not included in CC4.

## Process

Obtain information through interviews with the person and family. Clinical record review may also be helpful.

## Coding

Code for both items a and b. The same list of codes is used for both items a and b. Where necessary, right-justify and use leading “0”s to fill all boxes.

- a. **Admitted From** — Indicate the type of residence/facility from which the person was admitted.
- b. **Usual Residence** — Indicate the type of residence/facility in which the person usually lives.

Use the most applicable options from the list to code CC4a and CC4b (they may be the same or different).

**Example 1:** For persons living at home who are admitted to a mental health bed through the emergency department (in same or different facility) — CC4a = 12 and CC4b = 1.

**Example 2:** For persons living at home who are first admitted to a medical bed and then transferred and admitted to an inpatient mental health bed — CC4a = 12 and CC4b = 1.

## X65. Referred From Facility Number

### Intent

To capture the facility number if the person was admitted immediately to a mental health bed from another psychiatric hospital, long-term care home, rehabilitation unit/hospital, acute unit/hospital or emergency department.

### Definition

The provincial/territorial prefix and 4-digit facility number of the referring facility.

### Process

Determine the 4-digit ministry-issued master number for the facility making the referral, including emergency departments. Indicate the facility identifier number for emergency departments located within the same facility. Consultation with health records or ministry reference materials may be necessary. This applies to persons who are admitted from a facility as defined in AA4.

### Coding

Enter the 1-character provincial/territorial code as in data element AA4 (page 22) and 4-digit facility code in the space provided. Code “Z9999” for facilities located outside the country. Leave the space blank if the person was not admitted from a facility.

---

**Validation**

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The first character of X65 Referred From Facility Number must be a valid province/territory code (0–9, N, Y, V, Z); if Z is coded, then the remaining 4 digits must be 9999.

---

If CC4a Admitted From = any of 7, 9, 10 or 12, then X65 Referred From Facility Number must not be blank.

---

If CC4a Admitted From = any of 1–6, 8, 13 or 14, then X65 Referred From Facility Number must be blank.

---

## CC5. Residential Stability

### Intent

To assess the stability of the person’s living arrangements, which can have implications for discharge planning.

### Definition

“Stability” refers to the permanence of the person’s current living arrangements (temporary versus long term); it does not refer to the appropriateness or desirability of the current living arrangements.

A temporary residence is one in which the person has lived for less than 30 days and from which he or she plans to move within 30 days (e.g., a shelter, a hostel).

### Process

Obtain information through person and family interviews. A medical record review may also be helpful.

### Coding

**Code “0”** if the person’s living arrangement is stable.

**Code “1”** if the person’s living arrangement is considered unstable.

## Section DD — Mental health service history

Obtaining a mental health service history provides information about service utilization patterns at both the individual and aggregate levels. This information could be helpful for care planning and broader program planning.

### DD1. Number of Psychiatric Admissions (Recent)

#### Intent

To record how many times the person was admitted to hospital as an inpatient for mental health services in the last 2 years.

**Definition**

The person was formally admitted as an inpatient for mental health services (either voluntary/informal, involuntary or forensic) and stayed 1 or more nights. The person may or may not have been admitted to a designated mental health bed while receiving mental health services. Outpatient services are not included here.

**Process**

Review for prior psychiatric admissions with the person and family. If available, review the clinical record. Do not include this admission.

**Coding**

**Code “0”** if there have been no admissions in the last 2 years.

**Code “1”** if there have been 1 or 2 admissions in the last 2 years.

**Code “2”** if there have been 3 or more admissions in the last 2 years.

**Validation**


---

DD1 Number of Psychiatric Admissions (Recent) must be coded as 0 (None) when DD2 Number of Psychiatric Admissions (Lifetime) is coded as 0 (None).

---

DD1 Number of Psychiatric Admissions (Recent) must be coded as 0 (None) when DD3 Time Since Last Discharge is coded as 8 (Not Applicable).

---

DD1 Number of Psychiatric Admissions (Recent) must be coded as 0 (None) when DD4 Amount of Time Hospitalized is coded as 0 (No other admissions in last 2 years).

---

**DD2. Number of Psychiatric Admissions (Lifetime)****Intent**

To record the number of previous admissions to a mental health facility or mental health inpatient unit.

**Process**

Ask the person, consult with family members, check with other health care providers and review the medical records. Do not include this admission.

**Coding**

**Code “0”** if this is the person’s first-ever inpatient admission.

**Code “1”** if there have been 1, 2 or 3 admissions.

**Code “2”** if the total number of admissions has been 4 or 5.

**Code “3”** if the total number of admissions has been 6 or more.

---

**Validation**

---

DD2 Number of Psychiatric Admissions (Lifetime) must be coded as 0 (None) when DD3 Time Since Last Discharge is coded as 8 (Not Applicable).

---

## **DD3. Time Since Last Discharge**

### **Intent**

To record the amount of time since last discharge from a mental health facility. If readmission occurs within a month of discharge, alterations in follow-up may be warranted.

### **Process**

Review the clinical chart and/or ask the person directly.

### **Coding**

**Code “1”** if the last discharge was more than 1 year ago.

**Code “2”** if the last discharge occurred at some time in the last year, but prior to 31 days from this admission.

**Code “3”** if the last discharge was 30 days ago or less from another facility.

**Code “4”** if the last discharge was 30 days ago or less from this facility.

**Code “8”** if this item is not applicable because this is the person’s first admission to a psychiatric hospital.

---

**Validation**

---

DD3 Time Since Last Discharge must be coded as 8 (Not Applicable) when DD2 Number of Psychiatric Admissions (Lifetime) is coded as 0 (None).

---

## **DD4. Amount of Time Hospitalized**

### **Intent**

To record the amount of time, over the last 2 years, during which the person was hospitalized as an inpatient for mental health services.

### **Definition**

The person was formally admitted as an inpatient for mental health services (either voluntarily or involuntarily) and stayed for 1 or more nights.



**Process**

Review prior psychiatric admissions for the last 2 years with the person and family and check the clinical record if available. Do not include time hospitalized during this admission.

**Coding**

**Code “0”** if the person was not hospitalized in the last 2 years.

**Code “1”** if the person was hospitalized for a total of 30 days or less in the last 2 years.

**Code “2”** if the person was hospitalized for a total of 31 days to 1 year in the last 2 years.

**Code “3”** if the total number of days hospitalized exceeds 1 year.

**Validation**


---

DD4 Amount of Time Hospitalized must be coded as 0 (No other admissions in last 2 years) when DD1 Number of Psychiatric Admissions (Recent) is coded as 0 (None).

---

DD4 Amount of Time Hospitalized cannot be coded as 0 (No other admissions in last 2 years) when DD1 Number of Psychiatric Admissions (Recent) is not coded as 0 (None).

---

DD4 Amount of Time Hospitalized must be coded as 0 when DD3 Time Since Last Discharge is coded as 8 (Not Applicable).

---

**DD5. Contact With Community Mental Health****Intent**

To identify involvement with a community-based mental health service in the last year prior to this admission.

**Definition**

Community mental health agency includes any mental health service provided through a community agency or outpatient clinic. General practitioners are not included in this item.

**Process**

Consult with the person, family, past medical records or community workers, if available.

**Coding**

**Code “0”** if the person was not involved with a community-based mental health service in the last year.

**Code “1”** if it has been 31 days or more since the person was last involved with a community mental health service.

**Code “2”** if the person was involved with a community mental health service in the last 30 days.

**Note:** DD5 refers to contact in the community prior to the current admission. Contact after admission for the purpose of discharge planning is captured in L4a Community Reintegration.

## **DD6. Age at First Hospitalization**

### **Intent**

To determine the person’s approximate age when he or she was first admitted as an inpatient for mental health services.

### **Definition**

The person’s age the first time he or she was admitted as an inpatient for mental health services and stayed for 1 or more nights. Do not include overnight stays in an emergency department only.

### **Process**

It is often difficult to remember the exact age for past events. Try to frame the question around major life phases. Was the person in public school at the time? What grade in high school? Was he or she married at the time or single? Determining the exact age is not as important as estimating the approximate age group.

### **Coding**

Code the appropriate age range category. If this is the person’s first hospitalization, enter the present age category.

**Code “1”** if the age at first hospitalization was between 0 and 14.

**Code “2”** if the age at first hospitalization was between 15 and 24.

**Code “3”** if the age at first hospitalization was between 25 and 44.

**Code “4”** if the age at first hospitalization was between 45 and 64.

**Code “5”** if the age at first hospitalization was 65 or older.

---

### **Validation**

DD6 Age at First Hospitalization must be in the appropriate range as per (CC1 Date Stay Began – BB2 Birthdate).

---

## Section A — Assessment information

The information collected in this section relates to the medical–legal aspects of the person’s care. It will be used for care planning and outcome measurement.

### A1. Assessment Reference Date

#### Intent

To provide a reference point for time frames applied to items in the assessment, thereby ensuring the commonality of the assessment period.

#### Definition

This is the last day of the MDS-MH assessment process. It is the designated endpoint for the observation period.

#### Process

Set the Assessment Reference Date as follows: for a Full Admission Assessment, 72 hours after admission; for a Quarterly Assessment, 92 days after the Assessment Reference Date of the most recent assessment; and for a Discharge Assessment, the last day the person occupied the mental health bed.

For the current assessment, the date specified in A1 is the last day of **all** observation/assessment periods, regardless of length (3 days, 7 days, 30 days, 1 year, etc.). The date specified in A1 may be different from the date on which the assessment is completed or the date on which the person is discharged.

#### Coding

Enter the Assessment Reference Date as follows: use 4 digits for the year and 2 digits for the month and day, respectively, using a leading “0” as filler when needed.

For example, the Assessment Reference Date for a person admitted on March 20, 2017, would usually be March 23, 2017, entered as follows:

2	0	1	7
---	---	---	---

Year

0	3
---	---

Month

2	3
---	---

Day

---

**Validation**

---

A1 Assessment Reference Date must be greater than or equal to October 1, 2005 (start of Ontario mandate).

---

A1 Assessment Reference Date must be after or the same date as CC1 Date Stay Began.

---

A1 Assessment Reference Date must be prior to or the same date as X80 Discharge Date.

---

A1 Assessment Reference Date must be prior to or the same date as the Z5 Date of Submission specified on the control record.

---

If Z1 Record Type is 3 (Admission), 4 (Quarterly), 5 (Discharge), 6 (Change in Status), 7 (Short Stay) or 8 (Medication), then A1 Assessment Reference Date must be within the Z2 Fiscal Year of Submission specified on the control record.

---

If Z1 Record Type is 3 (Admission), 4 (Quarterly), 5 (Discharge), 6 (Change in Status), 7 (Short Stay) or 8 (Medication), then A1 Assessment Reference Date must be within the Z3 Fiscal Quarter of Submission specified on the control record.

---

If Z1 Record Type is 4 (Quarterly) or 6 (Change in Status), then A1 Assessment Reference Date must be greater than A1 Assessment Reference Date of the Admission Assessment within the episode.

---

If Z1 Record Type is 4 (Quarterly) or 6 (Change in Status), then A1 Assessment Reference Date must be less than or equal to A1 Assessment Reference Date of the Discharge Assessment within the episode.

---

If Z1 Record Type is 5 (Discharge), then A1 Assessment Reference Date must be greater than or equal to the A1 Assessment Reference Date of the most recent previous Admission, Change in Status or Quarterly assessment within the episode.

---

## A2. Reason for Assessment

### Intent

To document the reason for completing the assessment.

### Definitions

1. **Initial assessment** (Admission Assessment) — An assessment that is completed for each separate admission for the person, whether the person is admitted from another facility or organization or directly from the community.
2. **Routine assessment at fixed intervals** (Quarterly Assessment) — A comprehensive reassessment at specified intervals during the course of care (e.g., 92 days since the most recent assessment).
3. **Review prior to discharge from program** (Discharge Assessment) — Use this code whenever a permanent program discharge is anticipated. This is a means of closing the clinical record at the point of discharge and laying the foundation for subsequent service initiatives.
4. **Review upon return to unit/hospital** — The purpose of the review is to identify if the person’s needs changed when he or she was readmitted or transferred back to a mental health bed directly from a stay in an acute care hospital or another unit for medical reasons, as in the case of a service interruption. (**Note:** This assessment is not a requirement of OMHRS reporting.)

5. **Change in status** — A comprehensive reassessment conducted at any time during a single episode of care that is prompted by a significant, unexpected change in a person’s clinical status (changes in a person’s legal status are captured in A3).
6. **Other** — The purpose can be for quality assurance, clinical research, confirmation of the current plan, development of an acuity scale, etc.

## Process

Determine the appropriate reason for completing an assessment based on the definitions above and the person’s clinical status.

## Coding

Enter the number corresponding to the reason for assessment.

Validation
A2 Reason for Assessment must be coded as 1 (Initial assessment) when Z1 Record Type is coded as 3 (Admission) and X2 Submission Type is N or C.
A2 Reason for Assessment must be coded as 2 (Routine assessment at fixed intervals) when Z1 Record Type is coded as 4 (Quarterly).
A2 Reason for Assessment must be coded as 3 (Review prior to discharge from program) when Z1 Record Type is coded as 5 (Discharge) and X90 Discharge Reason = 1 and (X80 Discharge Date – CC1 Date Stay Began – X130 Total Days Away From Bed) is greater than 6.
A2 Reason for Assessment must be coded as 4 (Review upon return to unit/hospital), 5 (Change in status) or 6 (Other) when Z1 Record Type is coded as 6 (Change in status).

## A3. Inpatient Status

### Intent

To identify inpatient status, as outlined in the *Ontario Mental Health Act* and the *Ontario Mental Health Statute Law Amendment Act, 2015*, at the time of admission and the time of assessment. Time of admission is identified by Date Stay Began (CC1), and time of assessment is identified by the Assessment Reference Date (A1). This item may require jurisdiction-specific alterations.

### Definitions

1. **Application for psychiatric assessment or order for psychiatric examination** — The person is admitted to and detained in a psychiatric facility for the purpose of assessment (e.g., Form 1 or Form 2 of the *Ontario Mental Health Act* as completed by a physician or justice of the peace). Exclude forensic admissions from this item.
2. **Voluntary** — Consent for admission is obtained from the person.

3. **Informal** — Consent for admission is obtained from the person’s designated decision-maker.
4. **Involuntary** — A person is detained in a psychiatric facility under a Certificate of Involuntary Admission or a Certificate of Renewal (e.g., Form 3 or Form 4 of the *Ontario Mental Health Act*) or a Certificate of Continuation (Form 4a of the *Ontario Mental Health Statute Law Amendment Act, 2015*).
5. **Forensic** — This includes an admission for a forensic assessment, designations of “not criminally responsible” or “unfit to stand trial,” and judicial treatment orders.

### Process

Review the clinical record for documentation of the person’s inpatient status at the time of admission and as of the Assessment Reference Date.

### Coding

Code for the person’s inpatient status at the time of admission to the unit/facility and at the time of assessment (i.e., the Assessment Reference Date). Note that the status at the time of admission will remain the same in subsequent assessments, but the status at the time of assessment may change.

### A3a. Inpatient Status at Time of Admission

Enter the corresponding number for the person’s inpatient status on the Date Stay Began (CC1).

### A3b. Inpatient Status at Time of Assessment

Enter the corresponding number for the person’s inpatient status as of the Assessment Reference Date (A1). This may differ from the person’s inpatient status at the time of admission.

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#### Validation

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If A3b Inpatient Status at Time of Assessment = 5, then A3a Inpatient Status at Time of Admission must = 5.

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For admission and short stay assessments: If A3a Inpatient Status at Time of Admission = 5, then A3b Inpatient Status at Time of Assessment must = 5.

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If Q5 Current Patient Type = 4, then A3b Inpatient Status at Time of Assessment must = 5.

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## X9. Forensic Status

### Intent

To establish the status of forensic patients at the time of admission and the time of assessment.

**Note:** Complete X9a Forensic Status at Time of Admission and X9b Forensic Status at Time of Assessment **only if** A3a or A3b is coded “5 — forensic”; otherwise, leave X9a and X9b blank and continue to A4.

### Definitions

The following list of coding options for forensic status has been approved for use in Ontario. Not all items will apply in other jurisdictions.

RAI-MH code	Forensic status	Definition
1	Fitness assessment	Court order for inpatient hospital assessment, per Criminal Code Section 672.13.
2	Not criminally responsible (NCR) assessment	Order for assessment to determine whether the accused suffered from a mental disorder so as to exempt the accused from criminal responsibility, per Criminal Code Subsection 16(1).
3	Treatment order	Order for inpatient treatment, per Criminal Code Section 672.58.
4	Keep fit order	Provision that allows for a person with a verdict of “fit to stand trial” to be hospitalized until the completion of his or her trial, in order to preserve fitness.
5	Warrant of committal — unfit	The person is to be held in hospital pending a Review Board hearing.
6	Warrant of committal — NCR	The person is to be held in hospital pending a Review Board hearing.
7	Inter-hospital transfer — NCR	Person is either unfit to stand trial or NCR and is being moved from 1 forensic facility to another under Review Board order.
8	Inter-hospital transfer — unfit	
9	Other	Includes court-ordered disposition recommendations and holds.

### Coding

#### Item X9a

Code for the person’s forensic status at the time of admission to the unit/facility. From the list above, enter the corresponding number indicating the forensic status on the Date Stay Began (CC1).

### Item X9b

Code for the person’s forensic status at the time of assessment. From the list above, enter the corresponding number indicating the forensic status as of the Assessment Reference Date (A1). Select 1 coding option only; if more than 1 option is applicable, choose the 1 most applicable. Note that forensic status may change during an episode of care.

Validation
If A3a Inpatient Status at Time of Admission = 5 (Forensic), then X9a cannot be blank.
If A3a Inpatient Status at Time of Admission = blank, then X9a must be blank.
If A3a Inpatient Status at Time of Admission = 1, 2, 3 or 4, then X9a must be blank.
If A3b Inpatient Status at Time of Assessment = 5 (Forensic), then X9b cannot be blank.
If A3b Inpatient Status at Time of Assessment = 1, 2, 3 or 4, then X9b must be blank.

## A4. Capacity/Competency

### Intent

To record whether or not the person has been assessed as competent and/or capable to participate in decisions about his or her health care, treatment and/or financial affairs and to document if another person is authorized to make decisions for the person.

### Definitions

Capacity/competency is the ability to understand information relevant to making an informed decision and the appreciation of the consequences of a decision or a lack of a decision.

- a. **Treatment** — Anything done for therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purposes.
- b. **Managing property** — Includes real estate; life, accident, disability and income protection insurance; pension or superannuation; cash on hand or in bank accounts/safety deposit; investments; and personal property (e.g., motor vehicles).
- c. **Disclose information related to clinical record** — The person permits or allows others to have access to, or to examine the information in, his or her clinical record.
- d. **Guardian/substitute decision-maker** — Someone designated to be responsible for the financial or personal care needs of the person.

### Process

**Items A4a, A4b and A4c:** Check the medical record for this admission for the presence of the necessary forms declaring the person incapable to consent to treatment, manage property or disclose information relating to the clinical record.



**Item A4d:** This item can be obtained directly from the person or from other sources, such as the family, other health care workers or the medical record. Ask directly about the existing status of guardianship or a substitute decision-maker.

### Coding

Items A4a, A4b and A4c

**Code “0”** if the person has not been deemed incapable and no documentation is present.

**Code “1”** if supporting documentation is on the chart declaring the person incapable in the specific domain.

Item A4d

**Code “0”** if the person does not have a guardian/substitute decision-maker for financial or personal affairs who is acting on his or her behalf.

**Code “1”** if the person has a guardian/substitute decision-maker acting on his or her behalf for either financial or personal affairs.

## A5. Police Intervention

### Intent

To determine if the person has been involved with the police (other than as a victim) and the nature of the involvement. This information is important for understanding the nature of the person’s history as it relates to any involvement with the police. It is important for care planning and provides a marker regarding the intensity of the problem behaviour.

### Definitions

Police intervention is any history of police contact/intervention (e.g., arrests, police escort to hospital for psychiatric examination, police intervention to de-escalate a situation with no resulting charges). This item excludes any contact with the police that involved the person as a victim or civil litigation.

**A5a. Violent** — Violent circumstances include incidents that result in (or could potentially result in) some form of bodily harm to others. Included are threats, intimidations and attempts to be violent toward others. Robbery is often categorized as a violent crime since it involves face-to-face contact between perpetrator and victim. In contrast, break and enter is more likely to be classified as non-violent, since the intent is to avoid contact with and detection by victims.

**A5b. Non-violent** — Many circumstances that lead to police intervention fall under this broad category (fraud, automotive theft, trespassing, etc.). Property damage would be included here, unless the intent was to intimidate or threaten others (which would be classified as a violent circumstance).

### Process

People are not always honest about or willing to share information about their police contact. You may approach the subject by asking the person if he or she has ever been in trouble with the law. Validate this information with referral sources and a review of clinical records.

### Coding

Code for the most recent instance of contact with the police for violent behaviour and non-violent behaviour.

**Code “0”** for never.

**Code “1”** for more than 1 year ago.

**Code “2”** for 31 days to 1 year ago.

**Code “3”** for 8 to 30 days ago.

**Code “4”** for 4 to 7 days ago.

**Code “5”** for the last 3 days.

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#### Validation

If CC2f Reason for Admission — Justice System = 1 or CC2h Reason for Admission — Forensic Assessment = 1, then A5a Police Intervention for Violent Behaviour and A5b Police Intervention for Non-Violent Behaviour cannot both = 0.

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If A3b Inpatient Status at Time of Assessment = 5, then A5a Police Intervention for Violent Behaviour and A5b Police Intervention for Non-Violent Behaviour cannot both = 0.

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If Q5 Current Patient Type = 4, then A5a Police Intervention for Violent Behaviour and A5b Police Intervention for Non-Violent Behaviour cannot both = 0.

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## Section B — Mental status

The information collected in this section will be important for care planning and assessing the outcomes of clinical interventions.

### B1. Mental State Indicators

#### Intent

To provide a profile of the person’s mental state of the last 3 days by recording the frequency of a number of indicators. The information can be used for care planning and quality indicators and, when combined with other items in the instrument, provides information relevant to the severity of the illness.

This section is divided into 5 subsections: Mood Disturbance, Anxiety, Psychosis, Negative Symptoms and Other, with each subsection containing key indicators. However, the indicators are not necessarily exclusive to a subsection; therefore, caution should be taken to avoid completing this section based on diagnosis. Rather, consider the observable signs of all indicators and document accordingly.

#### Definitions

##### Indicators of Mood Disturbance

- a. **Facial expression** — Objective observations of facial expression (e.g., furrowed brow) that indicate the person is worried, sad or pained.
- b. **Tearfulness** — Objective observation or subjective reporting that the person has had periods of tearfulness or crying throughout the assessment period.
- c. **Decreased energy** — Subjective reporting from the person indicating a decline in energy level (e.g., “I just don’t feel like doing anything,” “I have no energy”).
- d. **Made negative statements** — Subjective reporting indicating the person has a negative view of his or her world at the present time (e.g., “Let me die,” “What’s the use?”).
- e. **Self-deprecation** — Subjective reporting indicating a negative view of self (e.g., “I am nothing,” “I am no use to anyone”).
- f. **Guilt/shame** — Any statement suggesting a feeling of self-blame, self-reproach, self-accusation or shame, regardless of the legitimacy or cause of the feelings (e.g., “This is all my fault,” “I am a terrible person”).
- g. **Hopelessness** — Subjective reporting of a negative view for the future or future circumstances, with little or no hope for change (e.g., “Nothing’s going to change for the better”).

- h. **Inflated self-worth** — Exaggerated self-opinion, arrogance, inflated belief about his or her own ability, etc.
- i. **Hyperarousal** — Observations of motor excitation, increased reactivity and exaggerated startle response.
- j. **Irritability** — A marked increase in being short-tempered or becoming easily upset.
- k. **Increased sociability or hypersexuality** — A marked increase in social or sexual activity; unusually high activity.
- l. **Pressured speech/racing thoughts** — Rapid speech or rapid transition from topic to topic.
- m. **Labile affect** — Objective observation of rapid, abrupt shifts in affect (e.g., the person may be observed to have periods of tearfulness alternating with laughter, with or without an external explanation).
- n. **Flat or blunted affect** — Objective observation of an absence or severe reduction in the intensity of affective expression (e.g., the person appears indifferent or unresponsive).

### Indicators of Anxiety

- o. **Anxious complaints** — Verbalizations focusing on issues that are of worry or concern where the person persistently seeks attention or reassurance (e.g., she or he frequently expresses concern about being on time for an appointment with a therapist, worries that the spouse will not come to visit, worries about an upcoming weekend pass). Do not include health-related concerns in this item, as they are entered in B1cc — Health Complaints).
- p. **Fears/phobias** — Expression (including non-verbal) of what appear to be unrealistic fears, such as fear of being abandoned or left alone or fear of being with others; or reporting of a persistent, irrational, intense fear of a specific object or situation (e.g., agoraphobia, claustrophobia).
- q. **Obsessive thoughts** — Unwanted, intrusive ideas or irrational thoughts that cannot be eliminated through conscious attempts by the person to ignore or suppress them (e.g., thoughts about being responsible for a tragedy, sinister thoughts about his or her children, reporting that he or she “just can’t get this thought out of my head”).
- r. **Compulsive behaviour** — An uncontrollable, persistent urge to perform an act repetitively, often according to certain rules, manner or pattern (e.g., handwashing, checking appliances, avoiding stepping on cracks on the sidewalk or tiled flooring).
- s. **Intrusive thoughts/flashbacks** — Disturbing memories, nightmares or images that intrude into the person’s thoughts; unwanted recall of adverse events.
- t. **Episodes of panic** — The person unexpectedly becomes overwhelmed by a sense of panic.

## Indicators of Psychosis

- u. **Hallucinations** — False sensory perceptions, with or without insight, without corresponding stimuli. These may occur in 1 or more of the senses: hearing (auditory hallucinations), seeing (visual hallucinations), feeling (tactile hallucinations), tasting (gustatory hallucinations) and smelling (olfactory hallucinations). Do not include command hallucinations in this item.
- v. **Command hallucinations** — Hallucinations directing the person to do something or to act in a particular manner (e.g., a voice telling the person to hide in a contained space to avoid contact with enemies or saying that the person must kill his or her father before the father kills the person). Command hallucinations are separated out from the others because of their severity and the potential lethality resulting from acting on the hallucination.
- w. **Delusions** — Fixed, false, unchangeable beliefs of any of the following types: delusions of grandeur — a false belief that one’s own importance is greatly exaggerated; paranoid/persecutory delusions — a false belief of being attacked, harassed, cheated, persecuted or conspired against; somatic delusions — a false belief related to the body, such as believing that one has cancer, despite exhaustive negative testing. Exclude beliefs specific to the person’s religion or culture.
- x. **Abnormal thought process/form** — Objective observations indicating abnormalities in the form or way in which the person is expressing thoughts. Include indicators such as loosening of association, thought-blocking, flight of ideas, tangentiality, circumstantiality, clang association, incoherence, neologisms and punning.

## Negative Symptoms

- y. **Anhedonia** — Any statement suggesting a general lack of, or inability to experience, pleasure with any aspect/event of life that may have previously given the person a sense of enjoyment.
- z. **Loss of interest** — Withdrawal from activities of interest or from long-standing social relations (e.g., no interest in long-standing activities or being with family/friends).
- aa. **Lack of motivation** — Subjective reporting or objective observation of an absence of spontaneous goal-directed activities (activities that are purposeful and have an expectation of accomplishment, impact or meaning) related to any aspect of living. Examples are ADLs, IADLs, and social and recreational activities (e.g., the person may show limited or no motivation to get dressed in the morning, get ready for meals, attend to grooming or attend activities).
- bb. **Reduced interaction** — Objective observation of reduced social interaction, as noted by activities such as being less talkative, being more isolated in social situations or secluding self in his or her room.

## Other Indicators

- cc. **Health complaints** — Repetitive health complaints, but not to the degree of being a somatic delusion (e.g., persistently seeking medical attention, excessive concern over bodily functions such as bowel movements).
- dd. **Anger** — Persistent periods of anger with self or others (e.g., being easily annoyed, expressing anger about his or her admission to the facility or the care received).
- ee. **Unusual or abnormal physical movements** — Objective observation of unusual facial expressions or mannerisms (e.g., looking over to the side with no external stimulus to prompt such a gesture), peculiar motor behaviour or body posturing (e.g., waxy flexibility) or maintaining an unusual body position for an extended period of time.
- ff. **Hygiene** — The person is observed to have unusually poor hygiene, well beyond what is considered culturally appropriate, or has an unkempt or dishevelled appearance.
- gg. **Sleep problems** — Can include 1 or more of the following:
  1. **Difficulty falling asleep**, as indicated by the person experiencing an extended time gap between the point at which he or she attempted to fall asleep and the time at which sleep was actually initiated.
  2. **Restless or non-restful sleep**, as indicated by the person's sleep being accompanied by repeated tossing and turning, dreaming, etc. and the fact that he or she does not feel relaxed when sleeping or rested when awake.
  3. **Interrupted sleep**, as indicated by the person being easily awakened during sleep by sounds or movements and experiencing 1 or more periods of awakening after sleep is initiated or awakening earlier than desired, as indicated by the person waking up well before the desired time and being unable to get adequate sleep, regardless of how tired she or he is. (**Note:** Exclude situations in which the person is awakened by some external source, such as a nurse or a noisy roommate. This item is intended to assess only those situations where the person wakes up due to some factor inherent to him or her.)
  4. **Too much sleep**, as indicated by the person complaining of, or being observed to be, sleeping more than is usual for the person.

## Process

Much of the above information can be obtained through a chart review, observation and checking with other staff or family or friends. If information is not available from these sources, interviewing the person in a manner similar to doing a mental status examination will yield the necessary information (keeping in mind the need to assess frequency). In situations where there is a discrepancy between what the person reports and what others report, use your clinical judgment to determine the best response.

## Coding

Code for the presence of each indicator over the last 3 days, regardless of the number of times per day it occurred. For example, if a behaviour occurs only once in 1 of the last 3 days, code “2.” If the behaviour is present on all 3 days and is persistent over that time frame **or** was observed to occur only once a day, but on all 3 days, code “3.”

**Code “0”** if there is no indication that the indicator was present in the last 3 days.

**Code “1”** if there is no indication that the indicator was present in the last 3 days, but the person has been reported to have had episodes of the indicator in the recent past and it continues to have a meaningful impact on the person’s care needs.

**Code “2”** if the indicator was present on 1 or 2 of the last 3 days.

**Code “3”** if the indicator was present on all 3 of the last 3 days.

## B2. Insight Into Mental Health

### Intent

To determine the person’s level of awareness of his or her mental health problems and the contributing factors. Insight in this context is not intended to imply an in-depth understanding of the signs and symptoms that the person is experiencing. Rather, the person is assessed as having insight if there is recognition of a problem and that he or she needs some help. The level at which the person is aware of his or her problems is an important factor to consider for care planning, treatment and the person’s willingness to participate in a treatment plan.

### Process

Insight can be assessed by asking the person about his or her view of the present situation or what the person thinks is happening to him or her. Is there recognition that a problem exists? Does the person recognize the causes and the need for help?

### Coding

**Code “0”** if the person recognizes that a problem exists and appears to understand the problem or that he or she needs treatment.

**Code “1”** if there is limited insight (i.e., the person acknowledges the problem but may not be able to identify causative factors).

**Code “2”** if the person appears to have no awareness of difficulties or the presence of a mental health problem.

## Section C — Substance use and excessive behaviours

The data collected in this section will be used for early detection of and intervention with addictions. This is important to know because of the impact of substance abuse on the course of the psychiatric illness.

### C1. Alcohol

#### Intent

To document the number of alcoholic drinks in a single sitting during the last 14 days. This information can be helpful in determining the presence of a potential problem and subsequent care planning.

#### Definitions

**Alcoholic drinks** — Includes beer, wine, liquor and liqueurs.

**Single sitting** — A single sitting refers to any given point in time (e.g., at dinner, after work, while out at a social event).

#### Process

Ask the person and, if possible, family members about the amount of alcohol consumption at various times in the last 14 days. If there is a discrepancy in reporting the amount taken at a single sitting, use your best clinical judgment to code this item.

#### Coding

Code for the single sitting with the highest number.

**Code “0”** if no alcoholic drinks were consumed in the last 14 days.

**Code “1”** if the person or others report that the person had only 1 drink at any given sitting in the last 14 days.

**Code “2”** if the person consumed 2, 3 or 4 alcoholic drinks at any given sitting in the last 14 days.

**Code “3”** if the person consumed 5 or more alcoholic drinks at any given sitting in the last 14 days.



## C2. Substance Use

### Intent

To obtain an inventory of substances that the person may be taking or has taken in the past. These substances can have particularly harmful effects when combined with certain medications that the person may be taking concurrently.

**Note:** C2 includes any of the drugs listed in C2a–f, whether prescribed or illicit.

**Note:** Misuse of any prescribed drugs (including prescribed drugs coded in C2a–f) should be captured in K4 — Intentional Misuse of Medication.

### Definitions

- a. **Inhalants** — Hydrocarbons found in inhalants are sniffed by users to achieve a “high” and include substances like glue, gasoline, paint, paint thinner and solvents.
- b. **Hallucinogens** — Examples include phencyclidine or “angel dust,” LSD or “acid,” magic mushrooms and ecstasy. These substances are known for the hallucinations they produce.
- c. **Cocaine and crack** — Powerful stimulants derived from the coca plant that can be inhaled or smoked.
- d. **Stimulants** — Examples include amphetamines, such as uppers, speed and methamphetamine. Stimulants are often used to control normal fatigue and create feelings of euphoria.
- e. **Opiates** — For example, heroin.
- f. **Cannabis** — Any of various preparations of different parts of the hemp plant that are smoked, chewed or drunk for their intoxicating or hallucinogenic properties.

### Process

Asking about substance-related problems can be introduced to the person by letting him or her know that this information is important for care planning or treatment (e.g., possible medication interactions). Observe the person’s body language and any reluctance in responding. If unsure of the accuracy of the person’s response, you may want to check with others (family, friends, community workers) to determine if they know whether the person has used these substances. If the person’s response is in disagreement with these sources, the assessor must go with his or her clinical judgment in completing this section.

## Coding

Code for the most recent time that each substance was used.

**Code “0”** if the person has not taken the substance at any time in the last year or if the substance was used, but it was more than a year ago.

**Code “1”** if the substance was used in the last year, but not within the last 3 months.

**Code “2”** if the substance was used in the last 3 months, but not in the last month.

**Code “3”** if the substance was used in the last month, but not in the last 7 days.

**Code “4”** if the substance was used in the last 7 days, but not in the last 3 days.

**Code “5”** if the substance was used in the last 3 days.

## C3. Withdrawal Symptoms

### Intent

To identify and document the severity of signs or symptoms indicative of withdrawal from alcohol or drugs in the last 3 days in order to assist with care planning around potential or actual withdrawal.

### Definitions

#### 0. None present

1. **Mild** — Symptoms that are typical of early stages of withdrawal from alcohol or drugs (e.g., agitation, “jitters,” cravings, gastrointestinal upset, anxiety, hostility, vivid dreaming).
2. **Moderate** — Symptoms that are typical of the mid-stage of withdrawal, including a noted increase in the severity of early-stage symptoms, as well as weakness, sweating, hot flashes, fainting and muscle twitching.
3. **Severe** — Symptoms that are typical of late stages of withdrawal from alcohol or drugs, including exhaustion, seizures, tremors, tachycardia, disorientation and hyperventilation.

### Process

Clinical observation and reporting from the person and those who have been with the person over the last 3 days are the best sources for information about withdrawal symptoms.

### Coding

Code for the most severe stage observed in the last 3 days. If the person has symptoms typical of the mid-stage of withdrawal and also has symptoms related to late stages, code “3” for Severe.

## C4. Patterns of Drinking or Other Substance Use

### Intent

To identify behaviours that would indicate that the person may have had a problem with an alcohol or drug addiction in the last 3 months.

### Definitions

- a. **In the last 3 months, the person felt the need or was told by others to cut down on drinking or drug use, or others were concerned about the person’s substance use** — People in the person’s life, or the person, express concern regarding the person’s alcohol consumption or use of substances. The concern may have various motivations. For example, a person may be concerned about his or her own amount of drinking since finding out about a friend who recently died from liver disease, or a spouse may express concern that the person drinks too much since losing a job. The person, the family or others may also report that there has been trouble because of substance use. For example, the person’s family or friends may have withdrawn because of the person’s behaviour when drunk or high, or the person’s driver’s license may have been taken away because of driving while under the influence of alcohol and/or drugs.
- b. **In the last 3 months, the person has been bothered by criticism from others about drinking or drug use** — The person, family members or others indicate that the person becomes angry or agitated when others express disapproval of the person’s substance use. The person may say that it is “no one else’s business how much I drink” or that others are too critical and there is nothing wrong with having a few drinks or using a few drugs.
- c. **In the last 3 months, the person has reported feelings of guilt about drinking or drug use** — The person, the family or others report that the person has given indications that he or she feels guilty about his or her substance use. This guilt could have several origins. For example, the person may feel guilty about the emotional and financial distress it has caused the family, the embarrassment it has caused loved ones or the way he or she treats others when under the influence of alcohol and/or drugs.
- d. **In the last 3 months, the person had to have a drink or use drugs first thing in the morning to steady his or her nerves (e.g., as an “eye opener”)** — The person, the family or the significant other reports that the person drinks and/or uses drugs, or has been observed to do so, early in the day. The person may use the phrase “I need an eye opener.”

## **Process**

Engage the person in a conversation about his or her patterns of substance use. This information may be sensitive to the person or create uneasy feelings within the assessor. Care must be taken to acknowledge these feelings. Begin asking the person about alcohol and drugs with a simple non-judgmental statement like “Do you drink?” or “Do you ever get high?” It is important that the person does not feel judged to be doing something wrong. Address substance use with the person in a gentle way, e.g., “Like the other questions I asked, I am just trying to find out about you . . . it doesn’t mean that what you are doing is wrong.” Ask the person how he or she feels about his or her drinking and/or drug use. Ask if others express disapproval of this behaviour; if the answer is affirmative, ask how this criticism makes the person feel. Discuss the person’s substance use with family members. This discussion should not take place in front of the person.

## **Coding**

Code observations reported by the person himself or herself **or** by others.

**Code “0”** for items that do not apply to the person’s situation or if the person does not drink or use drugs.

**Code “1”** for items that reflect the person’s situation over the last 3 months, regardless of the amount or number of days of drug and/or alcohol use, the number of people who expressed a concern or the number of times the concern was raised in the last 3 months.

## **C5. Smoking**

### **Intent**

To determine if the person is addicted to nicotine.

### **Process**

Ask the person directly if he or she smokes or chews tobacco and how often or how much. Consult with other staff or family members. Reassure the person that he or she is not being judged on smoking behaviour and that this is simply a further effort to find out more about him or her.

### **Coding**

**Code “0”** if the person does not smoke or chew tobacco.

**Code “1”** if the person has not smoked or chewed tobacco in the last 3 days, but is a daily smoker.

**Code “2”** if the person has smoked or chewed tobacco in the last 3 days.

## C6. Gambling

### Intent

To determine if the person has been gambling excessively or uncontrollably in the last 3 months.

### Definitions

**Excessive or uncontrollable behaviours** — The person partakes in behaviour excessively and does not seem able to ignore the urge to partake in the behaviour.

**Gambling** — Includes gambling of any type (e.g., casino gambling, horse races, lottery tickets).

### Process

Ask the person if he or she has had difficulty controlling the amount or number of times he or she spends gambling because he or she liked doing it or felt the need to do it, despite negative consequences or the concern of others. Because the person may not be willing to be entirely honest about his or her participation in this behaviour, it is important to consult with family, friends and other staff who have worked closely with the person.

### Coding

**Code “0”** if there is no indication that the person has gambled excessively or uncontrollably in the last 3 months.

**Code “1”** if the person has gambled excessively or uncontrollably in the last 3 months.

## Section D — Harm to self and others

Tracking safety and security information is vital to the initial and subsequent care plans for the person. To mitigate risk and increase awareness of potential or actual concerns, great care should be taken to accurately code this section based on the best available evidence and comprehensive assessment. Direct questioning of the person is required when assessing for violence, whether directed at self or others. This information is combined with evidence from the clinical record, family, caregivers and health professionals to establish the level of risk.

### D1. Self-Injury

#### Intent

To identify individuals engaging in or who are at risk of engaging in self-injurious behaviour.

## **D1a. Most Recent Self-Injurious Attempt**

Includes both lethally motivated suicidal behaviour (intentional, self-inflicted attempt to kill oneself) and behaviour that inflicts intentional self-injury without suicidal intent (e.g., self-mutilation). Non-intentional, accidental or unconscious self-destructive behaviours that may lead to injury or premature death (such as chronic substance abuse, hyper-obesity, non-compliance with treatments for illness or risk-taking behaviour) are not considered self-injurious behaviours for the purposes of this item.

### **Process**

Interview the person and consult with others. Family, if available, should be interviewed separately from the person so that they may express their feelings openly. Check the clinical record.

### **Coding**

Code for the most recent instance. Include non-intentional behaviours during psychotic episodes and compulsive self-stimulation.

**Code “0”** for never.

**Code “1”** for more than 1 year ago.

**Code “2”** for 31 days to 1 year ago.

**Code “3”** for 8 to 30 days ago.

**Code “4”** for 4 to 7 days ago.

**Code “5”** for the last 3 days.

## **D1b. Intent of Any Self-Injurious Attempt Was to Kill Self**

### **Intent**

To determine whether the intent of the self-injurious act was to kill self.

### **Definition**

**Intent** — The self-injurious action was intentionally undertaken with the aim of ending the person’s own life (regardless of the potential lethality of the method).

### **Process**

Interview the person and consult with family, if available. Family should be interviewed separately from the person, if possible. Check the clinical record.

**Coding**

Code for intent to end his or her life.

**Code “0”** for no.

**Code “1”** for yes.

**Code “8”** for no attempt.

**D1c. Considered Performing a Self-Injurious Act****Intent**

To determine if the person has thought about performing an act of self-injury. This includes a command hallucination that is telling the person to harm himself or herself.

**Process**

Interview the person and consult with others. Family, if available, should be interviewed separately from the person so that they may express their feelings openly. Check the clinical record.

**Coding**

Considered performing a self-injurious act:

**Code “0”** for never.

**Code “1”** for more than 1 year ago.

**Code “2”** for 31 days to 1 year ago.

**Code “3”** for 8 to 30 days ago.

**Code “4”** for 4 to 7 days ago.

**Code “5”** for the last 3 days.

**Validation**


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If D1a Self-Injury — Most Recent Attempt = 0, then D1b Self-Injury — Intent must = 8.

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If D1a Self-Injury — Most Recent Attempt does not = 0, then D1c Self-Injury — Considered must not = 0.

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If D1a Self-Injury — Most Recent Attempt is (1, 2, 3, 4 or 5), then D1b Self-Injury — Intent cannot = 8.

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## **D1d. Other Indicators of Self-Injurious Behaviour**

### **Intent**

To identify other indicators of risk of possible self-injury.

### **Definitions**

D1da. **Family, caregiver, friend or staff expresses concern that person is at risk for self-injury** — The person’s behaviour indicates to someone else (including a member of the health care team) that he or she is at risk for self-injury, whether or not the person has verbalized thoughts of harming himself or herself.

D1db. **Suicide plan** — In the **last 30 days**, the person formulated a scheme to end his or her life.

### **Process**

Interview the person and consult with others. Family, if available, should be interviewed separately from the person so that they may express their feelings and concerns openly. Check the clinical record.

### **Coding**

D1da. Family, caregiver, friend or staff expresses concern that person is at risk for self-injury

**Code “0”** for no.

**Code “1”** for yes.

D1db. Suicide plan

**Code “0”** for no.

**Code “1”** for yes.

## **D2. Violence**

### **Intent**

To identify those who are or are at risk of becoming violent. These items focus on acts of ill-will, active opposition, hostility or antagonism that may be directed to others or inanimate objects. Past violence is often the best predictor of future violence. Awareness of those with violent tendencies can help the health care team with management strategies and protect the person, staff and others.



## Definitions

- a. **Violence to others** — Violent acts that result in physical harm to another person. These are characterized by **purposeful, malicious or vicious intent** by the perpetrator and can include violence driven by command hallucinations. Violent actions can include, but are not limited to, any physical act of harm to another, such as stabbing, choking or hitting/ beating (with or without a weapon).
- b. **Intimidation of others or threatened violence** — Attempts by the person to force or deter someone by using threatening gestures, a threatening stance with no physical contact, shouting angrily, aggressive or intimidating staring, yelling personal insults or curses, using foul language in anger, kicking the wall, throwing furniture, etc. The person may also make explicit threats of violence against others.
- c. **Violent ideation** — The person reports (or someone else has credible information) that the person has had premeditated thoughts, made statements, fantasized or planned to take actions of violence toward others.

## Process

This information can be obtained through family, therapist or self-report, clinical records, arrest records and other records of judicial proceedings, if available. Family members should be interviewed away from the person so that they can speak openly.

## Coding

For each item, code for the most recent instance.

**Code “0”** for never.

**Code “1”** for more than 1 year ago.

**Code “2”** for 31 days to 1 year ago.

**Code “3”** for 8 to 30 days ago.

**Code “4”** for 4 to 7 days ago.

**Code “5”** for the last 3 days.

### **D3. History of Sexual Violence or Assault as Perpetrator**

#### **Intent**

To document whether the person has engaged in sexual violence towards others in the past. A prior history of sexual violence or assault is a strong predictor of such future acts. Care planning should consider methods to prevent such acts and to protect staff and others.

#### **Definition**

Sexual violence or assault is any attempted or completed instances of sexual violence, such as heterosexual or homosexual pedophilia or incest, rape of adult males or females, exhibitionism to adult males, females or children, or sexual violence toward family members or others.

#### **Process**

The person may or may not disclose this information. The information can also be obtained from family, therapists, arrest records or other available documentation.

#### **Coding**

Code for any known history of sexual violence as a perpetrator.

**Code “0”** for no.

**Code “1”** for yes.

## **Section E — Behaviour disturbance**

People with mental health problems may exhibit behaviours that can lead to harm to themselves or to other people. The assessment elements in this section are designed to capture information on behaviours that pose a potential risk to self or others and/or that tend to be socially inappropriate.

### **E1. Behavioural Symptoms**

#### **Intent**

To identify the frequency of behavioural symptoms that cause distress to the person or are distressing or disruptive to others with whom the person comes in contact. This item is designed to pick up problem behaviours exhibited by the person in the last 3 days. Acknowledging and documenting behavioural symptoms provides a basis for further evaluation, care planning and delivery of consistent, appropriate care aimed at ameliorating the behavioural symptoms.

## Definitions

- a. **Wandering** — The person moves about with no discernible, rational purpose. A wandering person 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 around the unit in search of food). Wandering may be by walking or by wheelchair. Do not include pacing and elopement (see below) as wandering behaviour.
- b. **Verbal abuse** — Verbally intimidating, threatening, screaming at, demeaning, humiliating or cursing at family members, staff or others.
- c. **Physical abuse** — Any violence towards others, regardless of intent. This item identifies physically aggressive behaviour without making an “intentional” or “unintentional” distinction, whereas section D2a (Violence) identifies purposeful, malicious or vicious intent. People who were identified in the Violence item (D2a) will also be identified in this section, but other people who are physically abusive without the malicious intent (e.g., those with dementia) would be identified in this item only.
- d. **Socially inappropriate/disruptive behavior** — This includes, but is not limited to, behaviours such as making disruptive sounds, making noise, screaming, spitting, smearing/throwing food/feces, rummaging through others’ belongings, hoarding articles or stealing.
- e. **Inappropriate public sexual behaviour (or public disrobing)** — Sexual behaviour should only be considered inappropriate when it contravenes usual social norms (e.g., the person deliberately exposing himself or herself, masturbating in public or in a room while staff are present, making unacceptable sexual gestures, touching, pinching). Sexual activity done in private is not considered here. Public disrobing targets dress behaviour that contravenes local community laws/by-laws. In the case of disrobing, you should remember to code for the absence or presence of the behaviour and not the intent. For example, if a person reports that she or he was undressing in public because there were no private places available, you would still code this item as “1” or higher.
- f. **Resistance to care** — The person resists taking medications/injections or pushes caregiver during ADL assistance. This category does not include instances where the person has made an informed choice not to follow a course of care (e.g., he or she has exercised the right to refuse treatment and reacts negatively as others try to reinstate treatment). Signs of resistance may be verbal or physical.
- g. **Elopement attempts/threats** — The person attempts to leave, or actually leaves, the unit without the staff’s knowledge and/or formal discharge (e.g., unauthorized leave of absence). This includes the intent to abscond without leave for any reason, as well as occasions when the person threatens to leave the unit, making him or her an elopement risk.

## Process

It is important to start the assessment by recording any behavioural symptoms. The fact that others may have become familiar with the behaviour and minimize the person’s presumed intent (“He doesn’t really mean to hurt anyone. He’s just frightened.”) is not pertinent to this coding. Does the person manifest the behavioural symptom or not? This is the test you should use in coding these items. Observe the person during your assessment. Observe how he or she responds to attempts by caregivers to deliver care. Check with the person’s medical chart to see if any incidents are documented. Consult with family members and staff who provide direct care. Ask if they know what occurred throughout the day and night for the last 3 days and nights or if they are aware of past incidents.

## Coding

**Code “0”** if the behavioural symptom was not exhibited in the last 3 days.

**Code “1”** if there is no indication that the behaviour was present in the last 3 days, but the person has been reported to have had episodes of the behaviour in the recent past and it continues to have a meaningful impact on the person’s care needs.

**Code “2”** if the behavioural symptom occurred on 1 or 2 days during the last 3-day period, regardless of the number of times it occurred on each day. The behaviour did not occur on all 3 days.

**Code “3”** if the behavioural symptom occurred every day during the last 3-day period, regardless of the number of times per day it occurred.

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### Validation

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E1a Wandering must be coded as 0 (Indicator not exhibited in the last 3 days) when G1b Walking and G1c Wheeling are coded as 6 (Total dependence) or 8 (Activity did not occur).

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## E2. Extreme Behaviour Disturbance

### Intent

To assess if caregivers have concerns, due to knowledge of prior behaviours, that the person may pose a serious current risk of harm to self or others.

### Definition

Extreme behaviour disturbance is any type of **extreme** behaviour known to have put the person or others at **serious** risk. Examples include homicide, rape, torture of humans or animals, assault resulting in serious injury to another person, severe self-mutilation, a suicide attempt that would very likely have been successful or a history of fire-setting that caused, or had the potential to cause, serious damage to people or property.

**Process**

Consult the person’s medical record, other staff, referral sources, community supports or others who are familiar with the person’s behaviour.

**Coding**

**Code “0”** if there is no concern that there is a current serious risk of harm to self or others based on the person’s previous behaviour.

**Code “1”** if the person’s behaviour prior to the last 7 days suggests a current serious risk of harm to self or others.

**Code “2”** if the person demonstrated an extreme behaviour during the last 7 days that placed the person or others at serious risk.

**Section F — Cognition**

This section assesses the person’s abilities to think coherently and to remember and organize thoughts into actions, including daily self-care activities. These items focus on the person’s functional performance, including demonstration of the ability to remember recent events and to perform key decision-making skills. This information can significantly contribute to the development of a care plan, including the discharge plan.

Questions about cognitive function and memory can be threatening or sensitive for some people. Some may react defensively or become agitated if they are unable to remember or answer the questions. It is important to recognize these responses and to be as supportive as possible.

It is also important to establish an environment that enables the person to function at an optimal level. Be sure to interview the person in a private, quiet area (e.g., limit distractions and interruptions as much as possible) and not in the presence of other people or family, unless the person would prefer that they stay. Clarify and validate your findings with the person’s family or other clinicians as needed, especially when the person has limited communication skills or a language barrier.

- Engage the person 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 person (e.g., “Do you sometimes have trouble remembering things? Tell me what happens. I will try to help you.”).

If the person becomes very agitated, respond to his or her feelings of agitation and **stop** discussing cognitive function. The information-gathering process does not need to be completed in 1 sitting, but may be ongoing during the entire assessment period. Say to the agitated person, 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 person’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.

## **F1. Memory/Recall Ability**

### **Intent**

To determine the person’s functional capacity to remember recent events (short-term memory) and to assess the person’s ability to perform sequential activities over the last 3 days.

### **Definitions**

- a. **Short-term memory** — The ability to remember recent events.
- b. **Procedural memory** — The cognitive ability to perform sequential activities.

### **Process**

**Short-term memory:** To assess short-term memory, ask the person to remember 3 unrelated items (e.g., book, watch, table). After you have named all 3 items, ask the person to repeat them back to you (to verify that you were heard and understood by the person). Then proceed to talk about something else — perhaps another part of the assessment. Do not be silent. Do not leave the room. In 5 minutes, ask the person to repeat the name of each item. If the person is unable to recall all 3 items, code “1,” Memory problem.

You could also ask the person to describe a recent event that both of you have had the opportunity to remember. (You should be able to validate the person’s memory with your knowledge of such an event.) Examples include what the person had for breakfast or when the person received his or her last medication dosage. (You can validate the person’s recollection with information from the medical record.) For persons with verbal communication deficits, non-verbal responses are acceptable (e.g., when asked how many children the person has, he or she can correctly tap out a response of the appropriate number). If there is no positive indication of memory ability, code “1,” Memory problem.

**Procedural memory:** Procedural memory can be assessed by reviewing any task that has multiple steps (e.g., dressing, having a bath or shower). The person must be able to perform or remember to perform all or most of the steps in sequential order to be assessed as not having a procedural memory problem. If the person demonstrates difficulty in 2 or more steps, code “1.”

**Coding**

For items F1a and b

**Code “0”** if the person’s memory appears to be okay.

**Code “1”** if the person seems to have a memory problem.

**F2. Cognitive Skills for Daily Decision-Making****Intent**

To record the person’s ability and actual performance in making everyday decisions about the tasks or activities of daily living. This item is especially important for further assessment and care planning for 2 reasons: 1) the information can alert health care providers to new changes (decline or improvement) in the person’s cognitive function; and 2) the information can alert staff to a discrepancy between a person’s capacity for decision-making and his or her current level of performance. This may indicate that caregivers or family may be inadvertently fostering the person’s dependence and may have an impact on the course of treatment and the discharge plan.

**Process**

Consult the person first and then a family member or others who know the person. Observations of the person can also be helpful. Review the events of each day with the person. The inquiry should focus on whether the person is actively making these decisions and not on whether there is the belief that the person might be capable of doing so. Remember, the intent of this item is to record what the person is doing (performance). When another person takes decision-making responsibility away from the person regarding tasks of everyday living or the person does not participate in decision-making, whatever his or her level of capability may be, the person should be considered to have impaired performance in decision-making. In this case, document how the person functions now versus her or his capacity to function.

This item also requires you to differentiate between an ability or lack of ability to participate in decision-making or a lack of opportunity to do so versus being involved in making decisions that others may not agree with (e.g., refusing treatments, refusing to have a shower). The latter would not be considered impairment if the person was actively involved in making the decision.

## Coding

Enter the number that most accurately characterizes the person’s cognitive performance in making decisions regarding the tasks of daily life over the last 3 days.

Code for decisions the person is actually making, not for decisions others *believe* the person is capable of making.

**Code “0” for Independent** — The person’s decisions in planning and executing daily routines and making decisions were consistent, reasonable, safe and organized, reflecting lifestyle, culture and values.

**Code “1” for Modified Independence** — The person was organized in daily routines and made safe decisions in familiar situations but experienced some difficulty in decision-making when faced with new tasks or situations.

**Code “2” for Minimally Impaired** — For the most part, the person was organized in daily routines and made safe decisions, but in specific situations the person demonstrated poor or unsafe decision-making skills and required cues or supervision.

**Code “3” for Moderately Impaired** — The person consistently demonstrated poor or unsafe decision-making skills. The person needs reminders, cues and supervision in planning, organizing, correcting and carrying out daily routines at all times.

**Code “4” for Severely Impaired** — The person’s decision-making was severely impaired; the person never (or rarely) made decisions.

**Code “5” for No Discernible Consciousness** — The person was non-responsive.

## F3. Indicators of Delirium — Periodic Disordered Thinking/Awareness

### Intent

To assess and record behavioural signs that may indicate that delirium is present. The characteristics of delirium are often manifested behaviourally and therefore can be observed. For example, disordered thinking, a typical characteristic of delirium, may first be observed as rambling, irrelevant or incoherent speech. Other typical behaviours are described in the definitions below.

### Definitions

- a. **Easily distracted** — The person has episodes of difficulty paying attention and does not complete tasks or conversations without getting sidetracked.
- b. **Periods of altered perception or awareness of surroundings** — For example, the person moves his or her lips or talks to someone not present (excluding prayers), believes he or she is somewhere else and confuses night and day.



- c. **Episodes of disorganized speech** — The person speaks in an incoherent, nonsensical or irrelevant manner, rambling from subject to subject, and loses his or her train of thought.
- d. **Periods of restlessness** — Examples are fidgeting or picking at skin, clothing and napkins; frequently changing positions; repetitive physical movements; and calling out.
- e. **Periods of lethargy** — For example, sluggishness, staring into space, difficult to arouse, little body movement.
- f. **Mental function varies over the course of the day** — Alertness and behaviours vary during the course of the day (sometimes better, sometimes worse; behaviours are sometimes present and sometimes not).

### Process

Ask the person or others who know the person if any of the behaviours have been noticed over the last 3 days. If the response is yes, determine if the behaviour is different from the person's usual functioning.

### Coding

Code for the person's behaviour in the last 3 days, regardless of what you believe the cause to be. Focus on when the manifested behaviour first occurred.

**Code "0"** if the behaviour was not present.

**Code "1"** if the behaviour was present in the last 3 days but is not of recent onset.

**Code "2"** if the behaviour was present over the last 3 days and appears different from the person's usual functioning of 2 weeks ago (e.g., new onset, worsening).

## F4. Cognitive Decline

### Intent

To document change in cognitive status.

### Definition

The person demonstrates more difficulty in decision-making than he or she demonstrated 90 days ago or since the last assessment, if that was less than 90 days ago.

### Process

Ask the person if he or she has noticed a difference in the ability to make decisions, or check with others who are familiar with the person to determine if there is a difference from 90 days ago.

## Coding

**Code “0”** if there has not been a decline, if the person is the same or if it is not possible to make a clear decision (e.g., you are unsure).

**Code “1”** if the person is more impaired in decision-making now than he or she was 90 days ago or since the last assessment, if that was less than 90 days ago.

## Section G — Self-care

Some mental illnesses or cognitive deficits can limit the ability or willingness to initiate or participate in self-care or constrict understanding of the tasks required to complete the ADL. As well, 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.

### G1. Activities of Daily Living (ADL) Self-Performance

#### Intent

To record the person’s self-care performance in the activities of daily living (i.e., what the person actually did for himself or herself and/or how much help was required from staff members or others) during the last 3 days. Individualized plans of care can be successfully developed only when the person’s self-performance has been accurately assessed and the amount and type of support being provided to the person by others has been evaluated. The focus of the Admission Assessment is on determining the person’s baseline functional abilities as a basis for developing a plan of care.

#### Definitions

Measures what the person actually did (not what he or she might be capable of doing) within each ADL category over the last 3 days according to the performance-based scale.

- a. **Personal hygiene** — How the person maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup and washing/drying the face, hands and perineum. (**Note:** Exclude baths and showers in the coding of this item.)
- b. **Walking** — How the person walks between locations on the same floor indoors.
- c. **Wheeling** — How the person moves between locations on the same floor indoors when he or she is using a wheelchair.
- d. **Toilet use** — Includes how the person uses the toilet room, commode, bedpan or urinal; cleans himself or herself after toilet use or an incontinent episode(s); changes a pad; manages any special devices required (ostomy or catheter); and adjusts his or her clothes. (**Note:** Exclude transfer on and off the toilet.)
- e. **Eating** — How the person eats and drinks (regardless of skill), including the intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).

## Process

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

A person's ADL self-performance may vary from day to day or within days. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willingness to perform for the nurse but not for family members), medication and alcohol consumption. The responsibility of the assessor, therefore, is to capture the total picture of the person's actual ADL self-performance over the 3-day period, 24 hours a day (i.e., not only how you see the person).

To accomplish this, you must gather information from multiple sources (e.g., interviews/discussions with the person, family and other staff; review of documentation used to communicate with staff across shifts). Ask questions pertaining to all aspects of the ADL definitions. For example, when discussing personal hygiene, be sure to inquire specifically how the person manages washing in the mornings, combing his or her hair, brushing his or her teeth and shaving.

A person can be independent in 1 area of personal hygiene yet require extensive assistance in another. 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 reflects real-world situations, where slight variations are common. Where variations occur, the coding ensures that the person is not assigned to an excessively independent or dependent category. By definition, codes "0," "1," "2," "3," "4" and "5" (Independent, Set-Up Help Only, Supervision, Limited Assistance, Extensive Assistance and Maximal Assistance) permit 1 or 2 exceptions for the provision of heavier care. For example, a person may have received no help in eating on almost all occasions, but on 1 occasion a staff member helped the person by opening containers. The person did most of the activity, receiving only set-up help. Because this was only 1 exception to the normal pattern, the correct code for eating is "0" (Independent).

To evaluate a person's ADL self-performance, begin by observing how the person performs physical tasks. Talk with the person to ascertain what the person does for himself or herself in each ADL activity as well as the type and level of assistance by others. Also talk with family members and weigh all responses to come up with a consistent picture of ADL performance.

## **Guidelines for Assessing ADL Self-Performance (in Last 3 Days)**

Record the person’s actual level of involvement in self-care and the type and amount of support actually received during the last 3 days. This requires that you have knowledge of all episodes of each of the activities of daily living (or as near as possible to all episodes).

Do not record your assessment of the person’s capacity for involvement in self-care — i.e., what you believe the person might be able to do for himself or herself based on demonstrated skills or physical attributes.

Do not record the type and level of assistance that the person “should” be receiving according to any written plan of care or expectations the family may have. The type and level of assistance actually provided may be quite different from what is indicated in a plan of care. Record what is actually happening.

Engage staff from all shifts that have cared for the person over the last 3 days in discussions regarding the person’s ADL functional performance. Remind staff that the focus is on the last 3 days only.

When you are uncertain whether the person can perform the activity as described or, conversely, when you wonder why the person is not more independent, observe a session where this activity is carried out (e.g., eating a meal). Observation will help you validate reported behaviours and will be useful as you proceed with care planning.

## **Coding**

For each ADL category, code the appropriate response for the person’s actual performance during the last 3 days. Consider the person’s performance during all shifts, as function may vary.

**Code “0” for Independent** — No help, set-up or supervision was provided **or** help, set-up or supervision was provided only once or twice during the period (with any task or subtask).

**Code “1” for Set-Up Help Only** — An article or device was provided or placed within reach of the person 3 or more times.

**Code “2” for Supervision** — Oversight, encouragement or cueing was provided 3 or more times **or** supervision (1 or more times) plus physical assistance was provided only once or twice during the period for a total of 3 or more episodes of help or supervision.

**Code “3” for Limited Assistance** — The person was highly involved in the activity, received physical help in guided manoeuvring of limbs or other non-weight-bearing assistance 3 or more times **or** a combination of non-weight-bearing help with more help was provided only 1 or 2 times during the period, for a total of 3 or more episodes of physical help.

**Code “4” for Extensive Assistance** — The person performed part of the activity on his or her own (50 percent or more of the subtasks), **but** help of the following type(s) was provided by 1 person 3 or more times:

1. Weight-bearing support (e.g., holding the weight of the person’s limb or trunk); and/or
2. Full performance by others some of the time of a task or discrete subtask.

**Code “5” for Maximal Assistance** — The person was involved but completed less than 50 percent of the subtasks on his or her own (includes a 2-person assist) **or** received weight-bearing help or full performance of certain subtasks 3 or more times.

**Code “6” for Total Dependence** — Refers to full performance of the activity by others during the entire period with complete non-participation by the person in all areas of the ADL definition. For example, for a person 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 entirely by others) and would never initiate any subtask of eating (e.g., picking up finger foods, giving himself or herself tube feeding or assisting with the procedure).

**Code “8” for Activity Did Not Occur during the entire 3-day period** — Over the last 3 days, the ADL was not performed by the person or by others for the person. In other words, the particular activity did not occur. For example, a person who was restricted to bed and did not get up at all for the entire 3-day period would receive a code of “8” for walking and wheeling.

However, do not confuse a person who is totally dependent in an ADL activity (code “6,” Total Dependence) with the activity itself not occurring. For example, a person who receives tube feedings but 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 person who is highly involved in feeding himself or herself by tube is not totally dependent and should not be coded as “6” but rather as a lower code value, depending on the nature of the help received from others. Each of the ADL self-performance codes is exclusive; there is no overlap between categories. Changing from 1 self-performance category to another requires 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 have increased from once or twice up to 3 or more times during the last 3 days.

There will be times when not 1 type or level of assistance is provided to the person 3 or more times during a 3-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 person received that level or more of dependent support 3 or more times during the 3-day period.

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**Validation**

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Assessment will be flagged as suspicious if G1d ADL — Toilet Use is coded as 8 (Activity did not occur in last 3 days).

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Assessment will be flagged as suspicious if G1e ADL — Eating is coded as 8 (Activity did not occur in last 3 days).

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## **G2. Instrumental Activities of Daily Living (IADL) Capacity**

### **Intent**

To examine the areas of function that are most commonly associated with independent living.

### **Definitions**

- a. **Meal preparation** — How the person prepares meals (e.g., planning meals, cooking, assembling ingredients, setting out food and utensils).
- b. **Managing medications** — How the person manages medications (e.g., remembering to take medicines, opening bottles, taking correct dosages, giving injections, applying ointments).
- c. **Transportation** — How the person travels by public transportation (navigating the system, paying the fare), arranges other transport or drives himself or herself (including getting out of the house and into/out of vehicles). If a person arranges for someone to drive him or her from A to B, that will be coded as independent.
- d. **Managing finances** — How the person pays bills, balances a cheque book, balances household expenses and monitors a credit card account.
- e. **Phone use** — How the person makes or receives telephone calls (with assistive devices such as large numbers on the telephone and amplification, as needed).

### **Process**

The person is questioned directly about his or her capacity to perform normal activities around the home or in the community. You may also talk to family members or a community care worker, if they are available. Use your own observations. Since many IADLs do not occur within the hospital setting, you will need to use your best clinical judgment to determine the person's capacity.

## Coding

Code the person's capacity to perform instrumental activities of daily living. If the person has performed the activity in the last 3 days, code what you observed was the person's capacity to perform it at that time. If the person has not had an opportunity to perform the activity in the last 3 days, using your clinical judgment, code what you consider is the person's capacity to perform the activity. Code for the most dependent period if there is a discrepancy in the assessment from one day to another. (**Note:** This may well be a judgment call by the assessor because the person may never have done this activity, e.g., never cooked a meal himself or herself.)

**Code “0” for Independent** — The person would have required no help, set-up or supervision.

**Code “1” for Set-Up Help Only** — The person would have required help that was limited to providing an article/device or placing it within the person's reach 3 or more times; all other tasks would have been performed by the person on his or her own.

**Code “2” for Supervision** — The person would have required oversight, encouragement or cueing.

**Code “3” for Limited Assistance** — On some occasion(s) the person could have done the task on his or her own but at other times would have required help.

**Code “4” for Extensive Assistance** — The person would have required assistance throughout the task but would have performed 50 percent or more of the subtasks involved in the activity on his or her own.

**Code “5” for Maximal Assistance** — The person could have been involved but would have been able to complete less than 50 percent of the activity subtasks on his or her own.

**Code “6” for Total Dependence** — Full performance of the activity by another person would have been required at all times.

## G3. Stamina

### Intent

Moderate physical activity in connection with activities of everyday life or chosen activities can help keep people fit in many ways. Below a certain threshold of activity, functional decline may be accelerated.

### Process

Ask the person to describe his or her involvement in physical activities (e.g., ADLs, walking, shopping) in the last 3 days.

## **Coding**

**Code “0”** if the person has been involved in more than 2 hours of physical activity over the last 3 days.

**Code “1”** if the person has had 1 to 2 hours of physical activity over the last 3 days.

**Code “2”** if the amount of activity has been less than 1 hour in the last 3 days.

**Code “3”** if the person has not been involved in any activity in the last 3 days.

## **G4. ADL Decline**

### **Intent**

To compare current ADL status to 90 days ago (or since the last assessment if that was less than 90 days ago).

### **Process**

Ask the person, or others who would be familiar with the person’s functioning, if there has been a change in the person’s ability to perform ADLs as compared to 90 days ago.

### **Coding**

**Code “0”** if there has not been a decline, if the person is the same or if it is not possible to make a clear decision (e.g., you are unsure).

**Code “1”** if the person is more impaired in his or her ability to perform ADLs now than he or she was 90 days ago or since the last assessment, if that was less than 90 days ago.

## **Section H — Communication/vision patterns**

It is important to identify communication impairments early in a person’s psychiatric stay. The collection of this information will facilitate the development of necessary adaptations during the person’s stay in hospital.

### **H1. Hearing**

#### **Intent**

To evaluate the person’s physical ability to hear (with assistive devices, if used, and/or environmental adjustments, if necessary) during the last 3 days. The environment can often have an impact on the person’s ability to hear and must be considered in the assessment.



## Process

Hearing status should be assessed based on the person’s customary way of listening. If the person has an adaptive hearing device/aid/appliance, evaluate hearing ability with the working device in place. Be sure to ask if the battery works and if the hearing aid is on. Review the person’s record, interview the person (ask about hearing function) and observe for hearing function during your verbal interactions. Use a variety of observations to make your assessment (e.g., one-on-one versus group situations). If possible, observe the person interacting with others (e.g., family members). Always be mindful of environmental factors that may influence your assessment (e.g., a roommate’s conversations, outside noises). If necessary, to clarify the exact hearing level, consult with the person’s family, primary caregivers or speech or hearing specialists.

Be alert to what you have to do to communicate with the person. For example, do you have to speak more clearly, use a louder tone, speak more slowly or use more gestures? Does the person need to see your face to know what you are saying? Do you have to take the person to a quieter area to conduct the interview? All of these are cues that there is a hearing problem and should be indicated in the coding.

## Coding

Enter the number that corresponds to the most correct response.

**Code “0” for Adequate** — The person hears all normal conversational speech, including when using the telephone, watching television and engaging in group activities.

**Code “1” for Minimal Difficulty** — The person hears speech at conversational levels but has difficulty hearing when the environment is not quiet or when he or she is not in a one-on-one situation. Background noise affects the person’s hearing.

**Code “2” for Hears in Special Situations Only** — The person is hearing-deficient but compensates and hears better when the speaker increases the volume, adjusts voice tone and/or speaks distinctly; **or** the person can hear only when the speaker’s face is clearly visible.

**Code “3” for Highly Impaired** — The person hears only some sounds and frequently fails to respond, even when the speaker adjusts tone and volume, speaks slowly and distinctly or is positioned face-to-face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

## H2. Vision

### Intent

To evaluate the person's ability to see close objects in adequate lighting, using the person's customary visual appliances for close vision (e.g., glasses, magnifying glass) in last 3 days.

### Definition

**“Adequate” lighting** — What is sufficient or comfortable for a person with normal vision.

### Process

Ask the person, a family member or staff if the person has manifested any change in usual vision patterns over the last 3 days (e.g., is the person still able to read newsprint, menus, greeting cards?). Then ask the person about his or her visual abilities.

Test the accuracy of your findings by asking the person 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 person to read aloud, starting with larger headlines and ending with the finest, smallest print.

Be sensitive to the fact that some people are not literate or are unable to read English. In such cases, ask the person 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 person is unable to communicate or follow your directions for testing vision, observe the person's eye movements to see if his or her eyes seem to follow movement and objects. Although these are gross measurements of visual acuity, they may assist you in assessing whether the person has any visual ability.

### Coding

Enter the number corresponding to the most correct response.

**Code “0” for Adequate** — The person sees fine detail, including regular print, in newspapers and books.

**Code “1” for Impaired** — The person sees large print, but not regular print, in newspapers and books.

**Code “2” for Moderately Impaired** — The person has limited vision and is not able to see newspaper headlines but can identify objects in his or her environment.

**Code “3” for Highly Impaired** — The person’s ability to identify objects in his or her environment is in question, but the person’s eye movements appear to be following objects (especially people walking by).

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

**Code “4” for Severely Impaired** — The person has no vision or sees only light colors or shapes, or the person’s eyes do not appear to be following objects (especially people walking by).

### H3. Making Self Understood

#### Intent

To document the person’s ability to express or communicate requests, needs, opinions, urgent problems and social conversation, whether in speech, writing, sign language or a combination of these (includes the use of a word board or keyboard). Deficits in the 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 words and making sentences.

#### Process

The natural way to assess whether the person’s expressive ability is adequate is through the listener’s ability to understand the person; therefore, interact with the person. Observe and listen to the person’s efforts to communicate using assistive devices and/or modes of expression that she or he would normally use to communicate. Consult with others who would be able to report on their observations of the person’s interactions in different settings (e.g., one-on-one, groups), circumstances (e.g., when calm, when agitated) and times of day.

If staff is uncertain and you require further clarification, consult with a family member who frequently visits the person (if such a person is available). Note that this item is not intended to assess the person’s ability to be understood in English or French when this is not his or her primary language. The focus is on how cognitive deficits or other factors may be interfering with the person’s ability to express himself or herself.

## Coding

Enter the number corresponding to the person’s ability to make himself or herself understood over the last 3 days.

**Code “0” for Understood** — The person expresses ideas clearly and without difficulty.

**Code “1” for Usually Understood** — The person may have difficulty expressing ideas (finding words or finishing thoughts) but is able to make himself or herself understood if the listener gives the person time to express himself or herself. Little or no prompting is required by the listener.

**Code “2” for Often Understood** — The person has difficulty finding the right words or finishing thoughts, resulting in delayed responses. The person usually requires some prompting or cueing by the listener to complete or clarify the message (to make herself or himself understood).

**Code “3” for Sometimes Understood** — The person has limited ability but is able to express simple, concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet, pain).

**Code “4” for Rarely/Never Understood** — The person is not able to communicate effectively. At best, this communication requires staff to interpret the meaning of highly individual sounds or body language (e.g., the indicated presence of pain or the need to toilet).

## Section I — Health conditions and possible medication side effects

Signs and symptoms of physical health are often overshadowed by the urgency or acuity of the person’s mental health condition. Close attention to physical health concerns is warranted to ensure the person is assessed holistically and to find and treat physical issues that may be contributing to the person’s mental health deterioration. Chronic mental health problems can predispose people to experiencing lifestyle, social and environmental circumstances that may put them at risk for a wide variety of physical ailments.

### I1. Signs and Symptoms

#### Intent

To record specific problems or symptoms that affect, or could affect, the person’s health or functional status and to identify risk factors for illness, accident and functional decline. These problems may also be related to medication side effects.

## Definitions

- a. **Headache** — Any type of headache (e.g., migraine, tension).
- b. **Dizziness/vertigo or light-headedness** — The sensation of unsteadiness, that you are turning or that the surroundings are whirling around.
- c. **Shortness of breath** — Difficulty breathing (dyspnea) present at rest or when performing normal day-to-day activities (e.g., making a bed, dressing the lower body).
- d. **Chest pain/pressure** — Any type of pain in the chest area that may be described as burning, pressure stabbing, a vague discomfort, etc. during exertion or rest.
- e. **Blurred vision** — Subjective reporting that vision is blurred, hazy or unclear.
- f. **Dry mouth** — A decrease in or lack of saliva.
- g. **Increase or decrease in normal appetite** — Either an increase or a decrease in normal appetite for whatever reason.
- h. **Difficulty urinating/urinating 3 or more times a night/polyuria** — Includes the inability to void, difficulty starting a stream, pain on voiding or frequent voiding.
- i. **Nausea** — Unpleasant sensation that usually precedes vomiting.
- j. **Vomiting** — Regurgitation of stomach contents caused by any etiology (e.g., drug toxicity, influenza, psychogenic).
- k. **Constipation** — No bowel movement in 3 days or difficult passage of stool.
- l. **Diarrhea** — Frequent elimination of watery stools from any etiology (e.g., diet, viral or bacterial infection).
- m. **Daytime drowsiness/sedation** — Objective observation that the person looks drowsy or is sedated.
- n. **Fatigue/weakness** — Subjective observation of fatigue or weakness (e.g., the person states “I feel so tired all the time.”).
- o. **Impaired balance/ataxia** — Objective observation of a balance problem (e.g., the person may stumble frequently, hold on to the walls when walking, appear unsteady when walking).
- p. **Emergent conditions** — Includes signs and symptoms not listed (e.g., fever, rashes, itching, diaphoresis) that would be indicative of a developing condition.
- q. **Edema** — Excessive accumulation of fluid in tissues, either localized or systemic (generalized). Includes all types of edema (e.g., dependent, pulmonary, pitting).

## Process

Ask the person about the presence of the conditions listed in this section. Also, check the person’s medical chart and consult family members if necessary.

## Coding

For each sign or symptom listed, code as follows:

**Code “0”** if the indicator has not been reported or observed in the last 3 days.

**Code “1”** if the indicator occurred on 1 or 2 days of the last 3 days, regardless of the number of times per day.

**Code “2”** if the indicator was present on each of the last 3 days.

## 12. Extra-Pyramidal Signs and Symptoms

### Intent

Extra-pyramidal side effects are commonly seen with the administration of neuroleptic medication. These side effects can be very distressing to people and their families and are the primary reason for a person to discontinue medication use after discharge. Recognizing these symptoms early and treating them at the onset can improve person compliance with treatment.

### Definitions

- a. **Akathisia** — An extremely unpleasant, if not intolerable, state of motor restlessness, usually felt in the lower extremities. The person may complain of inner restlessness. This should not be confused with restlessness due to anxiety or agitation. In akathisia, the feeling is usually constant and the person finds it difficult, if not impossible, to stop moving.
- b. **Dyskinesia** — Involuntary movements that appear to have no apparent purpose, often observed in the face, lips, tongue, jaw or upper or lower extremities; or rocking or writhing of the trunk.
- c. **Tremor** — Involuntary rhythmic movements of the fingers, limbs, mouth or tongue.
- d. **Rigidity** — Resistance to flexion and extension of the muscles; increased resting tension of the muscles, sometimes called “lead pipe.” There is often an overlying “ratcheting” when the joint is passively flexed, known as cogwheeling.
- e. **Slow, shuffling gait** — Reduction in the speed and stride length of the gait. The person takes slow steps and moves the feet in a “shuffling” manner when walking, usually accompanied with a decrease in pendular arm movement.
- f. **Bradykinesia** — A decrease in spontaneous movements. Examples include reduced body movement and poverty of facial expression, gestures or speech.
- g. **Dystonia** — A long-lasting contraction or spasm in any muscle of the body (muscle hypertonicity) (e.g., muscle spasms or stiffness, protruding tongue, upward deviation of the eyes). These reactions usually occur 12 to 36 hours after a person is started on a neuroleptic medication. It is sudden and very frightening.

**Process**

Ask the person if he or she has experienced any of the extra-pyramidal signs and symptoms defined above in the last 3 days. Observe the person and consult other staff, the medical chart and family members. If a symptom is present but the person is not taking psychoactive medication, code it as present.

**Coding**

**Code “0”** if the item was not present in the last 3 days.

**Code “1”** if the item was present at any time in the last 3 days.

**13. Sexual Functioning****Intent**

To identify any sexual dysfunction the person may be experiencing. There may be any number of reasons for sexual functioning difficulty; however, this item is placed in this section as many psychotropic medications cause sexual problems that can be distressing to people.

**Definition**

**Sexual dysfunction** — Any sexual problem the person may be experiencing, such as loss of interest or drive, impaired erection or ejaculation or inhibited female orgasm.

**Process**

Sexual functioning is a sensitive matter. Make sure this discussion is held in private and in a delicate way. It is often a relief to people who are experiencing sexual functioning difficulty to have the subject raised, giving the person an opening to discuss his or her concerns. You may want to begin discussion of this item by stating that although the person may find this uncomfortable to discuss, some medications can cause side effects related to sexual functioning and it is important to know if this is a problem so that effective treatment planning can occur. If the person is not on medication, a way of beginning the discussion might be to point out that it is important that all areas of the person’s health be reviewed and that, although it is sometimes difficult to talk about, sexual functioning is another part of the review. You can then ask if the person is sexually active and, if so, whether the person has had any problems in the last month, such as difficulty maintaining an erection, pain during intercourse or a lack of interest in sex.

**Coding**

**Code “0”** if the person reports no problems or is not sexually active.

**Code “1”** if the person reports any problem occurring in the last 30 days.

## **14. Self-Reported Health**

### **Intent**

To evaluate the person’s perception of his or her physical health.

### **Definition**

Person’s perception of his or her physical health status over the last 3 days. Do not include perceptions of his or her mental health.

### **Process**

Ask the person, “In general, how would you rate your health?” Do not code based on your own inferences about the person’s physical health, and do not record ratings given by family, friends or other informants. This item should be treated strictly as a self-report measure. If the person is unable to respond (e.g., because of cognitive impairment) or refuses to respond, do not dwell on the item and do not presume responses for the person; instead, code that the person could not/would not respond.

### **Coding**

Record the person’s response according to 1 of the following categories.

**Code “0”** if the person rates his or her health as excellent.

**Code “1”** if the person rates his or her health as good.

**Code “2”** if the person rates his or her health as fair.

**Code “3”** if the person rates his or her health as poor.

**Code “8”** if the person could not (would not) respond.

## **15. Chewing and Swallowing**

### **Intent**

To document any problem with swallowing or chewing, regardless of the cause, for the purposes of care planning.

### **Process**

Observe for, and ask the person about, any problems with swallowing different food textures or with chewing caused by problems with teeth, dentures or the physical structure of the mouth or jaw.



## Coding

**Code “0”** if no problem is present.

**Code “1”** if a problem is identified, either through observation or reporting by the person. Include chewing/swallowing problems that are currently being managed by a modified diet.

## 16a. Skin Problems

### Intent

To document the presence of skin conditions or changes in the last 3 days. Those who have a history of homelessness may be particularly vulnerable to skin problems. As well, skin conditions can be a side effect of some psychotropic medications.

### Definitions

16aa. **Major skin problems** — For example, lesions, second- or third-degree burns, healing surgical wounds.

16ab. **Other skin conditions or changes in skin condition** — For example, bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema.

### Process

Ask the person (or family member, if necessary) if he or she has any bothersome skin problems. If the response is affirmative, ask to see the affected area. Review the clinical record for documentation concerning skin problems.

## Coding

For each item, code for skin problems present during the last 3 days.

**Code “0”** if no skin problem was present in the last 3 days.

**Code “1”** if any 1 problem or combination of problems is present or has been present in the last 3 days.

## **I6b. Foot Problems**

### **Intent**

To document the presence of problems with feet in the last 3 days. People who have a history of homelessness may be particularly vulnerable to such problems.

### **Definition**

Includes corns, calluses, infections, fungi, cuts, ulcers, fissures, swollen feet, cuts that do not heal, rashes and structural problems such as hammer toes, the absence of nails and bunions.

### **Process**

Ask the person (or family member, if necessary) if he or she has any foot problems. If the response is affirmative, ask if the problem is affecting his or her ability to walk and about the nature of the difficulty. The clinical record may also contain information about foot problems.

### **Coding**

Code for the presence of foot problems during the last 3 days.

**Code “0”** for no foot problems.

**Code “1”** for foot problems, no limitation in walking.

**Code “2”** for foot problems that limit walking.

**Code “3”** for foot problems that prevent walking.

**Code “4”** for foot problems, does not walk for other reasons.

## **I7a. Falls**

### **Intent**

To document whether the person fell in the last 90 days and the number of falls the person sustained in the last 30 days. People who have had at least 1 fall are at increased risk for future falls. Falls can be a side effect of some medications that are used to treat psychiatric conditions.

### **Definition**

Any unintentional change in position where the person ends up on the floor, ground or other lower level; includes falls that occur while being assisted by others.

**Process**

Ask the person if he or she has had any falls in the last 90 days. Also, check with other care providers and family and review the clinical record for information about the number and timing of falls. **Note:** Only the number of falls that occurred in the last 30 days is required.

**Coding**

**Code “0”** if there were no falls in last 90 days.

**Code “1”** if there were no falls in last 30 days but fell 31 to 90 days ago.

**Code “2”** if there was 1 fall in the last 30 days.

**Code “3”** if there were 2 or more falls in the last 30 days.

**17b. Recent Falls****Intent**

To determine if the person has a recent history of falling.

**Definition**

**Fall** — Any unintentional change in position where the person ends up on the floor, ground or other lower level; includes falls that occur while being assisted by others.

**Process**

This item is asked at follow-up assessment only and then only if less than 30 days have passed since the last assessment. Determine if the person has experienced a fall that occurred between the Assessment Reference Date of this assessment and the Assessment Reference Date of the last assessment **if less than 30 days** have passed between the 2 assessments.

**Coding**

If this is the first assessment, or if more than 30 days have passed since the last assessment, code “8” (not applicable).

If this is a follow-up assessment and it has been less than 30 days since the last assessment, code for the occurrence of 1 or more falls since the last assessment.

**Code “0”** if the person has not fallen.

**Code “1”** if the person has fallen 1 or more times.

**Code “8”** (not applicable) if this is the first assessment or more than 30 days have passed since the last assessment.

## 18. Pain

### Intent

To record the frequency and intensity of the signs and symptoms of pain in the last 3 days. For care planning purposes, this item can be used to identify indicators of pain as well as to monitor the person's response to pain management interventions.

### Definitions

- a. **Frequency with which person complains of or shows evidence of pain** — Measures how often the person experiences pain (reports or shows evidence of pain); includes grimacing, teeth clenching, moaning, withdrawal when touched and other nonverbal signs suggesting pain. If the person has not demonstrated any pain in the last 3 days because of an effective pain management regimen, the minimum value for pain frequency should be “1.”
- b. **Intensity of highest level of pain present** — Measures the level of pain as the person perceives it (as described or manifested by the person). Code the highest level of pain present.

### Process

Ask the person if he or she has experienced any pain in the last 3 days. Ask the person to describe the pain. If the person states he or she has pain, take his or her word for it. Pain is a subjective experience. Also observe the person for indicators of pain. Ask family or staff who work with the person if the person had complaints or indicators of pain in the last 3 days.

### Coding

Enter the most appropriate coding option to indicate the frequency and intensity of pain experienced by the person in the last 3 days.

#### a. Pain Frequency

**Code “0”** if no pain is reported and no signs or symptoms of pain have been observed.

**Code “1”** if pain has been present but less than daily over the last 3 days, regardless of the cause or intensity.

**Code “2”** if pain has been daily.

## b. Pain Intensity

**Code “0”** if no pain is reported and no signs or symptoms of pain have been observed.

**Code “1”** if the person has experienced some (a little) pain but has usually been able to carry on with daily routines, socialization and sleep.

**Code “2”** if the person has experienced a “medium” amount of pain.

**Code “3”** if the person has experienced intense pain.

**Code “4”** if the pain has been horrible or excruciating at times — the worst possible pain the person can imagine.

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### Validation

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I8a Pain Frequency must be coded as 0 (No pain) when I8b Pain Intensity is coded as 0 (No pain).

I8b Pain Intensity must be coded as 0 (No pain) when I8a Pain Frequency is coded as 0 (No pain).

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## 19. Bladder Continence

### Intent

To determine and record the person’s pattern of bladder continence (control) over the last 3 days.

### Definition

Refers to control of the urinary bladder function. This item describes the bladder continence pattern even with scheduled toileting plans, continence training programs or appliances.

It does not refer to the person’s ability to toilet himself or herself (e.g., a person can receive extensive assistance in toileting and yet be continent, perhaps as a result of staff help).

The person’s self-performance in toilet use is recorded in item G1d.

### Process

Complete your review in the following order. Remember to consider continence patterns over the last 3-day period, 24 hours a day.

1. Review the person’s clinical record and any urinary (bladder) elimination flow sheets (if available).
2. Validate the accuracy of the written record with the person if possible. Make sure that your discussions are held in private. Control of bladder function is a sensitive subject, particularly for people 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 may not report the problem to staff because they mistakenly believe that incontinence is a natural part of aging or naturally occurs after childbirth and that nothing can be done to reverse the problem. Despite these common reactions to incontinence, many people are relieved when a health care professional shows enough concern to ask about the nature of the problem in a sensitive, straightforward manner.

3. If deemed necessary, validate continence patterns with people who know the person well (e.g., a family member of a newly admitted person, direct care staff).
4. When the information you have received is inconsistent, and particularly when the person says he or she is more continent than staff or family assessment indicates, review for physical indications that the person is in fact incontinent. This could include being present at scheduled toileting intervals and observing clothing and bedclothes.

## Coding

Choose the response that best reflects the person’s level of bladder continence in the last 3 days.

**Code for the actual bladder continence pattern** — For example, the frequency with which the person is wet and dry during the 3-day assessment period. Do not record the level of control that the person might have achieved under optimal circumstances. For bladder continence, the difference between a “5” (frequently incontinent) and a “6” (incontinent) is determined by the presence (“5”) or absence (“6”) of any bladder control.

**Code “0” for Continent** — The person has complete control and **does not** use any type of catheter or urinary collection device.

**Code “1” for Managed With Catheter or Ostomy** — Managed with any type of catheter or urinary collection device.

**Code “2” for Infrequent Incontinence** — The person was not incontinent over the last 3 days but does have incontinent episodes.

**Code “3” for Episode of Incontinence** — An incontinent episode occurred on 1 day of the last 3 days.

**Code “4” for Occasionally Incontinent** — The person had incontinent episodes on 2 days, but not daily, in the last 3 days.

**Code “5” for Frequently Incontinent** — The person tends to be incontinent daily, but some control is present (e.g., continent during the day, nightly bedwetting).

**Code “6” for Incontinent** — The person has inadequate bladder control, with multiple daily episodes all or almost all of the time.

**Code “8” for Did Not Occur** — There was no urine output from the bladder.

---

### Validation

Assessment will be flagged as suspicious if I9 Bladder Continence is coded as 8 (Did not occur in the last 3 days).

---

## I10. Bowel Continence

### Intent

To determine and record the person's pattern of bowel continence (control) over the last 3 days.

### Process

The assessment of bowel continence should be completed simultaneously with the bladder continence review. It includes a review of the person's clinical record and any bowel records (if available). Validate the accuracy of written records with the person. Make sure that your discussions are held in private. Control of bowel function is a sensitive issue, so be sure to ask about the nature of the problem in a sensitive, straightforward manner. If deemed necessary, validate continence patterns with people who know the person well (e.g., a primary family member of a newly admitted person, direct care staff). Remember to consider continence patterns over the last 3-day period, 24 hours a day.

### Coding

Code for bowel continence over the last 3 days.

**Code “0” for Continent** — The person has complete control and does not use an ostomy device.

**Code “1” for Control With Ostomy** — The person has complete control with the use of an ostomy device that does not leak stool.

**Code “2” for Infrequent Incontinence** — The person was not incontinent in the last 3 days but does have incontinent episodes.

**Code “3” for Episode of Incontinence** — The person had an incontinent episode on 1 day of the last 3 days.

**Code “4” for Occasionally Incontinent** — The person had an incontinent episode on 2 days of the last 3 days.

**Code “5” for Frequently Incontinent** — The person tends to be incontinent daily, but some control is present (e.g., during the day).

**Code “6” for Incontinent** — The person has inadequate bowel control, with multiple daily episodes all or almost all of the time.

**Code “8” for Did Not Occur** — There was no bowel movement during the entire assessment period.

## **I11. Medical Diagnoses**

### **Intent**

To document the presence of medical diseases or infections for which the person is currently being treated or monitored and that have a relationship to the current self-care status, cognitive status, mood or behaviour disorder status, medical treatments or risk of death. Do not include conditions that have been resolved or that no longer affect the person's functioning. This section does not include psychiatric disorders.

### **Medical Diagnoses**

- a. Diabetes type 1
- b. Diabetes type 2
- c. Chronic obstructive pulmonary disease
- d. Congestive heart failure
- e. Chronic renal failure with dialysis
- f. HIV+
- g. Hepatitis C
- h. to m. Other medical diagnosis

### **Coding**

**Code “0”** for not present.

**Code “1”** for diagnosis present.

**Code “8”** for unknown.

### **Other Medical Diagnoses**

**I11h** — ICD-10-CA code 1

**I11i** — ICD-10-CA code 2

**I11j** — ICD-10-CA code 3

**I11k** — ICD-10-CA code 4

**I11l** — ICD-10-CA code 5

**I11m** — ICD-10-CA code 6



## Coding

In order of priority, code the diseases that are currently subject to active treatment or monitoring. The primary medical diagnosis should be listed first. If needed, refer to the health records department or consult the ICD-10-CA/CCI CD-ROM for the ICD-10-CA codes.

Validation
I11h–m Other Medical Diagnoses ICD-10-CA codes must not be a psychiatric condition (ICD-10-CA code) starting with F.
I11h–m Other Medical Diagnoses ICD-10-CA codes must be unique.
I11h–m Other Medical Diagnoses ICD-10-CA codes may contain 3 to 6 digits.
I11h–m Other Medical Diagnoses ICD-10-CA codes must not contain decimals.
If I11h–m Other Medical Diagnoses ICD-10-CA code is not blank, then the code must be in the ICD-10-CA diagnosis validation table.
For I11h–m Other Medical Diagnoses, if the ICD-10-CA validation table identifies the diagnosis code as valid only for gender F, then BB1 Sex must = F.
For I11h–m Other Medical Diagnoses, if the ICD-10-CA validation table identifies the diagnosis code as valid only for gender N, then BB1 Sex must = M or O.
For I11h–m Other Medical Diagnoses, if the ICD-10-CA validation table identifies the diagnosis code as valid only for gender M, then BB1 Sex must = M.
For I11h–m Other Medical Diagnoses, if the ICD-10-CA validation table identifies the diagnosis code as valid only for gender G, then BB1 Sex must = F or O.
The age at time of the assessment, in years, must fall within the minimum and maximum ages of the ICD-10-CA validation table for the diagnosis code in I11h–m.

## Section J — Stressors

The events in one’s life that are highly emotional in nature or that have potentially life-altering characteristics play a large role in patterns of psychological and social development and coping. These items are important when completing the clinical profile of a person, to better establish a framework for the delivery of care in a sensitive and individual manner and to track the degree of impact that any of these life events may have had, or continue to have, on function.

### J1. Life Events

#### Intent

Of particular relevance to health and well-being is the amount of change a particular event imposes upon the person and the degree of desirability the event represents for the recipient. This section provides a list of the more common life events that may be important to the person’s well-being.

## Definitions

Life events — Objective experiences that either disrupt or threaten to disrupt a person's current daily routine and that impose some degree of readjustment.

- a. **Serious accident or physical impairment** — Includes any serious accident or physical impairment sustained by the person, regardless of cause. Mental illness is not included in this definition.
- b. **Distressed about health of another person** — The person worries about someone within his or her social network who has significant ongoing health problems, who was recently diagnosed with a major illness (including mental health illness) or who has experienced a serious accident.
- c. **Death of close family member or friend** — The person has experienced the death of someone he or she considers a close family member or friend.
- d. **Child custody issues; birth or adoption of child** — The person has been involved in a child custody dispute, has given birth or fathered a child or has adopted a child.
- e. **Conflict-laden or severed relationship, including divorce** — The person is experiencing ongoing conflict as part of a significant relationship.
- f. **Failed or dropped out of education program** — The person has either been unsuccessful in completing or has failed an education program.
- g. **Major loss of income or serious economic hardship due to poverty** — Any loss of income resulting in the need to significantly change his or her standard of living to the point where he or she may have to sell the house, car or any property. This includes those at all income levels, regardless of whether or not the person's resulting income would be below the poverty line.
- h. **Review hearing**, e.g., a forensic review, an appeal of certification, an assessment of capacity to give consent — The person has gone through a review hearing regardless of the outcome.
- i. **Immigration, including refugee status** — The person immigrated to this country; this includes those with refugee or landed immigrant (permanent resident) status.  
  
Canadian-specific example: This category would include a Canadian-born person who left to live in another country for a prolonged period, fully intending not to return (such that he or she gave up Canadian residency) but eventually returned to Canada. This category would not include Canadian citizens who left Canada for temporary visits, such as a vacation or a sabbatical, fully intending to return to Canada.
- j. **Lived in war zone or area of violent conflict (combatant or civilian)** — Includes members of the military, paramilitary, rebel groups and other combatants. It also includes those who lived in the war zone or area of conflict who did not actively participate in the fighting but nonetheless directly experienced the conflict/war.

- k. **Witnessed severe accident, disaster, terrorism, violence or abuse** — The person was present at and a first-hand witness to a severe accident, disaster, act of terrorism, violence or abuse (e.g., terrible motor vehicle accident, tornado, bombing, homicide). Do not include watching televised or other media coverage of the event. Also exclude living in a war zone or area of violent conflict (which is coded in J1j).
- l. **Victim of crime** — The person has been a victim of a crime such as robbery, break and enter or vandalism. Do not include physical assault or abuse in this item.
- m. **Victim of sexual assault or abuse** — Any form of sexual abuse/assault experienced by the person, regardless of his or her age when the incident(s) occurred (e.g., an adult being subject to non-consenting fondling, exposure of genitals, sexual intercourse/rape or having had similar experiences as a child).  
This area should be approached with sensitivity. The recording of the response should not reflect what you believe may have occurred, but rather what the person or the record indicates.
- n. **Victim of physical assault or abuse** — Any form of physical abuse experienced by the person, regardless of his or her age when the incident(s) occurred (e.g., any incident resulting in non-accidental injury, physical confinement, excessive physical discipline, withdrawal of necessities of life, such as food and shelter).
- o. **Victim of emotional abuse** — The person has been in a pervasive and hostile emotional environment created by an abuser for the purposes of control. The abused person's self-esteem, identity, energy, ability to feel and question, wants and needs are invalidated by the abuser.
- p. **Parental abuse of alcohol or drugs** — 1 or more of the person's parents (e.g., biological, adoptive, step-parent) has/had a drug and/or alcohol problem.

### Process

Ask the person about any of the specified events that have had an important impact on his or her life. Also check the available documentation. Although there are other potentially serious life events, only code those that fit into these major categories.

**Note:** *Events captured here must be actual life events, not those based in a delusion.*

## Coding

Code for the most recent occurrence of the event.

**Code “0”** if the person has never experienced the life event.

**Code “1”** if the life event occurred more than 1 year ago.

**Code “2”** if the life event occurred 31 days to 1 year ago.

**Code “3”** if the life event occurred 8 to 30 days ago.

**Code “4”** if the life event occurred 4 to 7 days ago.

**Code “5”** if the life event occurred in the last 3 days.

## J2. Life Event (J1) Causes Sense of Horror or Intense Fear

### Intent

For care planning purposes, it will be necessary to assess the intensity of the subjective impact that any 1 of these life events is having on the person, as a potential indicator of post-traumatic stress.

### Process

If the person acknowledges experiencing 1 or more of the events in J1, ask how he or she is dealing with the memory of having experienced such an event. The person may describe (or others may have knowledge of the person reporting) intense fear or horror as a result of experiencing any of the specified situations. For example, the person (or others on the person’s behalf) may also describe the presence of disturbing nightmares, episodes of anxiety when he or she thinks of the experience or periods of intense unexplained anxiety.

Do not code what you or someone else believe should be the person’s response; code for what the person reports or for what someone else has heard from the person and then shared with you. For example, a soldier may or may not have reacted with intense fear or horror to his or her experience in a war zone. Your assessment should be based on the person’s subjective reaction.

## Coding

**Code “0”** for no or not applicable.

**Code “1”** for yes.

**Code “8”** for could not (would not) respond.

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### Validation

If all of J1a–p = 0, then J2 Life Event Causes Sense of Horror or Intense Fear must = 0.

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### J3. Other Indicators

#### Intent

The focus of this item is on 2 areas of abuse not captured elsewhere that may be important to the care of the person.

#### Definitions

- a. **Any history of physical/emotional/sexual abuse/sexual assault experienced by family members** — The person has observed or knows that family members have experienced trauma due to physical/emotional/sexual abuse/sexual assault.
- b. **Fear of a family member, friend, caregiver or staff** — The person expresses, either verbally or through behaviour, fear towards another person. Fear can be expressed in many ways. A person may state that he or she is afraid or may withdraw whenever that person is around.

#### Process

To assess the history of abuse in a person's family, information may be obtained from the person's record or in discussion with the person. This area should be approached with sensitivity, and the recording of the response should not reflect what you believe may or may not have occurred but rather what the person or the record indicates. For assessing fear of others, interactions between the person and others may provide indications that the person feels threatened. Consider the quality of the interaction coupled with the condition of the person. There is no need to definitively confirm that abuse has occurred at this point. The intent is to identify those who are at risk.

#### Coding

##### Item J3a

**Code "0"** if there is no indication of a history of physical/emotional/sexual abuse/sexual assault experienced by a family member(s).

**Code "1"** if there is any indication of a history of physical/emotional/sexual abuse/sexual assault experienced by a family member(s).

##### Item J3b

**Code "0"** if there are no indicators that the person is fearful of others.

**Code "1"** if the person demonstrates fear of others.

## Section K — Medications

Medications, psychotropic and other, are a key treatment modality in mental health. Issues such as adherence, compliance, side effects or misuse of medications are major factors in care planning, discharge planning and resources required for successful discharge. A complete record of the person’s medication history is necessary to facilitate appropriate plans of care.

### K1. History of Medication Adherence

#### Intent

To determine if the person was taking medication as prescribed during the month prior to admission. This item is important for discharge care planning.

#### Definition

**Adherence to medication** — The person was actually taking the medication as prescribed.

#### Process

Solicit information from the person about his or her medication. Ask general open-ended questions first, such as “What medication were you taking prior to coming to the hospital?” Ask the question of the caregiver if either the person is unable to answer or the caregiver administers the medication to the person. Cross-check the responses with medication available and known medication orders. Does the remaining supply seem appropriate considering when the prescription was filled? Did the person and caregiver give accurate information about medication administration?

#### Coding

Enter the number that most accurately describes the person’s medication adherence in the 30-day period before admission.

**Code “0”** if the person was always adherent.

**Code “1”** if the person was adherent 80 percent of the time or more; i.e., the person deviated from the prescribed medication regime 20 percent of the time or less.

**Code “2”** if the person was adherent less than 80 percent of the time; the person deviated from the prescribed medication regime more than 20 percent of the time.  
This includes failure to purchase prescribed medication.

**Code “3”** if no medication was prescribed for the person.

**Code “8”** for unknown, if the person’s adherence patterns prior to admission are unknown.

## K2. Medication Refusal

### Intent

To document any refusal to take prescribed medication, regardless of the reason, during the last 3 days.

### Definition

The person refused to take some or all of the medication prescribed while in hospital.

### Process

Review the clinical record and the medication administration record.

### Coding

**Code “0”** if the person took all prescribed medication as ordered or if the person is not taking medication.

**Code “1”** if the person refuses to take 1 or more medications or has refused on 1 or more occasions to take the medication, regardless of the reason for refusing.

## K3. Stopped Taking Psychotropic Medication

### Intent

To determine if the person has ever stopped taking psychotropic medication in the last 90 days because of side effects he or she has experienced. This knowledge will be useful for care-planning purposes. If a person has had side effects in the past, it is likely that he or she will have them again. However, this information will ensure preventive steps can be taken.

### Definition

**Side effects** — Examples include sedation, extra-pyramidal symptoms, sexual dysfunction and sleeping difficulties.

### Process

Ask the person or family if the person has ever stopped taking medication in the last 3 months, either on his or her own or as ordered by the physician, because of side effects. The referral source or past medical records, if available, may also be helpful.

## Coding

**Code “0”** if the person has not stopped taking psychotropic medication in the last 90 days due to side effects or if the person has not been taking psychotropic medication in the last 90 days.

**Code “1”** if the person stopped taking psychotropic medication in the last 90 days due to side effects, either having discontinued on his or her own or on the advice of a physician.

## K4. Intentional Misuse of Medication

### Intent

To determine whether the person uses medication as recommended or prescribed. It is important for the treatment team to know if misuse of medication is occurring or has occurred at any time in the last 3 months, as this has implications for possible drug interactions as well as physical and mental health.

### Definition

**Misuse** — Includes use of both prescription and over-the-counter medication. Misuse is defined as the overuse or underuse of a recommended/prescribed dosage (e.g., taking a greater dose of an analgesic, taking an anxiolytic more often than recommended or prescribed) or using medication for a purpose other than its intended use (e.g., taking a diuretic for the purpose of weight control).

### Process

Ask the person if he or she is taking medication as prescribed or as indicated on the label for either prescription or non-prescription drugs. Consultation with the referral source and family members may also assist in determining medication misuse.

## Coding

**Code “0”** if the person has not misused medication or has not taken any medication in the last 3 months.

**Code “1”** if the person has misused any medication in the last 3 months.



## K5. Acute Control Medications

### Intent

To record the frequency at which an acute control medication was administered to the person over the last 3 days.

### Definition

**Acute control medication** — Psychotropic medication administered as an immediate response to control agitation or threatening, destructive or assaultive behaviours in order to prevent harm to self or others. This is typically used in situations where the person has already lost behavioural control or where the person is displaying behaviours that have the potential to escalate to loss of control and/or harm to self or others.

This definition excludes the use of psychotropic medication for treatment purposes where a diagnosis has been identified and an ongoing course of treatment has been prescribed. It also excludes the use of PRN medication as part of an ongoing treatment plan.

**For example**, a person with schizophrenia may receive anti-psychotic medication on a regular basis to treat core psychotic symptoms and may also receive a minor tranquilizer/anxiolytic on a PRN basis to treat anxiety. Such use would not be considered an “acute control medication.” However, either or both of these same medications **could** be used as an acute control medication if the person’s behaviour escalates to a point where there is a risk of harm to self or others.

### Process

Count the number of times an acute control medication was given to the person by any route (orally, IM or IV) in the last 3 days. Include any PRN doses given specifically for purposes of behavioural control.

### Coding

Record the number of times acute control medication was actually received. If the person received acute control medication more than 9 times in the last 3 days, code “9.” If none, enter “0.”

## **K6. Allergy to Drugs**

### **Intent**

To determine whether the person has any known drug allergies to either prescription or over-the-counter medication.

### **Definition**

The presence of an allergy would include a history of a serious reaction to a particular drug or category of drugs.

### **Process**

Ask the person or check the medical record.

### **Coding**

**Code “0”** if no known drug allergies are reported.

**Code “1”** if the person or other sources report a known drug allergy.

## **Section L — Service utilization/treatments**

This section collects information on the professional health care received in the period immediately before the assessment. The discipline, frequency, modality and focus of the professional involvement are captured here. For an Admission Assessment, the time frame will be from admission, but for quarterly, change in status or planned discharge records the period is 7 days. A history of electroconvulsive therapy (ECT), if present, is coded in section L6.

### **L1. Formal Care**

#### **Intent**

To capture the number of days spent by formal caregivers in providing care or care management in the last 7 days (or since admission if less than 7 days ago).

## Definitions

Care or care management includes both the direct services provided to the person and the management of care received (e.g., performing assessments, care-planning conferences).

- a. **Visit with psychiatrist** — Either a routine, scheduled appointment or a visit for assessment or crisis intervention with a psychiatrist.
- b. **Nurse practitioner or MD (non-psychiatrist)** — Includes a family doctor or general practitioner, medical/surgical specialist, dentist or nurse practitioner.
- c. **Social worker** — Visit with a social worker or student for the purposes of assessment or intervention.
- d. **Psychologist or psychometrist** — Visit with a psychometrist, licensed psychologist or student for the purposes of assessment or intervention.
- e. **Occupational therapist** — Assessment or therapy services that are provided or directly supervised by a qualified occupational therapist. A qualified therapy assistant may provide therapy but not supervise others giving therapy.
- f. **Recreation therapist** — Assessment or therapy services that are provided by a qualified recreation therapist or recreation therapy assistant. The recreation therapy assistant must work under the direction of a qualified recreation therapist. The person may participate in hobbies, crafts and sports activities within a broader supportive context. Recreation therapy (e.g., horticultural therapy) permits people to participate in enjoyable activities while building sociability and self-esteem.
- g. **Addiction counsellor** — Any health care professional with training specific to the treatment of addictions. (**Note:** If an addiction counsellor’s discipline is listed above, document formal care services using the discipline-specific designation rather than “addiction counsellor.” For example, if a social worker with training in addiction counselling spent time on 2 of the last 7 days with a person, a “2” would be coded beside item “c.”)
- h. **Dietitian** — Specialist in food and nutrition.

## Process

Check the clinical record or contact the relevant professionals to obtain their reported time spent with each person.

## Coding

Record the number of days that each of these services was received for at least 15 minutes a day. The 15 minutes can be cumulative (i.e., three 5-minute periods during a day).

**Record “0”** if no service from the identified health care provider occurred or if the service occurred over the last week but on no given day did it occur for at least 15 minutes.

## L2. Nursing Interventions

### Intent

To determine the extent to which the person receives nursing services. This concept actively focuses on achieving and maintaining optimal physical, mental and psychosocial well-being.

### Definitions

- a. **Medical interventions** — Nursing involvement with medical procedures/interventions (e.g., monitoring IVs, doing a dressing change, assisting with procedures such as blood work or X-rays). Administering medication is not included in this section.
- b. **One-to-one counselling, teaching** — Scheduled time with the person for a single period of at least 15 minutes for the purposes of specific psychosocial intervention/counselling as part of treatment/care plan goals (e.g., supportive counselling, insight-oriented counselling). Teaching includes any health teaching provided directly to the person or to a family member (e.g., medication side effects, nutrition, relaxation techniques).
- c. **Crisis intervention** — Responding to a specific, unexpected occurrence that requires immediate nursing intervention that was otherwise unplanned (e.g., responding to a person who is experiencing a panic attack, a severe medication reaction or an episode of extreme agitation requiring intervention or who requires support in response to receiving disturbing news).
- d. **Family support/consultation** — Meeting with family or friends (including phone contact) for the purpose of gathering information, providing support to the person's informal network or solving problems concerning the person and his or her relationship with family or friends.

### Process

Review the person's documentation to determine the type and amount of time spent on each activity during the last 7 days (or since admission if less than 7 days ago).

### Coding

Record the number of days each activity was provided for at least 15 minutes per day in the last 7 days or since admission.

- For L2a, c and d: 15 minutes can be in 1 block or it can be cumulative over 24 hours.
- For L2b: 15 minutes must be in 1 block (not cumulative), i.e., the activity must have been scheduled for at least 15 minutes in order for any days to be captured.

**Code "0"** if the services did not occur or if the services occurred over the last week but on no given day for at least 15 minutes.

### L3. Treatment Modalities

#### Intent

To identify the type of treatment modalities offered to the person during the last 7 days (or since admission if less than 7 days ago). Include those that are to be initiated in the next 7 days.

#### Definitions

- a. **Individual therapy** — Includes individual therapy with a mental health care worker (e.g., psychiatrist, psychologist, nurse, social worker).
- b. **Group therapy** — Any group therapy that the person attends, regardless of who leads the group or the focus of the group. Do not include self-help groups in this item.
- c. **Family therapy, couple therapy** — Any therapy program that includes the person and 1 or more family members or the spouse/partner.
- d. **Self-help group** — Includes any self-help program, regardless of the type.

#### Process

Review the person's clinical record to determine the type of treatment modalities offered to the person during the last 7 days (or since admission if less than 7 days ago) and those that are scheduled to begin sometime in the next 7 days.

#### Coding

**Code “0”** if the person was not involved in the treatment modality over the last 7 days (or since admission if less than 7 days ago).

**Code “1”** if the treatment modality was offered but the person refused involvement, regardless of the reason.

**Code “2”** if the person was involved in the treatment modality at any time in the last 7 days.

**Code “3”** if the treatment modality has been offered but not yet initiated, and the person is scheduled to begin the treatment some time during the next 7 days.

## L4. Focus of Intervention

### Intent

To document the focus of the intervention(s) listed in item L3 that the person is receiving or is scheduled to receive.

### Definitions

- a. **Community reintegration** — To assist the person in the transition from a stay in an institution to living in the community. Guidance and assistance given to the person may include help in finding employment and a place to live, strengthening social contacts and supports and providing skills for daily living (e.g., cooking, cleaning).
- b. **Social/family functioning** — To assist and educate the person and/or the person's family with any aspect of social or family functioning.
- c. **Psychosocial rehabilitation** — To increase the person's level of success and satisfaction in independent living, learning, working and socializing.
- d. **Detoxification** — To treat addiction during the initial stages of withdrawal from the substance (e.g., alcohol, chemical dependency).
- e. **Alcohol/drug treatment** — To provide support and counselling in order to assist the person in learning how to control the use of substances, as well as to help him or her cope with emotional difficulties without turning to these substances.
- f. **Smoking cessation** — To assist the person in quitting smoking.
- g. **Vocational counselling** — To assist the person in obtaining suitable employment.
- h. **Anger management** — To assist the person in controlling expressions of anger by encouraging acknowledgment of the anger and the stress that causes it, as well as establishing alternative ways to express and cope with these emotions.
- i. **Eating disorder** — To assist those with eating disorders such as anorexia nervosa and bulimia nervosa, with the aim of educating persons about healthy nutrition and eating habits, appropriate exercise routines and the development of effective coping skills. Also addressed are the psychological issues usually underlying the disorder, such as poor self-esteem, distorted self-image and relationship problems.
- j. **Behaviour management** — The focus of intervention is crisis and maintenance strategies. Behaviour management is based on the assessment of behaviour triggers. It uses observation techniques such as Behaviour Observation Records (BORs) and Behaviour Logs that will reduce the frequency and intensity of the behaviour or maintain behaviour(s) at acceptable levels that allow for the safety of the person and others around him or her and minimize the impact of behaviour(s) on the person's day-to-day functioning.
- k. **Post-traumatic stress** — To assist the person in dealing with the trauma of a specific event or ordeal.

- l. **Pain management** — To help individuals deal with acute and/or chronic pain (e.g., medications, relaxation therapy, transcutaneous electrical nerve stimulation [TENS]).
- m. **Alternative or non-traditional therapy** — Any complementary therapy, such as aromatherapy, acupuncture or massage therapy.

### Process

Review any of the treatments, programs or procedures the person is involved with and determine the focus of these interventions.

### Coding

Identify the major focus of interventions.

**Code “0”** if there is no intervention with the identified focus.

**Code “1”** if intervention with the particular focus was offered to the person but he or she refused it.

**Code “2”** if the person has received interventions with the identified focus in the last 7 days (or since admission if less than 7 days ago).

**Code “3”** if intervention with the identified focus has not yet been initiated but is scheduled to start within the next 7 days.

## L5. Adherence to Treatments, Therapies, Programs

### Intent

To determine whether the person has adhered to treatments, therapies or programs as planned. A person’s compliance history should be considered when planning future clinical interventions.

### Definition

**Adherence** — Defined as the person having followed the treatment plan as prescribed in the last 7 days (or since admission if less than 7 days ago).

### Process

Review the chart and discuss with team members to determine the adherence pattern with prescribed activities.

## **Coding**

**Code “0”** if the person is always adherent.

**Code “1”** if the person is adherent 80 percent or more of the time but not always.

**Code “2”** if the person is adherent less than 80 percent of the time.

**Code “3”** if there are no treatments or programs in place for the person.

## **L6. Electroconvulsive Therapy (ECT)**

### **Intent**

To document the person’s history of receiving ECT.

### **Definition**

Includes unilateral or bilateral ECT received on either an inpatient or outpatient basis.

### **Process**

This information can be obtained by asking the person, the family, therapists or staff or by checking the medical record.

## **Coding**

Code for the most recent instance.

**Code “0”** if the person has never received ECT.

**Code “1”** if the person received ECT more than 1 month ago.

**Code “2”** if the person received ECT during the last month but more than 7 days ago.

**Code “3”** if the person received ECT during the last 7 days.

**Code “4”** if the person has not yet received ECT but is scheduled to begin it within the next 7 days.

## **X6. Number of ECT Treatments Received Since Last Assessment**

### **Intent**

To document the number of ECT treatments received since last assessment, or since admission if this is an admission or short stay assessment.



**Process**

This information can be obtained by asking the person, the family, therapists or staff or by checking the medical record.

**Coding**

Record the actual number of ECT treatments received since previous assessment, or since admission if this is an admission or short stay assessment.

0	2
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**Validation**

If L6 ECT = 0, then X6 Number of ECTs Since Last Assessment must = 0.

**Section M — Control procedures/observation**

The procedures and levels of observation that have been utilized for the management of safety and security concerns are captured in this section. The tracking of potentially high-risk interventions is of vital importance, and any action that limits an individual's freedoms must be closely documented and frequently reviewed.

**M1. Control Interventions****Intent**

To record the frequency with which the person was restrained by any of the devices or interventions listed below at any time during the day or night over the last 3 days.

**Definitions**

- a. **Mechanical restraint** — The person is placed in mechanical restraints and is unable to ambulate (e.g., restrained in bed), or the person is placed in mechanical restraints but is able to ambulate (e.g., wrist restraints only).
- b. **Chair prevents rising** — Any type of chair with a locked lap board, a chair that places the person in a recumbent position that restricts rising or a chair that is soft and low to the floor (e.g., a bean bag chair). This includes “comfort cushions” (e.g., the “lap buddy” and “merry walker”). Code “0 not used” if the person does not have the physical ability to rise from **any** chair.
- c. **Physical or manual restraint by staff** — Person is manually held to restrict his or her movement for a brief period. This does not refer to holding a person in order to apply a mechanical restraint.

- d. **Confinement to unit** — The person’s activity level is restricted to the unit only. The person is not to leave the unit unless accompanied by staff or designated family or friends. In the absence of a physician confinement order, persons admitted to locked units or affected by hospital or unit policies that restrict privileges at night should not be considered “confined to unit.”
- e. **Confinement to room** — Confinement to a room, other than a designated seclusion room. This is usually the person’s room but may be any room on the unit (e.g., a quiet room).
- f. **Seclusion room** — Any room that confines the person and from which he or she cannot exit freely.

### Process

Check the person’s clinical record and restraint flow sheets if available. Consult staff.

### Coding

Code for the use of each device or intervention used in the last 3 days.

**Code “0”** if the device or intervention was not used in the last 3 days.

**Code “1”** if the device or intervention was used but less than daily in the last 3 days.

**Code “2”** if the device or intervention was used daily but at night only.

**Code “3”** if the device or intervention was used daily but during the day only.

**Code “4”** if the device or intervention was used during both the day and night but use was not constant.

**Code “5”** if the device or intervention was in constant use for a full 24 hours (may include periodic release).

## M2. Close or Constant Observation

### Intent

To document the level of supervision required over the last 3 days and to assist in determining the acuity of the person’s condition.

### Definitions

- a. **Checked at 15-minute intervals** — The person is observed by a staff member on a regular basis at 15-minute intervals.
- b. **Checked at 5-minute intervals** — The person is observed by staff at regular 5-minute intervals.

- c. **Constant observation for less than 1 hour** — The person is not left unattended at any time for a designated period of time that is less than 1 hour. For example, constant observation may be required for less than an hour while the person settles following the use of an acute control medication, meals or a medical procedure. (Constant observation may be required for longer periods; in this case, item “d” would be used.) Do not include psychiatric intensive care units in the assessment of these items.
- d. **Constant observation for more than 1 hour** — The person is not left unattended at any time, and this constant observation is in effect for more than 1 hour. Do not include psychiatric intensive care units in the assessment of these items.

### **Process**

Review the chart or consult with staff.

### **Coding**

Record the actual number of days that each of the types of observation was in place in the last 3 days. If the type of observation was not used, code “0.”

## **M3. Psychiatric Intensive Care Unit**

### **Intent**

To document the use of a psychiatric intensive care unit during the last 3 days.

### **Definition**

The physical environment is such that people in the defined area can be observed at all times by at least 1 staff member.

### **Process**

Review the person’s clinical record.

### **Coding**

Record the actual number of days the person was in a psychiatric intensive care unit during the last 3 days. If the person was not admitted to a psychiatric intensive care unit because it was not required or there is no such designated unit available, code “0.”

## **M4. Authorized Activities Outside of Facility**

### **Intent**

To determine whether the person left the facility or locked unit at any time in the last 3 days, with or without staff accompaniment.

### **Process**

Review the person's records.

### **Coding**

Code for the number of times the person left the facility or locked unit, either accompanied by staff (item M4a) or not accompanied by staff (item M4b).

**Code “0”** if the person did not leave the facility or locked unit in the last 3 days.

**Code “1”** if the person left the facility or locked unit once.

**Code “2”** if the person left the facility 2 or more times.

## **Section N — Nutrition**

Nutrition, like other physical health concerns, is an important consideration in care planning for the person. This section captures information to assist in the assessment of the person's nutritional status. Indicators for the occurrence of eating disorders and polydipsia are also assessed.

### **N1. Height and Weight**

#### **Intent**

To record a current height and weight in order to establish a baseline to monitor changes in weight as well as nutrition and hydration status.

#### **Process**

If actual measures of height and weight can be obtained, they should be used. Utilize your facility's standard of practice to ensure consistency in measuring weights (e.g., in the morning after voiding, before breakfast, with shoes off and in night clothes). In the absence of actual measures, use the person's, a family member's or your own estimations of height and weight.

## Coding

Record the actual height in centimetres and weight in kilograms. Round height and weight measures in metric to the closest number.

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### Validation

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Assessment will be flagged as suspicious if N1a Height is coded as less than 91 cm (3 ft.) or greater than 213 cm (7 ft.).

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Assessment will be flagged as suspicious if N1b Weight is coded as less than 23 kg (50 lbs.) or greater than 200 kg (440 lbs.).

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## N2. Nutritional Problems

### Intent

To identify issues related to nutrition as manifested by an increase or decrease in weight, insufficient fluid intake or a decrease in food or fluid usually consumed.

### Definitions

- a. **Weight loss in percentages** — Based on a loss of 5 percent or more in the last 30 days or 10 percent or more in the last 180 days. Marked declines in weight can indicate failure to thrive, a symptom of a potentially serious medical problem; poor nutritional intake due to physical, cognitive and social factors; or an eating disorder.
- b. **Weight gain in percentages** — Based on a gain of 5 percent or more in the last 30 days or 10 percent or more in the last 180 days. Weight gain may be an indication of poor nutritional intake or an eating disorder. As well, a striking degree of excess weight can put a person at risk for multiple diseases.
- c. **Insufficient fluid** — The person's fluid intake is less than 1,000 cc per day (approximately 4 8-oz. cups per day).
- d. **Decrease in the amount of food or fluid usually consumed** — This is a decrease in overall consumption as compared with the amount of food or fluid that the person normally consumes.

### Process

Review the clinical record, weight records and dietary notes to assess weight history. Since the person may have been in your facility for only a few days, it may be difficult to obtain accurate factual information. Whenever possible, interview the person and/or the family.

If actual weight records are available, they should be used. In their absence, a subjective estimate of weight change from the person or family can be used. Identifying a particular time approximately 6 months previous (e.g., “compared to last New Year’s”) may help visualize this previous point in time. You may be able to help the respondent answer the question by asking, “How much weight do you think you have lost/gained?” and mentally compare this with the reported or your estimated current weight of the person. You can also ask, “Have you lost/gained a lot of weight? Do you feel much thinner or heavier?” or “Your clothes seem very loose/tight on you. Were you much heavier/thinner 6 months ago?” These questions should be asked in a sensitive manner to elicit useful information.

Example for calculating weight loss and weight gain:

To calculate the percentage of weight loss, divide the amount of weight the person has lost by the person’s previous weight reference. Then, multiply that number by 100 to get the percentage of weight loss. For example, you have on record that 3 months ago the person weighed 65 kilograms. Currently the person weighs 58 kilograms, which represents a loss of 7 kilograms over those 3 months.

$$7 \div 65 = 0.108$$

$$0.108 \times 100 = 10.8\%$$

The person has had a weight loss of nearly 11 percent in 3 months.

The calculation is similar for weight gain. Divide the amount of weight that the person has gained by the person’s previous weight reference. Then multiply that number by 100 to get the percentage of weight gain.

For example, a person tells you that he weighed 84 kilograms a month ago. Currently, he weighs 87 kilograms, which represents a weight gain of 3 kilograms.

$$3 \div 84 = 0.035$$

$$0.035 \times 100 = \text{or } 3.5\%$$

The person has had a weight gain of 3.5 percent in a month.

## Coding

Code as follows for each item.

**Code “0”** if the indicator was not present during the specified time frame.

**Code “1”** if the indicator was present during the specified time frame.

### N3. Indicators of Eating Disorders

#### Intent

To document any potential signs of eating disorders in the last month, since this behaviour may not always be evident through weight change.

#### Definitions

- a. **Binge eating** — An episode of binge eating is characterized by the following:
  - Loss of control over eating
  - Eating a particularly large amount of food, larger than most people would eat given the same or similar time period and circumstances

**Purging** — Behaviours such as self-induced vomiting or the use of laxatives and diuretics.
- b. **Unrealistic fear of weight gain, statements that suggest a distorted body image** — The person has expressed a fear of weight gain or has indicated that his or her body image is incongruent with its actual size.
- c. **Fasting or major restriction of diet** — The person restricts food intake or has reported periods of no food intake (fasting). Do not include issues such as fasting for religious practices or excluding meat from the diet because the person is a vegetarian.

#### Process

The person may be hesitant to admit to experiencing these symptoms. Consult with other staff members or family who are familiar with the person's activity, a referral source for new admissions or the medical record.

#### Coding

**Code “0”** if the item is not reported or was not observed in the last month.

**Code “1”** if the person or others acknowledge that the person had episodes of binge eating, bulimia, purging or fasting or made statements suggesting a distorted body image or an unrealistic fear of weight gain in the last month.

## **N4. Polydipsia**

### **Intent**

To document any excessive intake of fluids in the last 3 days.

### **Definitions**

Inappropriate or excessive fluid consumption. (This can occur among people with chronic mental illness, particularly those with schizophrenia. A person may consume excessive fluids in a variety of ways, e.g., drinks fluids many times during the day, drinks a huge amount at a time, refuses to stop drinking, drinks secretly from unusual sources.) While this is difficult to quantify in absolute terms, observation of the person’s fluid consumption will assist in determining if he or she is drinking excessively throughout the day or consumes excessive amounts at one time.

### **Process**

Information about polydipsia (excessive fluid consumption) can be obtained through staff observation of the person or through a family report. People are often not aware of or will hide excessive fluid consumption.

### **Coding**

**Code “0”** if inappropriate or excessive fluid consumption was not observed in the last 3 days.

**Code “1”** if any 1 or more of the indicators have been present in the last 3 days.

## **Section O — Role functioning and social relations**

This section captures those variables in the life of the person that define him or her socially. Indicators of the quality of relationships within the person’s family, peer group and community; his or her current employment and social situation; and the related risks and potential conflicts are noted. This information is important for establishing plans of care that reflect the person as a whole.

### **O1. Family Roles**

#### **Intent**

To describe perceptions of the quality of relationships that the person has with his or her family members and perceptions that others have of the relationships. Incongruence in perception may be an indicator of difficulties in relationships.



## Definitions

**Disturbed or dysfunctional relationship** — The degree to which a long-term relationship is characterized as being unsatisfactory and unfulfilling and generally not meeting the emotional needs of each participant.

**Others** — Includes formal caregivers such as therapists and staff members.

## Process

The assessments should be done separately with the person and family members. Ask about their perception of communication between one another (e.g., do they talk together about ordinary daily events, household chores, the children?). To what extent do they report that family relationships are based upon mutual respect, emotional affection and caring? To what extent is the emotional climate between family members filled with hostility and/or resentment? Your answer should be based on views of dysfunction reported by the person, the partner or others (e.g., family, staff, therapist) who have information about or observations of the relationship.

## Coding

**Code “0”** if the belief is not present by anyone.

**Code “1”** if only the person believes there are problems, but problems are either not reported by the family or others or the family or others do not believe problems exist.

**Code “2”** if the family, friends or others believe there are disturbed or dysfunctional family relationships, but the person believes no problems are present.

**Code “3”** if the person as well as family, friends and others believe there are problems in the relationship.

## 02. Social Relations and Interpersonal Conflict

### Intent

To describe several important features of a person’s current social network.

### Definitions

- a. **Reports having no confidant** — The person is unable to identify at least 1 person he or she is able to talk to concerning personal issues, troubles or concerns of a private nature. This does not include a therapist or formal care provider.
- b. **Family or close friend overwhelmed by person’s illness** — At least 1 member of the person’s social network is reported to be feeling overwhelmed and/or greatly stressed by the person’s behaviours and actions attributed to his or her mental illness, or a family or close friend feels overwhelmed with concern and worry over the person’s well-being.

- c. **Person is persistently hostile towards or critical of family/friends** — A fairly consistent pattern of person hostility or criticism (expressed either verbally or with physical gestures) directed towards family/friends.
- d. **Person is persistently hostile/critical of others, including staff** — A fairly consistent pattern of hostility or criticism (expressed either verbally or with physical gestures) directed towards others, including staff.
- e. **Family/friends are persistently hostile towards or critical of the person** — Family/friends speak about the person in a critical, disparaging manner.
- f. **Staff reports persistent frustration in dealing with the person** — 1 or more staff members report experiencing an ongoing, repetitive or continuous sense of frustration during interactions with the person.
- g. **Family or friends require unusual amounts of facility staff time** — A staff person identifies 1 or more individuals whom they have spent, in the staff person’s opinion, an excessive amount of time supporting.

### Process

**For item O2a:** Consult the person with respect to the question being asked. Ask the person if there is anyone he or she can talk to about a problem. Ask the person to describe the last time he or she talked to this person. Does the person think this person is a confidant?

**For items O2b and c:** Try to consult directly with a family member or friend. If you are not familiar with how the person interacts with family or friends, you may have to consult them directly to determine how they and the person get along. Alternatively, consult with a staff person familiar with the person. Check the clinical record, as such information is often recorded in a social work report.

**For items O2d, e, f and g:** Rely on your own observations and discuss with other staff. You may also consult with other staff familiar with the person and his or her interaction with others.

### Coding

**Code “0”** if the observation is not present.

**Code “1”** if the observation is present.

### **O3. Employment Status**

#### **Intent**

To document the person's present employment status as it relates to the need for care planning around vocational issues.

#### **Definition**

For the purposes of this assessment, employment refers to either part-time or full-time paid work.

#### **Process**

Ask the person or family members about the person's employment status.

#### **Coding**

##### *CIHI Tip*

O3 captures the person's present employment status as it related to planning for vocational issues; therefore, for homemakers, students and retirees not seeking employment, O3 = "3 other".

**Code "0"** if the person is presently employed.

**Code "1"** if the person is not employed but is actively seeking employment.

**Code "2"** if the person is not employed and is not presently seeking employment.

**Code "3"** for Other — This would include a person with full-time status that does not include remuneration (e.g., homemaker, pensioner, student).

**Code "4"** for Unknown.

### **O4. Risk of Unemployment/Disrupted Education**

#### **Intent**

The intent of this item is to identify factors that place the person at risk for financial problems because of employment and/or education difficulties.

#### **Process**

Question the person directly about his or her employment situation. If the person is unable to respond, you may also speak with family members (if available).

**Indicators:**

- a. Increase in lateness or absenteeism over the last 6 months
- b. Poor productivity or disruptiveness at work/school
- c. Expresses intent to quit work/school
- d. Persistent unemployment or fluctuating work history over the last 2 years

**Coding**

**Code “0”** if the indicator is not present for each of the items.

**Code “1”** if the indicator is present.

**Code “8”** if the indicator is not applicable (e.g., the person is not employed or is not attending school).

## **05. Trade-Offs**

**Intent**

To determine if limited funds prevented the person from receiving required medical and environmental support. This item does not include “trading” of non-essential health or environmental items, such as cigarettes for other goods.

**Process**

Ask the person or a family member if prescribed medication, sufficient home heat (electricity, gas), household supplies, rent, necessary health care, clothing or adequate food was not obtained due to limited funds. Asking financial questions can be a sensitive area; therefore, questioning must be sensitive and respectful of the person.

**Coding**

**Code “0”** if no trade-offs were required in the last month.

**Code “1”** if any of the above occurred in the last month.

## O6. Social Relationships

### Intent

To assess the nature and recentness of social relationships.

### Definitions

- a. **Participation in social activities of long-standing interest** — The person has maintained involvement in voluntary associations (e.g., church group) or other activities that involve being with others (e.g., chess club).
- b. **Visit by long-standing social relation/family member** — Refers to face-to-face interactions with persons who have had persistent, ongoing relationships with the person (e.g., family or friends visit with the person while he or she is in the hospital, person visits with family over a weekend leave from the hospital). This item excludes recent acquaintances the person may have made during or shortly before this admission.
- c. **Telephone or email contact with long-standing social relation/family member** — Like the previous item, this item refers to interactions with persons who have had persistent, ongoing relationships with the person. However, this item deals only with interactions that did not occur in person.

### Process

Ask the person about the nature of his or her social activities and contacts with family or friends and the last time a contact was made or an activity was engaged in. The point here is to establish when the person last had contact with at least 1 family member or friend. If in doubt, you should clarify the duration of the relationship to ensure that the tie with the person has been long-standing.

### Coding

Code for the most recent instance.

**Code “0”** if the event occurred within the last 3 days.

**Code “1”** if the event occurred within the last week but more than 3 days ago.

**Code “2”** if the event occurred within the last month but not in the last week.

**Code “3”** if the event occurred more than 1 month ago.

## Section P — Resources for discharge

This section is intended to assess resources available to the person on discharge. This includes the informal support system currently available or potentially available to the person. Informal support persons include family, friends, coworkers and neighbours. Informal supports are differentiated from formal support providers such as health care professionals or social agencies. Other assessments in this section include discharge readiness and living arrangements.

### P1. Available Social Supports (Family/Close Friends)

#### Intent

To assess the availability of family or close friends in providing support the person will require following discharge. This information will assist the team in determining support services that might be required on discharge if family or friends are not available or are available on only an occasional basis to help out in a particular area.

#### Definitions

- a. **Help with childcare, other dependants** — A family member or friend helps the person with babysitting, driving a child to school or medical appointments, etc.
- b. **Supervision for personal safety** — Supervision that is required for the purpose of ensuring the person’s safety. This might include the need for someone to be on hand to prevent wandering, self-harm behaviour or other behaviours that have the potential of putting the person at risk.
- c. **Crisis support** — Support from a family member or friend during a crisis. A “crisis” refers to a sudden, specific episode of extreme stress for the person (e.g., an acute exacerbation of symptoms, the presence of suicidal ideation).
- d. **Support with ADLs or IADLs** — ADL (activity of daily living) support includes helping out with functional activities such as bed mobility, locomotion in the home, dressing, eating, toilet use, personal hygiene and bathing. IADL (instrumental activity of daily living) support involves helping out with activities such as preparing meals, housekeeping, managing finances or medications, using the phone, shopping and arranging transportation. Special needs with respect to the domain of ADLs are usually more common to people admitted to geriatric psychiatry.

## Process

Ask the person if he or she could identify informal caregivers or supports. The person may identify several people who “would help” if asked. Shape the questions with specific statements such as the following: Who helps or could help you shop? Who helps or could help with cleaning around the house? Who do you talk to when feeling troubled? Who helps or could help you pay your bills? Who drives you when you need a ride? Is there anyone you could call if you were stranded somewhere? If the person does not receive any support, ask if there is someone who would help, if needed. If the person is not able to understand or respond to questions or gives responses that are unclear, evasive or untrue (e.g., refers to husband when you know the husband is deceased), review any agency documentation or ask the family (if available).

It is important to understand that some helpers may not be described by the person as “social supports.” Many helpers do things in line with normal social relationships (e.g., it is what a daughter or wife is expected to do). Thus, it is useful to concentrate on what support is provided. When addressing these issues, use the name or title of the support person provided by the person (e.g., “Does ‘Mary’ live with you?” or “Does your ‘buddy’ live with you?”).

For IADLs, ask the person if there is anyone who helps, or could help, with preparing meals, housekeeping, managing finances or medications, shopping and arranging transportation. Support can range from the helper doing only light housework to doing all of the shopping and housework.

For ADLs, ask the person if there is anyone who provides, or could provide, help in ADL areas such as bed mobility, locomotion in the home, toilet use, personal hygiene, bathing, dressing, eating and transferring.

Once a family member or friend has been identified as being able to provide support, it is important to ask about the availability of the support person(s). It is key to differentiate between regular and occasional support; i.e., the person can count on the support on a regular basis whenever it is needed, or the family or friend could help out some of the time but would not necessarily be there every time help was needed. Check with family or friends who were identified by the person as sources of assistance on discharge in order to verify their availability to help if needed.

## Coding

A code of “0” indicates that support of this type **will not** be needed after discharge. A code of “3” indicates that support of this type **will** be needed after discharge **but that no** family member or close friend will be available to provide it.

**Code “0”** if support in a particular area is not needed.

**Code “1”** if family or friends will be available to help out on a consistent, predictable basis; i.e., the person will be able to depend on the family member or friends to help whenever needed.

**Code “2”** if family or friends are definitely willing and able to provide support following discharge for the listed area but can only commit to helping out on an occasional or inconsistent basis.

**Code “3”** if there are no family or friends available to provide the specified type of support or if family or friends report they are unable or unwilling to provide support in the particular area.

## P2. Discharge Readiness

### Intent

To identify indicators of discharge readiness and give further insight into discharge planning issues.

### Definitions

- a. **Person expresses or indicates a preference to return to/remain in the community** — The person has made insightful statements or given indications that he or she would rather be living in the community than in the present facility. Discharge readiness implies some insight as opposed to elopement risk.
- b. **Person has a supportive person who is positive towards discharge/maintaining residence in the community** — Family or friends have indicated to the person and the staff that they are positive and supportive of discharge and of the person maintaining his or her residence in the community.

### Process

Obtain information from the person, family or staff.

### Coding

**Code “0”** for no.

**Code “1”** for yes.



### **P3. Projected Time to Planned Discharge**

#### **Intent**

An estimate of the length of stay will assist with discharge planning.

#### **Definition**

This calculation is based on the estimated number of days the person is expected to remain in the facility from the time of Assessment Reference Date to the expected time of discharge.

#### **Process**

Use your best clinical judgment to determine the projected duration of the person's stay.

#### **Coding**

**Code “0”** if the expected length of stay is 1 to 7 days.

**Code “1”** if the expected length of stay is 8 to 14 days.

**Code “2”** if the expected length of stay is 15 to 30 days.

**Code “3”** if the expected length of stay is 31 to 90 days.

**Code “4”** if the expected length of stay is 91 or more days.

### **P4. Overall Change in Care Needs**

#### **Intent**

To evaluate the person's overall change in clinical status as compared with 30 days ago or since admission/last assessment, if less than 30 days ago. This is a key element in assessing discharge potential.

#### **Process**

Review the clinical record and care plan. Consult with other staff members or referral source for a new admission.

## Coding

Enter the number that most accurately reflects the person’s overall change in psychiatric symptoms over the last 30 days or since admission, if less than 30 days ago.

**Code “1”** if the person’s symptoms are more frequent and/or severe and the person requires more intensive treatment.

**Code “2”** if there is no change in the person’s psychiatric symptoms.

**Code “3”** if there is an observed improvement in symptom frequency or intensity, but the person continues to demonstrate some difficulties in some areas.

**Code “4”** if there is a marked/significant improvement in symptom frequency and intensity.

Clinicians should complete P4 with as much information as is available at the time of assessment. For example, in the case of an admission assessment, it is sometimes possible to access pre-admission information from a family member or referral source; however, when pre-admission information is unavailable, it may be necessary to consider only the last 3 days when completing P4.

## P5. Discharged To

### Intent

To document the living arrangement to which the person is being discharged.

### Definitions

1. **Private home/apartment/rented room** — Any house, condominium or apartment in the community, whether owned or rented by the person or another party. Any rented room, such as a resident hotel, whether rented by the person or another person. Also included in this category are retirement communities and independent housing for the elderly or disabled.
2. **Board and care** — A non-institutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home health, homemaker, personal care, meal service, transportation, etc.
3. **Assisted living or semi-independent living — A second type of non-institutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home health, homemaker, personal care, meal service, transportation, etc. (e.g., retirement homes in Ontario).**
4. **Mental health residence** (e.g., psychiatric group home) — A residence where specialized care is provided to adults with mental health problems who need supervision and limited services (meals, housekeeping).

5. **Group home for persons with physical disabilities** — A setting that provides services to persons with physical disabilities. Typically, people live in group settings with 24-hour staff presence but are encouraged to be as independent and active as possible.
6. **Setting for persons with intellectual disabilities** — A setting that provides services to persons with intellectual disabilities. Typically, people live in group settings with 24-hour staff presence but are encouraged to be as independent and active as possible.
7. **Psychiatric hospital or unit** — A hospital caring for persons with a psychiatric illness that is separate from other inpatient facilities, such as an acute, rehabilitation or complex continuing care hospital. A psychiatric unit is a designated care unit located within a general hospital.
8. **Homeless (with or without shelter)** — A homeless person does not have a fixed residence: a home, apartment, room or place to stay on a regular basis. The person may live on the streets or outside in wooded or open areas. The person may sleep in cars, abandoned buildings, under bridges, etc. People who are homeless may or may not take advantage of existing homeless shelters.
9. **Long-term care facility (nursing home)** — A health care facility that provides 24-hour skilled or intermediate nursing care.
10. **Rehabilitation hospital/unit** — A rehabilitation hospital or unit provides physical and occupational rehabilitation to persons who have experienced disease or injury resulting in subsequent decline in physical function. An entire rehabilitation hospital or a specific rehabilitation unit within an acute care hospital may be dedicated to this task.
11. **Hospice facility/palliative care unit** — A hospice facility (or unit within a facility providing more general care) provides care to persons who have a terminal illness with a prognosis of less than 6 months to live, as certified by the physician. The goal of hospice care is to provide comfort and quality of life while assisting the person and family. Palliative care is the care of persons whose diseases are not responsive to curative treatments. It targets pain and symptom relief without precluding the use of life-prolonging treatments, and provides support systems for the person and his or her family.
12. **Acute care hospital** — An acute care hospital primarily provides the diagnosis and treatment of acute medical disorders. Examples include complex continuing care hospitals, general hospitals and specialty hospitals. Do not include psychiatric wards of a general hospital, psychiatric hospitals or rehabilitation hospitals, as they are coded separately.
13. **Correctional facility** — Any jail, penitentiary or halfway house, whether operated by the local, provincial or federal government. Correctional staff is responsible for caring for and housing persons sentenced by a criminal court to incarceration.
14. **Other** — Any other type of setting not listed above.
15. **Deceased**

## Process

This item is completed only upon discharge. Review the medical record; if the information is unavailable in the medical record, ask the person or family.

## Coding

Code the living arrangement on discharge.

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### Validation

If X90 Discharge Reason = 2 or 3, then P5 Discharged To must = 15.

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## X140.Discharged to Facility Number

### Intent

To capture the number of the facility to which the person was discharged (if discharged to a facility).

### Definition

The provincial or territorial code and facility number for the facility to which the person was discharged.

### Process

Determine the ministry-issued master number of the facility to which the person was discharged. Consultation with health records or ministry reference materials may be necessary. This applies for people discharged to a facility as defined in P5.

### Coding

Enter the 1-digit provincial/territorial code provided in data element AA4 (Facility Number) and the 4-digit facility code in the space provided. Code “Z9999” for facilities located outside of the country. Leave blank if the person was not discharged to a facility.

**Note:** For persons discharged to a nursing home or specialty mental health hospital when the exact facility is unknown at time of discharge, or to a nursing home that does not have an assigned facility number, use the appropriate generic code below:

- Nursing home: Assigned province/territory number/character followed by “0004”
- Specialty mental health hospital: Assigned province/territory number/character followed by “0005”

**Validation**

The first character of X140 Discharged to Facility Number must be a valid province/territory code (0–9, N, Y, V, Z); if Z is coded, then the remaining 4 digits must be 9999.

If Z1 Record Type = 5 (Discharge) or 7 (Short Stay) and P5 Discharged To = any of 7, 9, 10 or 12, then X140 Discharged to Facility Number must not be blank.

If P5 Discharge To = any of 1–6, 8, 13, 14 or 15, then X140 Discharged to Facility Number must be blank.

**X141. Discharged With Support/Referral for Home Care Services****Intent**

To capture persons who are referred for or who will be receiving home care services upon discharge.

**Definition**

Identify patients who were referred for or who will receive supports from home health services or home support services.

**Process**

Determine whether the person is discharged with or without referral for home care support.

This applies for persons discharged to a living arrangement as defined in P5 Discharged To, options 1 to 14. It may be necessary to consult the discharge dispositions.

If a referral to home care services was made and these services were declined by the agency, capture this as “1.”

If home care services were provided before a current admission and they continue after a current discharge without a new referral, capture this as “1.”

**Coding**

A code of “0” indicates that referral for home care services/support was **not made and that there are no home care services upon discharge.**

**A code of “1” indicates that referral for home care services/support was made or home care services will be received upon discharge.**

**Note:** Do not include services or support provided by community mental health services.

---

**Validation**

---

If P5 Discharged To is not equal to 15 and A1 Assessment Reference Date is greater than or equal to April 1, 2020, then X141 Discharged With Support/Referral for Home Care Services must be coded.

If P5 Discharged To equals 15, then X141 Discharged With Support/Referral for Home Care Services must be blank.

---

## Section Q — Psychiatric diagnostic information

The applicable diagnoses, as determined by the attending psychiatrist, are recorded in this category.

### Q1. DSM-5-TR Diagnostic Category

#### Intent

To provide up to 3 diagnoses (or provisional diagnoses if this is an initial assessment), according to broad *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR) diagnostic categories, as determined by the psychiatrist or attending physician.

#### Diagnostic categories

- a. Neurodevelopmental disorders
- b. Schizophrenia spectrum and other psychotic disorders
- c. Bipolar and related disorders
- d. Depressive disorders
- e. Anxiety disorders
- f. Obsessive-compulsive and related disorders
- g. Trauma and stressor related disorders
- h. Dissociative disorders
- i. Somatic symptoms and related disorders
- j. Feeding and eating disorders
- k. Elimination disorders
- l. Sleep-wake disorders
- m. Sexual dysfunctions
- n. Gender dysphoria
- o. Disruptive, impulse-control and conduct disorders
- p. Substance related and addictive disorders
- q. Neurocognitive disorders

- r. Personality disorders
- s. Paraphilic disorders
- t. Other mental disorders
- u. Medication-induced movement disorders and other adverse effects of medication
- v. Not applicable

## Process

This information is important for the care and treatment planning of the person, and close attention to accuracy and completeness is required. While the diagnosing physician may code this section, transcription of the diagnoses by other clinicians or health records personnel may be appropriate for some facilities.

## Coding

Place a “1” beside the category containing the primary diagnosis and then code up to 2 more diagnosis categories, if present, with scores of “2” and “3” in their order of importance as factors contributing to this assessment. It is important to rank **all** mental health diagnostic categories that are present, not only the reason for admission.

**Note:** *Q1v = 1 “Not applicable” is only for persons admitted to a mental health bed in the absence of a mental health diagnosis (e.g., persons admitted for a forensic assessment in the absence of a mental health diagnosis).*

Validation
Only 1 of Q1a–v may = 1.
Only 1 of Q1a–u may = 2.
Only 1 of Q1a–u may = 3.
If any of Q1a–u = 2, then 1 of Q1a–u must = 1.
If any of Q1a–u = 3, then 1 of Q1a–u must = 2.
If Q1v = 1, then all of Q1a to Q1u must be blank.
1 of Q1a–v must be specified as 1 (most important).
Record will be flagged as suspicious if Z1 Record Type = 4 (Quarterly) and Q1v = 1.
Record will be flagged as suspicious if Z1 Record Type = 5 (Discharge) and net length of stay (X80 Discharge Date – CC1 Date Stay Began – X130 Total Days Away From Bed) is greater than 6 days and Q1v = 1.
Record will be flagged as suspicious if Q1v = 1 and the corresponding admission within the episode has a provisional psychiatric diagnosis.
Record will be flagged as suspicious if Q1v = 1 and CC2h Reason for Admission — Forensic Assessment is not coded as 1.

## Q2. Psychiatric Diagnosis

### Intent

To document the specific psychiatric diagnoses as determined by the psychiatrist.

### Process

Review the clinical record for the psychiatric diagnosis as determined by the psychiatrist. This item must be completed on discharge but can be completed sooner if the psychiatric diagnoses have been determined earlier.

### Coding

Write the 3- to 7-digit DSM-5-TR ICD-10-CM code in the space(s) provided for the specific psychiatric diagnosis. List the primary diagnosis first; the remaining disorders are listed in order of focus of attention and treatment. The DSM-5-TR coding can be completed by the staff or referred to the health records department to complete.

**Note:** Entering the **same** code twice in Q2 will cause the record to be flagged as suspicious.

**Note:** On a **full discharge assessment**, at least **one code** must be entered in Q2.

Validation
On the Full Discharge Assessment, a DSM-5-TR code must be completed
A valid ICD-10-CM code from DSM-5-TR must be inserted for each psychiatric diagnosis.
Q2a–f DSM-5-TR codes must not contain decimals.
Record will be flagged as suspicious if Q2a–Q2f contain duplicate DSM-5-TR diagnostic codes.
If Q2a = F20.9, F25.0 or F25.1, then X161–X164 cannot be blank.
If Q2 has a value other than F20.9, F25.0 or F25.1, then X161–X164 are not checked.

## Q3. Intellectual Disability

### Intent

To document conditions associated with intellectual disabilities.

### Definition

A confirmed diagnosis of intellectual disability as described in the DSM-5-TR: a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains.



**Process**

Review the person's medical record. For this item, the diagnosis must be documented in the record.

**Coding**

**Code "0"** if no diagnosis of intellectual disability is present.

**Code "1"** if an intellectual disability is present.

**Q4. Global Assessment of Functioning (GAF) Score****Intent**

To document the most current GAF score. This score is useful for tracking the clinical progress of a person in global terms, using a single measure.

**Definition**

As described in the DSM-IV TR, GAF is a clinical scale used to determine a person's overall level of psychological, social and occupational functioning. It ranges from 100 (superior functioning) to 1 (persistent danger, serious dysfunction).

**Process**

Review the clinical record for the GAF score as determined by the psychiatrist or other clinician who has the requisite training, skills and experience.

**Coding**

Enter the person's current GAF score in the space provided. In most instances, ratings on the GAF scale should indicate the level of functioning at the time of the evaluation, since ratings for current function will generally reflect the need for treatment. To account for day-to-day variability in functioning, the current score *may be* operationalized as the lowest level of function in the past week.

**Code "0"** if there is inadequate information available to score the person.

## Q5. Current Patient Type

### Intent

To provide a general categorization of patient type.

### Definitions

1. **Acute care** — The person is admitted for a new problem or an acute flare-up of an existing problem, and the expected length of stay is less than 14 days.
2. **Longer-term** — The person has a persistent mental illness, and length of stay is expected to be 14 days or more.
3. **Geriatric psychiatry** — Regardless of the length of stay, the person has a chronic condition typically associated with aging (e.g., Alzheimer’s disease, multi-infarct dementia).
4. **Forensic** — The person is admitted for a forensic assessment or because of a designation of unfit to stand trial or not criminally responsible. Use this coding option for all forensic admissions regardless of the expected length of stay and even when the person also has a condition typically associated with aging.

### Process

Review the clinical record and consult with the clinical team to determine the most applicable patient type.

### Coding

Enter the most appropriate code for the current patient type in the box per the definitions above.

---

**Validation**

---

If A3b Inpatient Status at Time of Assessment = 5, then Q5 Current Patient Type must = 4.

---

## X160. Schizophrenia Primary Diagnosis

### Intent

To identify persons with a primary diagnosis of schizophrenia or schizoaffective disorder as determined by the psychiatrist or attending physician.

### Definition

A confirmed diagnosis of schizophrenia or schizoaffective disorder is defined by the following ICD-10-CM codes in DSM-5-TR and confirmed by the psychiatrist or attending physician: F20.9 *Schizophrenia*, F25.0 *Schizoaffective disorder, Bipolar type* and F25.1 *Schizoaffective disorder, Depressive type*.

**Process**

Review the clinical record for the psychiatric diagnosis of schizophrenia or schizoaffective disorder as indicated by the designated ICD-10-CM codes in DSM-5-TR and as determined by the psychiatrist or attending physician. These are the only acceptable codes to be used to identify schizophrenia as the primary diagnosis.

This item must be completed on discharge but can be completed sooner if the psychiatric diagnoses have been determined earlier. If possible, have the psychiatrist or attending physician complete this data element.

**Coding**

**Code “0”** if no primary diagnosis of schizophrenia/schizoaffective disorder is present.

**Code “1”** if a primary diagnosis of schizophrenia/schizoaffective disorder is present.

**Validation**

If Q2a = F20.9, F25.0 or F25.1, then X161–X164 are mandatory.

If X160 = 1, then X161–X164 are mandatory. If X160 = 0, then X161–X164 are not checked.

**X161. Long-Acting Injectable Medication****Intent**

To identify persons admitted to hospital with a primary diagnosis of schizophrenia who are receiving treatment or received treatment with a long-acting injectable medication during their stay or before admission.

**Definition**

Long-acting injectable (LAI) antipsychotics are commonly used in the treatment of schizophrenia to improve adherence and clinical outcomes. Current guidelines for the treatment of persons with schizophrenia advocate that persons receive treatment with a LAI antipsychotic medication if they prefer such treatment or if they have a history of poor or uncertain adherence. Clinicians should consider offering depot/LAI antipsychotic medication to persons with schizophrenia

- Who would prefer such treatment after an acute episode; and/or
- Where avoiding covert non-adherence (either intentional or unintentional) to antipsychotic medication is a clinical priority within the treatment plan.

## Process

Review the person’s medication administration record and medication reconciliation record. Pharmacological interventions may be recorded under your hospital’s local pharmacy systems, digital order sets, medication reconciliation systems or clinical notes. Include those persons who are on active LAI treatment (administered either prior to or during admission).

## Coding

**Code “0”** if no LAI medication has been received.

**Code “1”** if treatment with LAI medication has been received during the hospital stay.

**Code “2”** if treatment with LAI medication was received prior to admission and not required during the hospital stay.

---

Validation
If Q2a = F20.9, F25.0 or F25.1, then X161–X164 cannot be blank.
If X160 = 1, then X161–X164 cannot be blank.

---

## X162. Treatment Resistant

### Intent

To identify a person with schizophrenia who is deemed treatment resistant/treatment refractory.

### Definition

Treatment resistant/treatment refractory refers to persons who have failed to respond to previous adequate trials of treatment with at least two antipsychotic medications. An adequate trial of antipsychotic medication is defined as having an adequate dose and duration with reasonable confidence of adherence, with each of the foregoing determined by the psychiatrist or attending physician.

### Process

Consult with the psychiatrist or attending physician and/or review the clinical record and psychiatrist or attending physician documentation. Determining treatment resistance is at the discretion of the psychiatrist or attending physician but must be documented. If possible, have the psychiatrist or attending physician complete this data element.

### Coding

**Code “0”** if the psychiatrist or attending physician has determined that the person is not treatment resistant.

**Code “1”** if the psychiatrist or attending physician has determined that the person is treatment resistant.

**Validation**


---

If Q2a = F20.9, F25.0 or F25.1, then X161–X164 cannot be blank.

---

If X160 = 1, then X161–X164 cannot be blank.

---

**X163. Treatment With Clozapine****Intent**

To identify a person admitted to hospital with a primary diagnosis of schizophrenia who has failed to respond to previous adequate trials of treatment with 2 antipsychotic medications (treatment resistant) and who received treatment with clozapine during this hospital stay.

**Definition**

Clozapine is the treatment of choice if someone with schizophrenia has a partial or total non-response to other antipsychotic treatments. Only persons who are eligible for clozapine may be treated with this antipsychotic medication. Eligibility is defined as having failed to respond to previous adequate trials of treatment with 2 antipsychotic medications (treatment resistant). The clinical decision to administer clozapine is at the psychiatrist/physician's discretion and should be documented in the clinical notes/local electronic health record.

**Process**

Review or validate the information with the person's medication administration record. Pharmacological interventions may be recorded under your hospital's local pharmacy systems, digital order sets, medication reconciliation systems or clinical notes. For persons who have been treated with clozapine but do not continue with clozapine on or after discharge, code "0."

**Coding**

**Code "0"** if the person did not receive treatment with clozapine during this hospital stay.

**Code "1"** if the person received treatment with clozapine during this hospital stay and is prescribed to continue at discharge.

**Validation****Validation**


---

If Q2a = F20.9, F25.0 or F25.1, then X161–X164 cannot be blank.

---

If X160 = 1, then X161–X164 cannot be blank.

---

## X164. Care Plan Sent

### Intent

To identify persons who have a documented care plan that will be made available to any receiving provider within 7 days of discharge.

### Definition

People with schizophrenia who have been admitted to inpatient mental health settings and with medication(s) initiated in the hospital require a scheduled follow-up appointment to continue their treatment. Care plan is defined as a treatment/care plan, discharge summary or discharge plan where the comprehensive interprofessional assessment and physical health assessment informs the continued care plan for the individual.

### Process

Consult available clinical documentation regarding discharge summary, care plan and scheduled follow-up appointments.

### Coding

**Code “0”** if no care plan is available or was not sent within 7 days of discharge.

**Code “1”** if a care plan is available to the follow-up provider within 7 days of discharge.

---

#### Validation

---

If Q2a = F20.9, F25.0 or F25.1, then X161–X164 cannot be blank.

---

If X160 = 1, then X161–X164 cannot be blank.

---

## Section R — Medications

The medications section comprises the indicator for the presence of medications within the last 3 days and the detailed medication record. The list of medication elements will provide valuable data on the pharmacological interventions used in inpatient mental health settings.

### R1. Prescribed Medications

#### Intent

To identify if the person has had any medication prescribed for use in the last 3 days.

#### Process

Check the medical record.

## Coding

**Code “0”** if no medication has been prescribed.

**Code “1”** if there has been 1 or more medications prescribed, regardless of the number of different medications.

## R2. List of Medications

### Intent

To provide a listing of all the medications the person has taken during the last 3 days, including medication that was taken but discontinued in that time period.

### Definitions

**Name** — Either the generic or the trade name is acceptable. (This information will not be collected by CIHI.)

**DIN** — Drug Information Number. The officially recognized 8-digit number assigned by Health Canada to the pharmaceutical in question. Be sure to enter the correct DIN for the drug name, strength and form. The DIN must match the drug dispensed by the pharmacy.

**Dose** — The actual total dose taken. (**Note:** If more than 1 pill or tablet is used to make up the dose, document the total dose taken [e.g., if the person is taking 2 Tylenol 325 mg tabs, the total dose to be documented would be 650 mg].)

**Form/route** — This is the route of administration.

**Freq.** — Frequency; the number of times taken per day.

**PRN** — The medication listed was received by the person on a PRN basis.

**Discontinued** — The medication was discontinued at some time in the last 3 days.

### Process

Review the medical administration record. If no medication has been prescribed, as indicated by R1 = 0, leave this section blank.

The DIN will be obtained in consultation with the facility’s pharmacy. Medication bottles and pharmacy receipts may also be used to determine the DIN.

For the submission of electronic records, medication records are separate from, but linked to, assessment records. A unique medication record is completed for each medication prescribed for use during hospitalization.

### **Coding**

Write in the 8-digit drug identification number of all medication taken in the last 3 days under the appropriate column, followed by the dose, the route of administration in the “Form” column and the frequency in the next column. If the medication was given as a PRN at any time during the last 3 days, place a check mark in the “PRN” column; otherwise leave it blank. If the medication was discontinued during the last 3 days, place a check mark in the D/C column; otherwise leave it blank.

## **Section S — Service history**

The items in this section report details related to the person’s stay in hospital (e.g., if the person was admitted through the emergency department, the discharge date, time spent away from the bed, time spent in an alternate level of care). While mainly administrative, establishing the reasons for the discharge and service interruptions, along with any days spent in an alternate level of care, may require consultation with the clinical area.

### **X8. Emergency Department Flag**

#### **Intent**

To capture additional information for persons admitted through the organization’s emergency department.

#### **Definition**

**Emergency department (ED)** — To be included here, the ED must be a part of the same organization as the mental health inpatient unit to which the person is being admitted.

### **X8A. Admitted Through Emergency Department**

#### **Process**

First determine if this organization has an ED. Then determine if the person was admitted to a mental health inpatient unit through the ED.



## Coding

**Code “0”** if the person was not admitted to a mental health inpatient unit through the ED or if this organization does not have an ED.

Leave X8B and X8C blank.

**Code “1”** if the person was admitted to a mental health inpatient unit through the ED.

**Note:** Although in some cases the person may not actually arrive on a mental health inpatient unit as expected, a code of “1” is still applicable if a decision to admit to the mental health unit was made in the ED. Proceed to X8B.

## X8B. Arrived on Inpatient Unit

### Process

Review the clinical record to determine if the person arrived on a mental health inpatient unit after being admitted through the ED.

### Coding

**Code “0”** if the person left or was discharged from the facility prior to arriving on a mental health inpatient unit.

Leave X8C blank.

**Code “1”** if the person did arrive on a mental health inpatient unit.

Proceed to X8C.

## X8C. Date Arrived on Inpatient Unit

### Process

Enter the date the person arrived on a mental health inpatient unit from the ED, if applicable.

### Coding

Enter the appropriate numbers in the boxes provided. If the month or day contains only a single digit, fill the first box with a “0.”

For example, a stay beginning on March 20, 2018, should be coded as follows:

2	0	1	8
---	---	---	---

Year

0	3
---	---

Month

2	0
---	---

Day

## **X75. Days of Alternate Level of Care (ALC) Since Last Assessment or Admission**

### **Intent**

To document the number of alternate level of care (ALC) days since last assessment, or since admission if this is an admission or short stay assessment.

The designation of ALC is applied to a person who no longer requires adult mental health inpatient services but is still occupying a designated bed due to the unavailability of resources in a setting more appropriate to the level of care that is required. While it most often will be a period of time before discharge, a person could have more than 1 instance of ALC if his or her needs warranted a return to active care.

### **Process**

Verify the number of days the person was determined to be in ALC by scrutinizing the clinical record and liaising with other clinicians responsible for making this determination, i.e., the attending psychiatrist. For a quarterly, change in status or discharge assessment, calculate the total number of days that the person spent in ALC since his or her last assessment. For an admission or short stay assessment, enter the total number of days that the person spent in ALC since the date of admission.

### **Coding**

If filling out a quarterly, change in status or discharge assessment, enter the total number of days that the person spent in ALC since the last assessment during this episode of care. If filling out an admission or short stay assessment, enter the total number of days that the person spent in ALC since the date of admission.

---

### **Validation**

X75 Days in Alternate Level of Care Since Last Assessment or Admission must be between 0 and 999.

On quarterly, discharge and change in status assessments, X75 Days in Alternative Level of Care Since Last Assessment or Admission must be less than or equal to the A1 Assessment Reference Date – A1 Assessment Reference Date of the most recent previous admission, change in status or quarterly assessment with the same AA4 Facility Number, X30 Chart Number and AA3 Case Record Number.

On short stay or admission assessments, X75 Days in Alternative Level of Care Since Last Assessment or Admission must be  $\leq$  A1 Assessment Reference Date – CC1 Date Stay Began.

---

## X80. Date of Discharge

### Intent

To record the date on which the person was discharged from the facility.

### Process

Review the clinical record to determine the date the patient was discharged.

### Coding

For the month and day of discharge, enter 2 digits each using a leading “0” as filler if needed. Use 4 digits for the year.

### Example

February 17, 2018

2	0	1	8		0	2		1	7
Year					Month			Day	

For persons discharged from leaves of absence (LOAs) or while receiving care in another facility, enter the date the decision was made to discharge the person from your facility.

---

### Validation

X80 Discharge Date must be greater than or equal to CC1 Date Stay Began of the associated admission record.

For a short-stay record, net length of stay (X80 Discharge Date – CC1 Date Stay Began – X130 Total Days Away From Bed) must be less than or equal to 3 days.

X80 Discharge Date of an earlier episode must be less than or equal to CC1 Date Stay Began of the later episode of the same person.

---

## X90. Reason for Discharge

### Intent

To establish the most appropriate and accurate reason for the person’s discharge from the facility.

### Process

Determine the most appropriate reason for this discharge by consulting with the clinical team and examining the person’s status on discharge.

## Coding

**Code “1”** for a planned discharge.

**Code “2”** if the person died as the result of suicide.

**Code “3”** if the person died but not as the result of suicide.

**Code “4”** if the person was transferred (unplanned) and was expected to return to the mental health bed but did not return within 92 days.

**Code “5”** if the person was discharged due to being absent without leave (AWOL).

**Code “6”** if the person was discharged due to a leave of absence (LOA) to the community longer than 92 days.

**Code “7”** if the person was discharged against medical advice.

**Code “8”** for other.

---

### Validation

If P5 Discharged To = 15 (Deceased), then X90 Reason for Discharge must = 2 or 3 (Death Due to or Not Due to Suicide).

---

## Days Away From Bed

### Intent

To capture those occasions when a person leaves the mental health bed for a period of time (equal to or greater than 24 hours and less than or equal to 92 calendar days) with the expectation of returning to the mental health bed to continue treatment.

Days away from bed include both planned absences (e.g., weekend passes) and unplanned absences (e.g., a temporary transfer to another level of care).

For instances in which the person is away from the mental health bed for longer than 92 days or does not return as expected, a Discharge Assessment should be completed. The discharge date should be the last day the person occupied the mental health bed.

## X130.Total Days Away From Bed

### Intent

To capture the total number of days (greater than or equal to 24 hours) the person was away from the mental health bed since the last assessment (or since admission if this is an Admission or Short-Stay assessment).

**Process**

Review the person’s medical record to determine the total number of days the person was away from the mental health bed since the last assessment (or since admission if this is an Admission or Short-Stay assessment). Include both planned and unplanned days away from the mental health bed.

**Coding**

Enter the total number of days the person was away from the bed since the last assessment (or since admission).

**Code “0”** if there were no days away from the bed.

**X131.Days Away From Bed in Previous Fiscal Year****Intent**

It is mandatory to capture those days away from the mental health bed (greater than or equal to 24 hours) that occurred **in the previous fiscal year** when the time since the last assessment (or since admission if this is an Admission or Short Stay assessment) straddles 2 fiscal years *and* some or all of the days away from the mental health bed occurred in the previous fiscal year, so the total days away from bed can be split correctly into 2 fiscal years.

**Definitions**

**Fiscal year** — Begins on April 1 of a given year and ends on March 31 of the following year.

**Quarter 4** — The months of January, February and March in any year of the mental health reporting cycle. Quarter 4 begins January 1 and ends March 31.

**Quarter 1** — The months of April, May and June in any year of the mental health reporting cycle. Quarter 1 begins on April 1 and ends on June 30.

**Process**

Review the person’s medical record to determine the total number of days away from the mental health bed since the last assessment (or since admission if this is an Admission or Short-Stay assessment). Include only those days that occurred in a fiscal year prior to the fiscal year of the current Assessment Reference Date (ARD). Total Days Away From Bed in Previous Fiscal Year will be most applicable when completing assessments with an ARD between April 1 and June 30, as this data element provides the ability to split days away from bed between the 2 fiscal periods of quarter 4 and quarter 1 when the time between assessments straddles 2 fiscal years.

**Example of X131 >0** when CC1 Date Stay Began occurs in the previous fiscal year to the Assessment Reference Date (ARD), causing the assessment period to straddle 2 fiscal years:

**Admission or Short Stay Assessment**

CC1 = March 29 (previous fiscal year)

ARD = April 3 (current fiscal year)

The person was away from the bed from March 30 to April 1.

X130 = 2 and X131 = 1

**Example of X131 >0** when the ARD of the most recent previous assessment occurs in the previous fiscal year to the ARD of the current assessment, causing the time between assessments to straddle 2 fiscal years:

**Quarterly, Change in Status or Discharge Assessment**

ARD of most recent previous assessment = February 20 (previous fiscal year)

ARD of current assessment = May 18 (current fiscal year)

The person was away from the bed from March 25 to April 3.

X130 = 9 and X131 = 6

**Example of X131 = 0**

**Quarterly, Change in Status or Discharge Assessment**

ARD of last assessment = February 20 (previous fiscal year)

ARD of current assessment = May 18 (current fiscal year)

The person was away from the bed from April 2 to April 4.

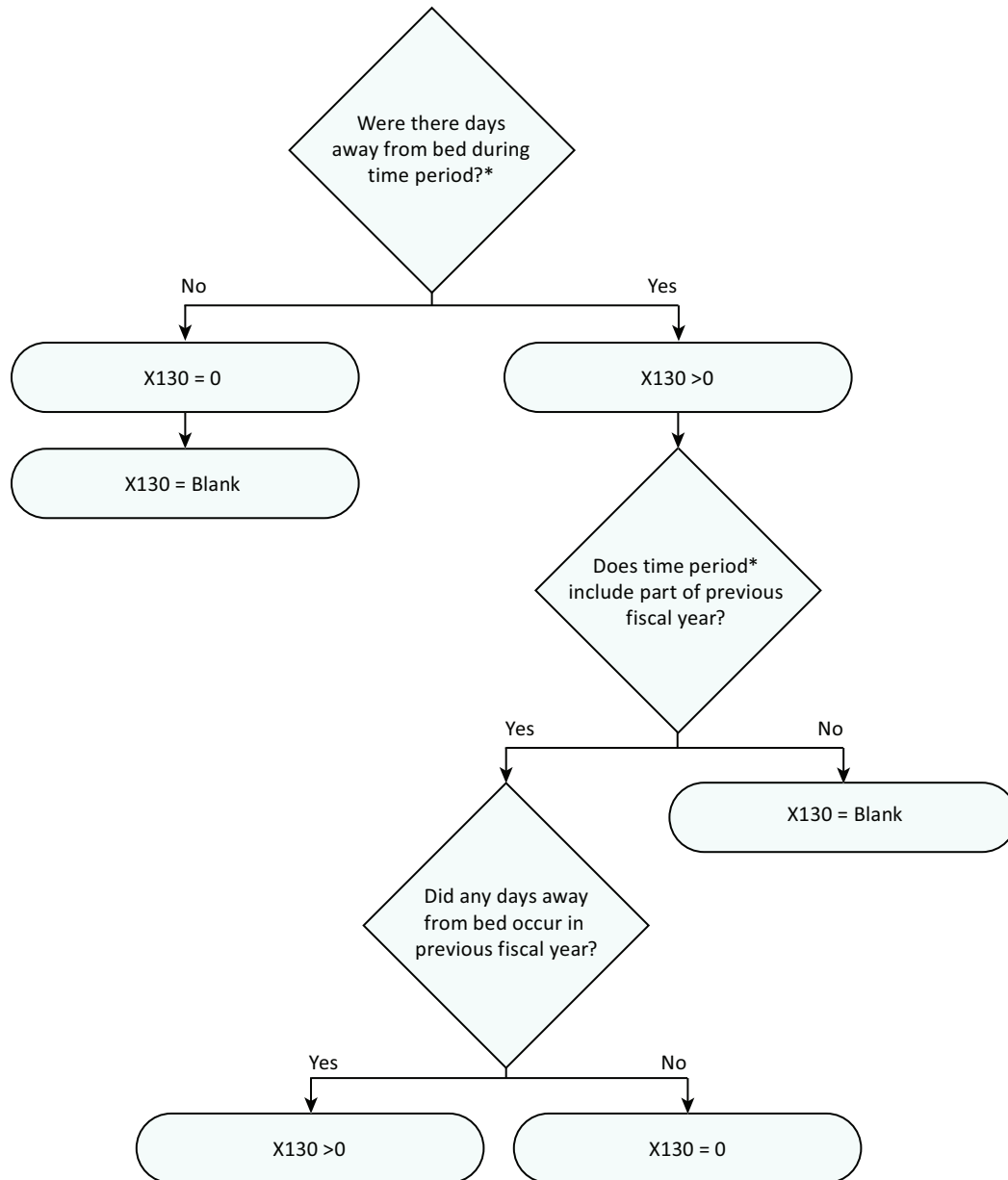
X130 = 2 and X131 = 0

**Coding**

Enter the total number of days the person was away from the mental health bed in the previous fiscal year, according to the following guidelines:

- X131 is blank when there are **no** days away from the bed.
- X131 is blank if the time since the most recent previous assessment or since admission (when applicable) does **not** include any part of a previous fiscal year.
- X131 = 0 if all days away from bed occurred in the current fiscal year (current with ARD).
- X131 >0 **only**
  - When there are days away from the bed; **and**
  - Time since the most recent previous assessment or since admission (when applicable) includes part of a previous fiscal year; **and**
  - 1 or more days away from bed occurred in the previous fiscal year.

**Figure 1** Coding X130 and X131



**Notes**

\* **For admission assessments**, *time period* refers to the time between CC1 Date Stay Began and A1 Assessment Reference Date (ARD).

For short stay assessments, *time period* refers to the time between CC1 Date Stay Began and X80 Discharge Date.

For quarterly and change in status assessments, *time period* refers to the time since the ARD of the most recent previous assessment up to the ARD of the current assessment.

For discharge assessments, *time period* refers to the time since the ARD of the most recent previous assessment up to the X80 Discharge Date.

---

**Validation**

---

If X130 Total Days Away From Bed = 0, then X131 Days Away From Bed in Previous Fiscal Year must be blank.

---

If Z1 Record Type = 3 (Full Admission) and A1 Assessment Reference Date and CC1 Date Stay Began occur in the same fiscal year, then X131 must be blank.

---

If Z1 Record Type = 3 (Full Admission), X130 >0 and A1 Assessment Reference Date and CC1 Date Stay Began occur in different fiscal years, then X131 cannot be blank.

---

If Z1 Record Type = 7 (Short Stay) and X80 Discharge Date and CC1 Date Stay Began occur in the same fiscal year, then X131 must be blank.

---

If Z1 Record Type = 7 (Short Stay), X130 >0 and X80 Discharge Date and CC1 Date Stay Began occur in different fiscal years, then X131 cannot be blank.

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If Z1 Record Type = 4 (Quarterly) or 6 (Change in Status) and A1 Assessment Reference Date of current assessment and A1 Assessment Reference Date for the most recent previous Admission, Change in Status or Quarterly Assessment occur in the same fiscal year, then X131 must be blank.

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If Z1 Record Type = 4 (Quarterly) or 6 (Change in Status), X130 >0 and A1 Assessment Reference Date of current assessment and A1 Assessment Reference Date of most recent previous Admission, Change in Status or Quarterly Assessment occur in different fiscal years, then X131 cannot be blank.

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If Z1 Record Type = 5 (Discharge) and X80 Discharge Date and A1 Assessment Reference Date for the most recent previous Admission, Change in Status or Quarterly Assessment occur in the same fiscal year, then X131 must be blank.

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If Z1 Record Type = 5 (Discharge), X130 >0, and X80 Discharge Date and A1 Assessment Reference Date of most recent previous Admission, Change in Status or Quarterly Assessment occur in different fiscal years, then X131 cannot be blank.

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## Section T — Assessor identification

### T1. Signature of Person Coordinating the Assessment

#### Intent

To document the name of the person coordinating the assessment.

#### Process

The staff member who coordinated the assessment should sign and date the assessment when it is completed. This information will not be collected by CIHI.



## Project Data Elements

### X200A–B. Project Code

#### Intent

The Project Code field is a specific unique code assigned by CIHI that is used to identify a project that could be used to collect supplemental data required to meet the information needs of CIHI, the provinces/territories, health regions and health care facilities.

#### Coding

Prior to using project fields to collect data, contact CIHI to have a specific unique project code assigned.

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#### Validation

If X210a Project Data does not equal blank, then X200a Project Code must not be blank.

If X210b Project Data does not equal blank, then X200b Project Code must not be blank.

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### X210A–B. Project Data

#### Intent

The Project Data field can be used to collect supplemental data required to meet the information needs of CIHI, the provinces/territories, health regions and health care facilities.

#### Coding

The codes for this element will be based on the requirements of the project as outlined by the organization requesting the data collection. At this time, CIHI will not be validating the information in this data element.

For information about using the project fields to collect data in addition to the existing data elements in OMHRS, send an email to [specializedcare@cihi.ca](mailto:specializedcare@cihi.ca).

## Facility Profile data elements

To ensure accurate and up-to-date contact information and other facility details, facilities must successfully submit a Facility Profile at the beginning of each fiscal year prior to submitting live data (and whenever changes are warranted). All communication between CIHI and facilities submitting data is based on the contact information in this record.

## **FP1. Facility Name**

### **Definition**

The facility name entered in this data element will appear on the quarterly and submission reports.

## **FP2. Site Name**

### **Definition**

The site name is an optional data element. The site name entered in this data element will appear on the quarterly and submission reports.

## **FP3a. Facility Address Line 1**

### **Definition**

The street address location of the facility.

## **FP3b. Facility Address Line 2**

### **Definition**

This is an optional data element.

## **FP3c. City**

### **Definition**

The city location of the facility.

## **FP3d. Province**

### **Definition**

The province or territory where the facility is located.

**Coding**

Enter the 2-letter code that represents the province or territory in which the facility is located.

**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**

**YT Yukon**

**NT Northwest Territories**

**NU Nunavut**

**FP3e. Postal Code****Coding**

Enter the 6-character postal code for the facility.

**Validation**

The first character of the postal code must not be D, F, I, O, Q, U or W.

Alpha characters must be upper case.

**FP4. Designated Number of Ministry of Health Beds****Coding**

Enter the number of designated adult inpatient mental health beds at the facility.

## **FP5. Ownership**

### **Coding**

Code the ownership per the legend below. If more than 1 code applies to the facility, choose the 1 that best describes the facility.

**Code “1”** for proprietary.

**Code “2”** for religious.

**Code “3”** for lay (not-for-profit, non-profit voluntary association, societies).

**Code “4”** for municipal.

**Code “5”** for provincial/territorial.

**Code “6”** for federal.

## **FP6. Vendor**

### **Coding**

Code the 5-digit vendor code as assigned and recognized by CIHI to submit OMHRS data.

## **FP7a. Facility Administrator**

### **Definition**

The facility administrator is the head of the facility or organization, e.g., the CEO or the president. The name entered here is not the primary contact for submission to CIHI, corrections or other day-to-day administrative functions related to OMHRS for the facility.

For facilities that are 1 site of many in a corporation or that have several heads, please select the most appropriate senior management person as the facility administrator.

## **FP7b. Administrator Phone Number**

## **FP7c. Administrator Phone Extension**

## **FP7d. Administrator Fax Number**

## **FP7e. Administrator Email**

## **FP8a. Site Coordinator Contact**

**Definition**

The site coordinator is responsible for coordinating all aspects of the implementation and ongoing management of OMHRS in her or his respective facility. The site coordinator is also the primary contact for facility comparative reports.

**FP8b. Site Coordinator Phone Number****FP8c. Site Coordinator Phone Extension****FP8d. Site Coordinator Fax Number****FP8e. Site Coordinator Email****Definition**

The site coordinator email address will be used for communication of OMHRS publications, including updates and revisions. The site coordinator email is also used to notify facilities of the availability of the quarterly facility comparative reports. The site coordinator is responsible for dissemination of OMHRS communication within his or her facility.

**FP9a. Database Contact****Definition**

The database contact is the primary contact for submission and corrections of OMHRS data for the facility. This may be the person entering and submitting data or the person overseeing this role. The database contact is the primary contact for submission reports.

**FP9b. Database Contact Phone Number****FP9c. Database Contact Phone Extension****FP9d. Database Contact Fax Number****FP9e. Database Contact Email**

## Definition

The database contact email address is the primary communication vehicle for notification of submission and correction issues between CIHI and the facility. Automated notifications that submission files have been processed and reports have been produced are sent to this email address.

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### Validation

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Email address must contain only 1 “@” symbol, at least 1 “.” (period) and no “,” (comma) and must be at least 5 bytes long (a@b.c).

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## FP10. Preferred Language of Correspondence

### Definition

This data element is used to specify the language of correspondence.

### Coding

**Code “eng”** for English.

**Code “fra”** for French.

## FP11. Facility Type

### Intent

The information from this data element is used to classify facilities into peer groups for the purposes of comparative reporting. The facility type is based on the nature of the services, the type of hospital in which the service is located, the provincial or regional designation and/or the self-assignment of the facility.

### Definitions

**Psychiatric Facility** — Provides comprehensive inpatient mental health services or specialized mental health programs. This includes facilities that may have specialty beds within a larger organization.

**Psychiatric Teaching Facility** — Provides comprehensive inpatient mental health services or specialized mental health programs. This includes facilities that may have specialty beds within a larger organization. A psychiatric teaching facility must have an affiliation with an academic teaching centre.

**General Facility With Fewer Than 25 Mental Health Beds** — Provides inpatient mental health services in designated units, programs or beds within a general hospital that has multiple levels of care and has fewer than 25 mental health beds.

**General Facility With 25 or More Mental Health Beds** — Provides inpatient mental health services in designated units, programs or beds within a general hospital that has multiple levels of care and has 25 or more mental health beds.

**General Teaching Facility** — Provides inpatient mental health services in designated units, programs or beds within a general hospital that has multiple levels of care. A general teaching facility must have an affiliation with an academic teaching centre.

### **Coding**

Use the definitions above as a guide and enter the code that best describes the facility.

**Code “1”** for psychiatric hospitals.

**Code “2”** for psychiatric teaching hospitals.

**Code “3”** for general hospitals with fewer than 25 mental health beds.

**Code “4”** for general hospitals with 25 or more mental health beds.

**Code “5”** for general teaching hospitals.

### **FP12. Date Facility Profile Updated**

# Submission requirements

Submission requirements are available in the *OMHRS Guide to Data Submission*, which can be found by logging in to Operational Reports, OMHRS or by emailing [specializedcare@cihi.ca](mailto:specializedcare@cihi.ca).

## Error and warning messages

Error number	Error message
000010	Invalid data
000020	Invalid data length. Data length must be $\geq$ the minimum specified length.
000030	Invalid data length. Data length must be $\leq$ the maximum specified length.
000040	Invalid numeric data. Data can only contain numerals.
000050	Invalid date. Date must be $\leq$ Z5 Date of Submission.
000060	Invalid date. Invalid year, month or day. Date should be YYYYMMDD.
000070	Invalid alphanumeric data. Data can only contain alphabets, numerals, space or dash/minus sign.
000080	X2 Submission type indicates New, but matching X1 Record ID already exists.
000090	Mandatory data element missing.
000100	No corresponding Admission Assessment found. For acceptance of a Quarterly, Change in Status or Discharge Assessment, an Admission Assessment must exist with the same AA4 Facility Number, X30 Chart Number, and AA3 Case Record Number.
000111	Invalid A2 Reason for Assessment. A2 Reason for Assessment must = 3 when Z1 Record Type = 5 and [X90 Discharge Reason = 1] and [(X80 Discharge Date - CC1 Date Stay Began - X130 Total Days Away from Bed) > 6] on a New or Correction submission.
000120	Duplicate record. Record with the same AA4 Facility Number, X30 Chart number, AA3 Case Record Number and A1 Assessment Reference Date already exists.
000140	Duplicate record. Admission or Short Stay record with the same AA4 Facility Number, X30 Chart Number, AA3 Case Record Number already exists.
000150	Inappropriate to delete Admission Assessment prior to Quarterly, Change in Status, Discharge or Medication records.
000160	Inappropriate to delete Quarterly Assessment when another Quarterly Assessment exists with a later A1 Assessment Reference Date.
000170	Inappropriate to delete Quarterly Assessment prior to Discharge record.
000190	Inappropriate to delete Discharge record prior to Medication record with the same A1 Assessment Reference Date.
000200	Inappropriate to delete Change in Status Assessment prior to Quarterly Assessment with $\geq$ A1 Assessment Reference Date.
000210	Inappropriate to delete Change in Status Assessment when another Change in Status Assessment exists with a later A1 Assessment Reference Date.
000220	Inappropriate to delete Quarterly assessment prior to Change in Status Assessment with $\geq$ A1 Assessment Reference Date.
000230	Inappropriate to delete Change in Status Assessment prior to Discharge record.



<b>Error number</b>	<b>Error message</b>
<b>000240</b>	Inappropriate to delete Change in Status Assessment prior to Medication record with $\geq$ A1 Assessment Reference Date.
<b>000250</b>	Invalid X80 Discharge Date. X80 Discharge Date must be $\geq$ CC1 Date Stay Began of the associated Admission record (same AA4 Facility Number, X30 Chart Number and AA3 Case Record Number).
<b>000260</b>	Invalid A1 Assessment Reference Date. A1 Assessment Reference Date must be $\geq$ CC1 Date Stay Began of the associated Admission record (same AA4 Facility Number, X30 Chart Number and AA3 Case Record Number).
<b>000270</b>	Invalid A1 Assessment Reference Date. A1 Assessment Reference Date must be $\leq$ X80 Discharge Date of the associated Discharge record (same AA4 Facility Number, X30 Chart Number and AA3 Case Record Number).
<b>000290</b>	X2 Submission Type indicates Correction, but no records with matching Facility Number, Record ID, Chart Number, Case Record Number, Assessment Reference Date and Record Type exists in the database.
<b>000300</b>	Number of data records in transmission file inconsistent with Z4 Number of records specified on the control record.
<b>000310</b>	Z3 Fiscal Quarter of Submission denotes Facility Profile but assessment records submitted.
<b>000320</b>	Z3 Fiscal Quarter of Submission denotes a quarter but Facility Profile record submitted.
<b>000330</b>	Invalid Z2 Fiscal Year of Submission. Z2 Fiscal Year of Submission must match the fiscal year of submission in the file name.
<b>000340</b>	Invalid Z3 Fiscal Quarter for this Submission. Z3 Fiscal Quarter for this Submission must match the fiscal quarter of submission in the file name.
<b>000350</b>	Invalid AA4 Facility Number. AA4 Facility Number must match the facility number in the file name.
<b>000401</b>	Missing Data. Data element cannot be blank when X90 Discharge Reason = 1 and Length of Stay (X80 Discharge Date - CC1 Date Stay Began) - X130 Total Days Away from Bed $>$ 6.
<b>000410</b>	Invalid AA2 Health Card Number. Invalid Health Card Number format for specified X20 Province/Territory Issuing Health Card Number. (alpha must be upper case)
<b>000421</b>	Invalid X4 Health Card Number Status. X4 must = 9 when X20 Province/Territory Issuing Health Card Number = -90.
<b>000431</b>	Invalid X4 Health Card Number Status. X4 must = 8 when X20 Province/Territory Issuing Health Card Number = -70.
<b>000440</b>	Invalid BB2 Birthdate. BB2 Birthdate must be $\leq$ CC1 Date Stay Began.
<b>000450</b>	Suspicious BB2 Birthdate or CC1 Date Stay Began. Calculated Age at Date Stay Began is less than 14 years or greater than 115 years. Check BB2 Birthdate and CC1 Date Stay Began.
<b>000460</b>	Invalid BB6a-BB6f. All elements BB6a-f must be coded as 0 when BB6g Income - No income = 1.
<b>000480</b>	Invalid BB6g Income - No income. BB6g Income - No income must = 0 when any of BB6a-BB6f = 1.
<b>000490</b>	Invalid CC1 Date Stay Began. CC1 Date Stay Began must be $\leq$ A1 Assessment Reference Date.

<b>Error number</b>	<b>Error message</b>
<b>000502</b>	Invalid CC2 Reason for Admission. CC2f Reason for Admission - Justice System must = 1 or CC2h Reason for Admission - Forensic Assessment must = 1 when A3a Status at Time of Admission or A3b Status at Time of Assessment = 5.
<b>000520</b>	Invalid DD1 Number of Psych Admits (recent). DD1 must = 0 when DD2 Number of Psych Admits (lifetime) = 0.
<b>000530</b>	Invalid DD1 Number of Psych Admits (recent). DD1 must = 0 when DD3 Time Since Last Discharge = 8.
<b>000540</b>	Invalid DD1 Number of Psych Admits (recent). DD1 must = 0 when DD4 Amount of Time Hospitalized = 0.
<b>000550</b>	Invalid DD2 Number of Psych Admits (lifetime). DD2 must = 0 when DD3 Time Since Last Discharge = 8.
<b>000560</b>	Invalid DD3 Time Since Last Discharge. DD3 Time Since Last Discharge must = 8 when DD2 Num Psych Admits (lifetime) = 0.
<b>000570</b>	Invalid DD4 Amount of Time Hospitalized. DD4 Amount of Time Hospitalized must = 0 when DD1 Number of Psych Admits (recent) = 0.
<b>000580</b>	Invalid DD4 Amount of Time Hospitalized. DD4 Amount of Time Hospitalized cannot = 0 when DD1 Number of Psych Admits (recent) does not = 0.
<b>000590</b>	Invalid DD4 Amount of Time Hospitalized. DD4 Amount of Time Hospitalized must = 0 when DD3 Time Since Last Discharge = 8.
<b>000600</b>	Invalid A2 Reason for Assessment. A2 Reason for Assessment must = 2 when Z1 Record Type = 4 on a New or Correction submission.
<b>000610</b>	Invalid A2 Reason for Assessment. A2 Reason for Assessment must = 4, 5 or 6 when Z1 Record Type = 6 on a New or Correction submission.
<b>000621</b>	Invalid D1b Self-Injury - Intent. D1b must not = 8 when D1a Self-Injury - Most Recent Attempt is (1, 2, 3, 4 or 5).
<b>000631</b>	Invalid D1c Self-Injury - Considered. D1c must not = 0 when D1a Self-Injury - Most Recent Attempt does not = 0.
<b>000641</b>	Invalid D1b Self-Injury - Intent. D1b must = 8 when D1a Self-Injury - Most Recent Attempt = 0.
<b>000650</b>	Invalid E1a Wandering. E1a Wandering must = 0 when G1b Walking = 6 or 8 AND G1c Wheeling = 6 or 8.
<b>000670</b>	Suspicious G1d ADL. G1d ADL - Toilet Use = 8 (Activity did not occur in last 3 days).
<b>000680</b>	Suspicious G1e ADL. G1e ADL - Eating = 8 (Activity did not occur in last 3 days).
<b>000691</b>	Invalid I11 Other Medical Diagnoses. ICD-10-CA code must not be a psychiatric conditions (F00 - F99).
<b>000710</b>	Invalid I8a Pain Frequency. I8a Pain Frequency must = 0 when I8b Pain Intensity = 0.
<b>000720</b>	Invalid I8b Pain Intensity. I8b Pain Intensity must = 0 when I8a Pain Frequency = 0.
<b>000730</b>	Suspicious I9 Bladder Continence. I9 Bladder Continence = 8 (Did not occur in last 3 days).
<b>000741</b>	Invalid J2 Life Event Causes Sense of Horror or Intense Fear. J2 must = 0 when J1a-J1p = 0.
<b>000750</b>	Suspicious N1a Height. N1a Height coded as < 91 cm (3 feet) or > 213 cm (7 feet).
<b>000760</b>	Suspicious N1b Weight. N1b Weight coded as < 23 kg (50 lbs) or > 200 kg (440 lbs).
<b>000771</b>	Invalid P5 Discharge To. P5 must = 15 when X90 Discharge Reason = 2 or 3.

<b>Error number</b>	<b>Error message</b>
<b>000820</b>	Invalid X50a-i. All elements X50a-h must be coded as 0 when X50i Responsibility for Payment - Unknown = 1.
<b>000830</b>	Invalid X50i Responsibility for Payment - Unknown. X50i must = 0 when any of X50a-h = 1.
<b>000841</b>	Missing X65 Referred From Facility Number. X65 must be specified when CC4a - Admitted From = 7, 9, 10, or 12.
<b>000851</b>	Invalid X80 Discharge Date, CC1 Date Stay Began, and X130 Total Days Away from Bed combination. Length of Stay (X80 Discharge Date - CC1 Date Stay Began) - Total Days Away from Bed must be <= 3 on Short Stay records.
<b>000901</b>	Missing X140 Discharged to Facility Number. X140 must be specified when P5 Discharge To = 7, 9, 10, or 12.
<b>000930</b>	Invalid A1 Assessment Reference Date. A1 Assessment Reference Date must be within the Z2 Fiscal Year of Submission specified on the control record.
<b>000940</b>	Invalid A1 Assessment Reference Date. A1 Assessment Reference Date must be within the Z3 Fiscal Quarter of Submission specified on the control record.
<b>000950</b>	Open episode of care exists for matching X30 Chart Number and AA4 Facility Number. Discharge record for prior episode of care must be submitted before a new Admission Assessment or Short Stay record can be submitted.
<b>001000</b>	Invalid Postal Code. Postal Code must not begin with D, F, I, O, Q, U, or W.
<b>001010</b>	Invalid email address. Email address must contain only one '@' symbol, at least one '.'(period), no ',' (comma) and must be at least 5 bytes long (a@b.c).
<b>001040</b>	X2 Submission Type indicates Delete, but no records with matching Facility Number, Record ID, Chart Number, Case Record Number, Assessment Reference Date and Record Type exists in the database.
<b>001060</b>	Inappropriate to delete Quarterly record when a Medication record exists with an Assessment Reference Date on or after the Assessment Reference Date of the record to be deleted
<b>001070</b>	Facility profile already exists. Once accepted into the database, the record ID of the facility profile must not change.
<b>001090</b>	No corresponding assessment record found. For acceptance of a medication record an assessment must exist with the same AA4 Facility Number, X30 Chart Number, AA3 Case Record Number and A1 Assessment Reference Date.
<b>001100</b>	Invalid A1 Assessment Reference Date. Assessments prior to the Oct 1, 2005 Ontario mandate will not be accepted into OMHRS.
<b>001110</b>	Invalid Control Record.
<b>001130</b>	Invalid X130 Total Days Away From Bed. Total Days Away From Bed must be less than or equal to the number of days between the Assessment Reference Date of the patient's current and last assessment.
<b>001150</b>	Invalid X80 Discharge Date. On a short stay record X80 Discharge Date must be greater than or equal to CC1 Date Stay Began.
<b>001170</b>	Invalid CC1 Date Stay Began. Admissions prior to the Oct 1, 2005 Ontario mandate will not be accepted into OMHRS.
<b>001181</b>	Invalid ICD-10-CA code.
<b>001190</b>	Invalid FP3e. FP3e Postal Code must be in ANANAN format with the alpha characters as upper case.

<b>Error number</b>	<b>Error message</b>
<b>001200</b>	Invalid X60. Postal Code of Patient's Residence must be one of (ANANAN, ANA, -70, -90) with the alpha characters as upper case.
<b>001221</b>	Invalid ICD-10-CA code. ICD-10-CA code must conform with age/sex validation rules.
<b>001250</b>	Invalid submission file construction. The first record in a submission file must be a control record.
<b>001260</b>	Invalid submission file construction. A submission file must only have one control record.
<b>001270</b>	Invalid ASCII file construction. The record length must not exceed specified length.
<b>001300</b>	Invalid XML file construction. XML declaration must be correct.
<b>001310</b>	Invalid XML file construction. XML root element must be correct.
<b>001320</b>	Invalid XML file construction. XML must be valid.
<b>001330</b>	Invalid file name format.
<b>001340</b>	Invalid Z1 Record Type.
<b>001360</b>	Invalid BB6g. BB6g must = 1 if all of BB6a-BB6f = 0.
<b>001430</b>	Invalid A1 Assessment Reference Date. Assessment Reference Date must be > A1 Assessment Reference Date of the associated Admission record (same AA4 Facility Number, X30 Chart Number and AA3 Case Record Number).
<b>001440</b>	Discharge or short stay record with the same AA4 Facility Number, X30 Chart Number, AA3 Case Record Number already exists.
<b>001450</b>	Invalid A2 Reason for Assessment. A2 Reason for Assessment must = 1 when Z1 Record Type = 3 on a New or Correction submission.
<b>001461</b>	Invalid A1 Assessment Reference Date. Assessment Reference Date must be <= A1 Assessment Reference Date of the associated Discharge record (same AA4 Facility Number, X30 Chart Number and AA3 Case Record Number).
<b>001471</b>	Invalid I11h-I11m Other Medical Diagnoses. ICD-10-CA codes in I11h-I11m must be unique.
<b>001490</b>	No corresponding Facility Profile found. New fiscal year Facility Profile must be submitted before new fiscal year data can be submitted.
<b>001500</b>	Invalid X50i. X50i must = 1 if all of X50a-X50h = 0.
<b>001511</b>	Invalid CC2g. CC2g must = 1 if all of CC2a-CC2f = 0 and CC2h = 0.
<b>001530</b>	Invalid province/territory code. The first character of AA4, X65 or X140 must be valid province/territory code (0-9, N, Y, V, Z), and if Z is coded then the remaining 4 digits must be 9999.
<b>001550</b>	Invalid DD6. DD6 Age at First Hospitalization must be in the appropriate range as per patient's age at admission.
<b>001561</b>	Invalid CC2 Reason for Admission. CC2f Reason for Admission - Justice System must = 1 or CC2h Reason for Admission - Forensic Assessment must = 1 when Q5 Current Patient Type = 4.
<b>001580</b>	Invalid A3a Status at Time of Admission. A3a must = 5 when A3b Status at Time of Assessment = 5.
<b>001590</b>	Invalid A3b Status at Time of Assessment. A3b must = 5 when A3a Status at Time of Admission = 5.
<b>001600</b>	Invalid A3b Status at Time of Assessment. A3b must = 5 when Q5 Current Patient Type = 4.

<b>Error number</b>	<b>Error message</b>
<b>001611</b>	Invalid A5 Police Intervention. A5 Police Intervention must not = 0 when CC2f Reason for Admission - Justice System = 1 or CC2h Reason for Admission - Forensic Assessment = 1.
<b>001630</b>	Invalid A5 Police Intervention. A5 Police Intervention must not = 0 when A3b Status at Time of Assessment = 5.
<b>001640</b>	Invalid A5 Police Intervention. A5 Police Intervention must not = 0 when Q5 Current Patient Type = 4.
<b>001651</b>	Invalid Q5 Current Patient Type. Q5 must = 4 when A3b Status at Time of Assessment = 5.
<b>001660</b>	Invalid X6 Number of ECTs Since Last Assessment. X6 must = 0 when L6 ECT = 0.
<b>001671</b>	Invalid X75 Days in Alternative Level of Care. X75 must be less than or equal to the number of days between the Assessment Reference Date of the patient's current and last assessment on a quarterly, discharge or change-in-status assessment.
<b>001675</b>	Invalid X75 Days in Alternative Level of Care. X75 must be less than or equal to the number of days between the Assessment Reference Date and Admission Date on an admission or short stay assessment.
<b>001690</b>	Invalid AA5 Unit Identifier. AA5 must not = 50 when AA4 Facility Number is an Ontario facility number.
<b>001700</b>	Missing AA2 Health Card Number. AA2 must be reported when X4 Health Card Number Status = 1.
<b>001810</b>	Invalid X90 Reason for Discharge. X90 must = 2 or 3 when P5 = 15.
<b>001840</b>	AA2 Health Card Number must be blank when X4 Health Card Number Status = 8 or 9.
<b>001870</b>	Invalid CC1 Date Stay Began. CC1 must >= X80 Discharge Date of the most recent previous episode with matching X30 Chart Number and AA4 Facility Number.
<b>001890</b>	Invalid X130 Total Days Away From Bed. Total Days Away From Bed must be less than or equal to the number of days between the Discharge Date of the patient's current and the Assessment Reference Date of last assessment.
<b>001900</b>	Invalid X130 Total Days Away From Bed. Total Days Away From Bed on Full Admission must be less than or equal to the number of days between CC1 Date Stay Began and A1 Assessment Reference Date.
<b>001910</b>	Invalid X130 Total Days Away From Bed. Total Days Away From Bed on Short Stay must be less than or equal to the number of days between CC1 Date Stay Began and X80 Discharge Date.
<b>002080</b>	Invalid CC2f Reason for Admission - Justice System. CC2f must = 1 when CC2h Reason for Admission - Forensic Assessment = 1.
<b>002090</b>	Missing X8B Arrived on Inpatient Unit from ED. X8B must not = blank when X8A Admitted via ED = 1.
<b>002100</b>	Invalid X8B Arrived on Inpatient Unit from ED. X8B must = blank when X8A Admitted via ED = 0.
<b>002110</b>	Missing X8C Date Arrived on Inpatient Unit from ED. X8C must not = blank when X8B Arrived on Inpatient Unit from ED = 1.
<b>002120</b>	Invalid X8C Date Arrived on Inpatient Unit from ED. X8C must = blank when X8B Arrived on Inpatient Unit from ED = 0.
<b>002130</b>	Invalid X8C Date Arrived on Inpatient Unit from ED. X8C must be <= X80 Discharge Date.
<b>002140</b>	Invalid X8C Date Arrived on Inpatient Unit from ED. X8C must be >= CC1 Date Stay Began.

<b>Error number</b>	<b>Error message</b>
<b>002150</b>	Missing X200a Project Code. X200a must be specified when X210a Project Data is entered.
<b>002160</b>	Missing X200b Project Code. X200b must be specified when X210b Project Data is entered.
<b>002170</b>	Inappropriate to delete Short Stay Assessment prior to Medication records.
<b>002210</b>	Invalid X80 Discharge Date. X80 of an earlier episode must <= CC1 Date Stay Began of the later episode with matching X30 Chart Number and AA4 Facility Number.
<b>002220</b>	Invalid A1 Assessment Reference Date. A1 must be >= A1 Assessment Reference Date of the most recent previous Admission, Change in Status or Quarterly Assessment with the same AA4 Facility Number, X30 Chart Number and AA3 Case Record Number.
<b>002230</b>	Invalid alphanumeric data. Alphabets must be upper case.
<b>002280</b>	Invalid X9a Forensic Status at Time of Admission. If A3a = 5 then X9a cannot be blank.
<b>002290</b>	Invalid X9a Forensic Status at Time of Admission. If A3a = blank then X9a must be blank.
<b>002300</b>	Invalid X9b Forensic Status at Time of Assessment. If A3b = 5 then X9b cannot be blank.
<b>002310</b>	Invalid X9a Forensic Status at Time of Admission. If A3a = 1, 2, 3 or 4 then X9a must be blank.
<b>002320</b>	Invalid X9b Forensic Status at Time of Assessment. If A3b = 1, 2, 3 or 4 then X9b must be blank.
<b>002350</b>	Invalid A3a Inpatient Status at Time of Admission. If X9a = blank then A3a must = 1, 2, 3 or 4.
<b>002360</b>	Invalid A3b Inpatient Status at Time of Assessment. If X9b = blank then A3b must = 1, 2, 3 or 4.
<b>002370</b>	Invalid X8c Date Arrived on Inpatient Unit. If X8b = blank then X8c must = blank.
<b>002540</b>	Invalid X65 Referred From Facility #. X65 Referred From Facility # must be blank when CC4a - Admitted From is not a health service facility (1-6, 8, 13, 14).
<b>002550</b>	Invalid X140 Discharged to Facility #. X140 Discharged to Facility # must be blank when P5 Discharge To is not a health service facility (1-6, 8, 13, 14, 15).
<b>002560</b>	Invalid X131 Days Away from Bed in Previous Fiscal Year. X131 Days Away from Bed in Previous Fiscal Year cannot be blank if X130 > 0 and A1 Assessment Reference Dates of patient's current and last assessments are in different fiscal years.
<b>002570</b>	Invalid X131 Days Away from Bed in Previous Fiscal Year. X131 Days Away from Bed in Previous Fiscal Year must be blank if A1 Assessment Reference Dates of the patient's current and last assessments are in the same fiscal year.
<b>002580</b>	Invalid combination of X130 Total Days Away From Bed and X131 Days Away From Bed in Previous Fiscal Year. X131 Days Away From Bed in Previous Fiscal Year must be blank when X130 Total Days Away from Bed = 0.
<b>002590</b>	Invalid X131 Days Away from Bed in Previous Fiscal Year. X131 Days Away from Bed in Previous Fiscal Year cannot be blank if X130 > 0 and CC1 Date Stay Began and A1 Assessment Reference Date occur in different fiscal years.
<b>002600</b>	Invalid X131 Days Away from Bed in Previous Fiscal Year. X131 Days Away from Bed in Previous Fiscal Year must be blank if CC1 Date Stay Began and A1 Assessment Reference Date occur in the same fiscal year.
<b>002650</b>	Invalid DSM-5-TR code. Decimals in DSM-5-TR codes must not be included.
<b>002660</b>	Invalid DSM-5-TR (ICD-10-CM) codes.
<b>002670</b>	Invalid A1 Assessment Reference Date. A1 Assessment Reference Date cannot occur after the file submission date.

<b>Error number</b>	<b>Error message</b>
<b>002680</b>	Invalid X131 Days Away from Bed in Previous Fiscal Year. X131 Days Away from Bed in Previous Fiscal Year cannot be blank if X130 > 0 and CC1 Date Stay Began and X80 Discharge Date occur in different fiscal years.
<b>002690</b>	Invalid X131 Days Away from Bed in Previous Fiscal Year. X131 Days Away from Bed in Previous Fiscal Year must be blank if CC1 Date Stay Began and X80 Discharge Date occur in the same fiscal year.
<b>002700</b>	Invalid X131 Days Away from Bed in Previous Fiscal Year. X131 Days Away from Bed in Previous Fiscal Year must be blank if A1 Assessment Reference Date of the patient's last assessment and X80 Discharge Date occur in the same fiscal year.
<b>002710</b>	Invalid X131 Days Away from Bed in Previous Fiscal Year. X131 Days Away from Bed in Previous Fiscal Year cannot be blank if X130 > 0 and A1 Assessment Reference Date of the patient's last assessment and X80 Discharge Date occur in different fiscal years.
<b>002720</b>	Invalid Z2 Fiscal Year of Submission. The fiscal year of submission in the control record cannot be later than the current fiscal year.
<b>002800</b>	Invalid to record more than one "1" within Q1a–Q1v.
<b>002810</b>	Invalid to record more than one "2" within Q1a–Q1u.
<b>002820</b>	Invalid to record more than one "3" within Q1a–Q1u.
<b>002830</b>	Invalid Q1. Q1a–Q1u must be blank if Q1v = 1.
<b>002840</b>	Invalid Q1a–Q1u. All elements Q1a–Q1u must be completed in order of importance.
<b>002861</b>	Suspicious Q1v DSM-5-TR — Not applicable. Q1v coded as 1 and CC2h Reason for Admission — Forensic Assessment not coded as 1.
<b>002870</b>	Invalid Q1a–Q1v. At least one DSM-5-TR provisional diagnostic category must be specified as 1 — most important.
<b>002880</b>	Suspicious Q1v DSM-5-TR — Not applicable, admitted to mental health bed for reasons not related to mental health. Q1v coded as 1 for long stay patient (Quarterly Assessment).
<b>002890</b>	Suspicious Q1v DSM-5-TR — Not applicable. Q1v coded as 1 on full Discharge Assessment.
<b>002900</b>	Suspicious Q1v DSM-5-TR — Not applicable. Q1v coded as 1 on Change in Status, Quarterly or Discharge Assessment when corresponding Admission Assessment has a provisional DSM-5 diagnosis.
<b>002911</b>	Suspicious Q2a–Q2f. Q2a–Q2f contain duplicate DSM-5-TR diagnostic codes.
<b>003120</b>	Invalid A3a Inpatient Status at Time of Admission. If X9a = 1–9, then A3a must = 5.
<b>003130</b>	Invalid A3b Inpatient Status at Time of Assessment. If X9b = 1–9, then A3b must = 5.
<b>003140</b>	Invalid X141 Discharged With Support/Referral for Home Care Services. Discharged With Support/Referral for Home Care Services must be specified as 0 or 1 when P5 Discharged To is not equal to 15 and A1 Assessment Reference Date ≥ April 1, 2020.
<b>003150</b>	Invalid X141 Discharged With Support/Referral for Home Care Services. Discharged With Support/Referral for Home Care Services must be blank when P5 Discharged To = 15.

# Reference

1. Hirdes JP, Pérez E, Curtin-Telegdi N, Prendergast P, Morris JM, Ikegami N, Fries BE, Phillips C, Rabinowitz T. *RAI-MH Training Manual and Resource Guide for Version 2.0*. 2003.





SECTION CC. REFERRAL ITEMS (cont'd) (Complete at intake only.)		
3	WHO LIVED WITH AT ADMISSION	1. Lived alone 2. Lived with spouse only 3. Lived with spouse and other(s) 4. Lived with child(ren) (but not with spouse/partner) 5. Lived with other(s) (not spouse or child(ren)) 6. Lived in group setting with non-relative(s)
4	ADMITTED FROM AND USUAL RESIDENCE	1. Private home/apartment/rented room 2. Board and care 3. Assisted living or semi-independent living 4. Mental health residence, e.g., psychiatric group home 5. Group home for persons with physical disabilities 6. Setting for persons with intellectual disabilities 7. Psychiatric hospital or unit 8. Homeless (with or without shelter) 9. Long-term care home (nursing home) 10. Rehabilitation unit/hospital 11. Hospice facility/palliative care 12. Acute unit/hospital 13. Correctional facility 14. Other a. Admitted from b. Usual residence
X65	REFERRED FROM FACILITY NUMBER	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prov./Terr.      Facility Number (See manual for provincial/territorial codes.)
5	RESIDENTIAL STABILITY	Prior to admission, most recent residence was temporary (e.g., shelter). 0. No      1. Yes

SECTION DD. MENTAL HEALTH SERVICE HISTORY		
1	NUMBER OF PSYCHIATRIC ADMISSIONS (RECENT)	Record the number of <b>recent (last 2 years)</b> psychiatric admissions. Do not include this admission. 0. None    1. 1 to 2    2. 3 or more
2	NUMBER OF PSYCHIATRIC ADMISSIONS (LIFETIME)	Record the number of <b>lifetime</b> mental health admissions. Do not include this admission. 0. None    1. 1 to 3    2. 4 to 5    3. 6 or more
3	TIME SINCE LAST DISCHARGE	Time since discharge from last mental health admission 1. More than 1 year 2. 31 days to 1 year 3. 30 days or less (from other facility) 4. 30 days or less (from this facility) 8. Not applicable
4	AMOUNT OF TIME HOSPITALIZED	Amount of time in a psychiatric hospital/unit in the <b>last 2 years</b> . Do not include this admission 0. No other admissions in the last 2 years 1. 30 days or less 2. 31 days to 1 year 3. More than 1 year
5	CONTACT WITH COMMUNITY MENTAL HEALTH	Time since last contact with a community mental health agency or mental health professional (e.g., psychiatrist, social worker) in the <b>last year</b> 0. No contact in the last year 1. 31 days or more 2. 30 days or less
6	AGE AT FIRST HOSPITALIZATION	Age at first overnight stay in a psychiatric hospital/unit 1. 0–14                      4. 45–64 2. 15–24                    5. 65+ 3. 25–44

SECTION A. ASSESSMENT INFORMATION		
1	ASSESSMENT REFERENCE DATE	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year                      Month                      Day
2	REASON FOR ASSESSMENT	TYPE OF ASSESSMENT 1. Initial assessment 2. Routine assessment at fixed intervals 3. Review prior to discharge from program 4. Review upon return to unit/hospital 5. Change in status 6. Other
3	INPATIENT STATUS	1. Application for psychiatric assessment (exclude forensics) 2. Voluntary 3. Informal 4. Involuntary 5. Forensic (including forensic assessment, unfit to stand trial, not criminally responsible) a. Status at time of admission b. Status at time of assessment
X9	FORENSIC STATUS	1. Fitness assessment 2. Not criminally responsible (NCR) assessment 3. Treatment order 4. Keep fit order 5. Warrant of committal — unfit 6. Warrant of committal — NCR 7. Inter-hospital transfer — NCR 8. Inter-hospital transfer — unfit 9. Other a. Forensic status at time of admission b. Forensic status at time of assessment
4	CAPACITY/COMPETENCY	Presence of formal decisions regarding capacity/competency 0. No      1. Yes a. Incapable of consenting to treatment b. Incapable of managing property c. Incompetent to disclose information related to clinical record d. Has legal guardian/substitute decision-maker
5	POLICE INTERVENTION	Code for the most recent instance of police intervention (exclude contact as victim). 0. Never 1. More than 1 year ago 2. 31 days to 1 year ago 3. 8 to 30 days ago 4. 4 to 7 days ago 5. In the last 3 days a. Police intervention for violent behaviour b. Police intervention for non-violent behaviour

SECTION B. MENTAL STATUS		
1	MENTAL STATE INDICATORS	Code for indicators observed in the <b>last 3 days</b> . 0. Indicator not exhibited in the <b>last 3 days</b> 1. Indicator not exhibited in the last 3 days but is <b>reported to be present</b> 2. Indicator exhibited on <b>1 to 2 of the last 3 days</b> 3. Indicator exhibited <b>daily in the last 3 days</b>
<b>INDICATORS OF MOOD DISTURBANCE</b>		
a. Facial Expression	Sad, pained, worried facial expression (e.g., furrowed brow)	
b. Tearfulness	Crying, tearfulness	
c. Decreased Energy	Statements of decrease in energy level (e.g., "I just don't feel like doing anything," "I have no energy.")	
d. Made Negative Statements	Made negative statements (e.g., "Nothing matters," "I would rather be dead," "Let me die," "What's the use?"); regrets having lived so long.	
e. Self-Deprecation	Self-deprecation (e.g., "I am nothing," "I am no use to anyone.")	
f. Guilt/Shame	Expressions of guilt or shame (e.g., "I've done something awful," "This is all my fault," "I am a terrible person.")	

SECTION B. MENTAL STATUS (cont'd)		
g. Hopelessness	Statements of hopelessness (e.g., "There's no hope for the future," "Nothing's going to change for the better.")	
h. Inflated Self-Worth	Exaggerated self-opinion, arrogance, inflated belief about his or her own ability, etc.	
i. Hyperarousal	Motor excitation, increased reactivity, exaggerated startle response	
j. Irritability	Marked increase in being short-tempered or easily upset	
k. Increased Sociability or Hypersexuality	Marked increase in social or sexual activity, unusually high activity	
l. Pressured Speech/Racing Thoughts	Rapid speech or rapid transition from topic to topic	
m. Labile Affect	Affect fluctuates frequently with or without an external explanation	
n. Flat or Blunted Affect	Indifference, non-responsiveness, hard to get to smile, etc.	
INDICATORS OF ANXIETY		
o. Anxious Complaints	Repetitive anxious complaints (non-health-related) (e.g., persistently seeks attention/reassurance)	
p. Fears/Phobias	Expression (including non-verbal) of what appear to be unrealistic fears (e.g., fear of being abandoned, of being left alone, of being with others) or intense fear of specific objects or situations	
q. Obsessive Thoughts	Unwanted ideas or thoughts that cannot be eliminated	
r. Compulsive Behaviour	Handwashing, repetitive checking of room, counting, etc.	
s. Intrusive Thoughts/Flashbacks	Disturbing memories, nightmares or images that intrude into the person's thoughts; unwanted recall of adverse events	
t. Episodes of Panic	Unexpectedly overwhelmed by sense of panic	
INDICATORS OF PSYCHOSIS		
u. Hallucinations	False sensory perceptions of any type, with or without insight, without corresponding stimuli (e.g., auditory, visual, tactile, olfactory, gustatory hallucinations), excluding command hallucinations	
v. Command Hallucinations	Hallucinations directing the person to do something or to act in a particular manner (e.g., to harm self or others)	
w. Delusions	Fixed false beliefs (e.g., grandiose, paranoid, somatic), excluding beliefs specific to culture or religion	
x. Abnormal Thought Process/Form	Loosening of association, blocking, flight of ideas, tangentiality, circumstantiality, etc.	
NEGATIVE SYMPTOMS		
y. Anhedonia	Statements that indicate a general lack of pleasure in life (e.g., "I don't enjoy anything anymore.")	
z. Loss of Interest	Withdrawal from activities of interest or from long-standing social relations (e.g., no interest in long-standing activities or being with family/friends)	
aa. Lack of Motivation	Absence of spontaneous goal-directed activities	
bb. Reduced Interaction	Reduced social interaction	
OTHER INDICATORS		
cc. Health Complaints	Repetitive health complaints (e.g., persistently seeks medical attention, excessive concern with bodily functions)	
dd. Anger	Persistent anger with self or others (e.g., easily annoyed, anger at care received)	
ee. Unusual or Abnormal Physical Movements	Unusual facial expressions or mannerisms, peculiar motor behaviour or body posturing	

SECTION B. MENTAL STATUS (cont'd)		
	ff. Hygiene	Unusually poor hygiene, unkempt, dishevelled
	gg. Sleep Problems	Any sleep problems present: difficulty falling asleep, restless or non-restful sleep, interrupted sleep (including awakening earlier than desired), too much sleep
2	INSIGHT INTO MENTAL HEALTH	Degree of insight into his or her mental health problem 0. Full                      1. Limited                      2. None

SECTION C. SUBSTANCE USE AND EXCESSIVE BEHAVIOURS		
1	ALCOHOL	Number of drinks in any single sitting episode in the <b>last 14 days</b> . Code for the highest number. 0. None 1. 1 2. 2 to 4 3. 5 or more
2	SUBSTANCE USE	Time since any use of the following substances: 0. Never or more than 1 year ago 1. Within the last year 2. Within the last 3 months 3. Within the last month 4. Within the last 7 days 5. Within the last 3 days
		a. Inhalants (e.g., glue, gasoline, paint thinners, solvents)
		b. Hallucinogens (e.g., phencyclidine or "angel dust," LSD or "acid," "magic mushrooms," ecstasy)
		c. Cocaine and crack
		d. Stimulants (e.g., amphetamines such as "uppers," "speed," methamphetamine)
		e. Opiates (e.g., heroin)
3	WITHDRAWAL SYMPTOMS	Severity of signs or symptoms possibly indicative of withdrawal from alcohol or drugs. Code for the most severe level in the <b>last 3 days</b> . 0. NONE PRESENT 1. MILD — symptoms typical of early stages of withdrawal (e.g., agitation, "jitters," craving, gastrointestinal upset, anxiety, hostility, vivid dreaming) 2. MODERATE — increased severity of early indicators, weakness, sweating, hot flashes, fainting, muscle twitching 3. SEVERE — symptoms typical of late stages of withdrawal (e.g., exhaustion, seizures, tremors, tachycardia, disorientation, hyperventilation)
4	PATTERNS OF DRINKING OR OTHER SUBSTANCE USE	Presence of behavioural indicators of potential substance-related addiction in the <b>last 3 months</b> 0. No                      1. Yes
		a. Person felt the need or was told by others to cut down on drinking or drug use, or others were concerned about person's substance use.
		b. Person has been bothered by criticism from others about drinking or drug use.
		c. Person has reported feelings of guilt about drinking or drug use.
		d. Person has to have a drink or use drugs first thing in the morning to steady nerves (e.g., an "eye opener").
5	SMOKING	Person smokes or chews tobacco daily. 0. No    2. Yes 1. Not in the last 3 days but is a daily smoker
6	GAMBLING	Person gambled excessively or uncontrollably during the <b>last 3 months</b> . 0. No                      1. Yes

SECTION D. HARM TO SELF OR OTHERS		
1	SELF-INJURY	Code for the most recent instance. a. Most recent self-injurious attempt 0. Never 1. More than 1 year ago 2. 31 days to 1 year ago 3. 8 to 30 days ago 4. 4 to 7 days ago 5. In last 3 days b. Intent of any self-injurious attempt was to kill self 0. No 1. Yes 8. No attempt c. Considered performing a self-injurious act 0. Never 1. More than 1 year ago 2. 31 days to 1 year ago 3. 8 to 30 days ago 4. 4 to 7 days ago 5. In last 3 days da. Family, caregiver, friend or staff expresses concern that person is at risk for self-injury 0. No 1. Yes db. Suicide plan — in last 30 days, formulated a scheme to end own life 0. No 1. Yes
2	VIOLENCE	Code for most recent instance 0. Never 1. More than 1 year ago 2. 31 days to 1 year ago 3. 8 to 30 days ago 4. 4 to 7 days ago 5. In last 3 days a. Violent to others — acts <b>with purposeful, malicious or vicious</b> intent, resulting in physical harm to another (e.g., stabbing, choking, beating) b. Intimidation of others or threatened violence (e.g., threatening gestures or stance with no physical contact, shouting angrily, throwing furniture, explicit threats of violence) c. Violent ideation
3	SEXUAL VIOLENCE	History of sexual violence or assault as perpetrator 0. No 1. Yes

SECTION E. BEHAVIOUR DISTURBANCE		
1	BEHAV-IOURAL SYMPTOMS	Behavioural symptom frequency in the <b>last 3 days</b> 0. Indicator not exhibited in the last 3 days 1. Indicator not exhibited in the last 3 days but is <b>reported to be present</b> 2. Indicator exhibited on 1 to 2 of the last 3 days 3. Indicator exhibited daily in the last 3 days a. Wandering (moving with no rational purpose, seemingly oblivious to needs or safety) b. Verbal abuse (e.g., threatening, screaming at, cursing at others) c. Physical abuse (e.g., hitting, shoving, scratching, sexually abusing others) d. Socially inappropriate/disruptive behaviour (e.g., making disruptive sounds, making noise, screaming, smearing/throwing food/feces, hoarding, rummaging through others' belongings) e. Inappropriate public sexual behaviour (or public disrobing) f. Resistance to care (e.g., taking medications/injections, ADL assistance, eating) g. Elopement attempts/threats
2	EXTREME BEHAVIOUR DISTURBANCE	Prior history of extreme behaviours that suggests <b>serious</b> risk of harm to self (e.g., severe self-mutilation) or others (e.g., setting fires, homicide) 0. No 1. Yes, but not exhibited in the <b>last 7 days</b> 2. Yes, and exhibited in the <b>last 7 days</b>

SECTION F. COGNITION		
1	MEMORY/RECALL ABILITY (over the last 3 days)	Code for recall of what was learned or known. 0. Yes, memory OK 1. Memory problem a. Short-term memory OK — seems/appears to recall after 5 minutes b. Procedural memory OK — can perform all or almost all steps in a multi-task sequence without cues for initiation
2	COGNITIVE SKILLS FOR DAILY DECISION-MAKING (over the last 3 days)	Making decisions regarding tasks of daily life (e.g., when to get up or have meals, which clothes to wear, which activities to do) 0. INDEPENDENT — decisions consistent/reasonable/safe 1. MODIFIED INDEPENDENCE — some difficulty in new situations only 2. MINIMALLY IMPAIRED — decisions poor or unsafe in specific situations; cues/supervision necessary at those times 3. MODERATELY IMPAIRED — decisions consistently poor or unsafe; cues/supervision required at all times 4. SEVERELY IMPAIRED — never/rarely makes decisions 5. NO DISCERNABLE CONSCIOUSNESS
3	INDICATORS OF DELIRIUM — PERIODIC DISORDERED THINKING/AWARENESS	Note: Accurate assessment requires conversations with staff and family who have direct knowledge of the person's behaviour over this time. 0. Behaviour not present 1. Behaviour present but not of recent onset 2. Behaviour present over the last 3 days AND the behaviour appears different from the person's functioning 2 weeks ago (e.g., new onset or worsening) a. EASILY DISTRACTED (e.g., episodes of difficulty paying attention, gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS (e.g., moves lips or talks to someone not present, excluding prayers; believes he or she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH (e.g., speech is nonsensical, irrelevant or rambles from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS (e.g., fidgeting or picking at skin, clothing, napkins; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY (e.g., sluggishness, staring into space, difficult to arouse, little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY (e.g., sometimes better, sometimes worse; behaviours sometimes present, sometimes not)
4	COGNITIVE DECLINE	Now more impaired in decision-making than 90 days ago (or since last assessment) 0. No or unsure 1. Yes, more impaired today

SECTION G. SELF-CARE		
1	3-DAY ADL SELF-PERFORMANCE	CODE for the person's performance over full 24-hour period, considering all occurrences of the activity <b>over the last 3 days</b> . 0. INDEPENDENT — no help, set-up, or supervision; OR help, set-up or supervision provided only 1 or 2 times during period (with any task or subtask) 1. SET-UP HELP ONLY — article or device provided or placed within reach of person 3 or more times 2. SUPERVISION — oversight, encouragement or cueing provided 3 or more times; OR supervision (1 or more times) plus physical assistance provided only 1 or 2 times during period, for a total of 3 or more episodes of help or supervision 3. LIMITED ASSISTANCE — person highly involved in activity, received physical help in guided manoeuvring of limbs or other non-weight-bearing assistance 3 or more times OR combination of non-weight-bearing help with more help provided only 1 or 2 times during period, for a total of 3 or more episodes of physical help 4. EXTENSIVE ASSISTANCE — person performed part of activity on own (50% or more of subtasks) BUT help of following type(s) from 1 person provided 3 or more times: – weight-bearing support (e.g., holding weight of limb, trunk) – full performance by others some of the time of a task or discrete subtask

**SECTION G. SELF-CARE (cont'd)**

	5. MAXIMAL ASSISTANCE — person involved but completed less than 50% of subtasks on own (includes 2+ person assist) OR received weight-bearing help or full performance of certain subtasks 3 or more times	
	6. TOTAL DEPENDENCE — full performance of activity by others during entire period	
	8. ACTIVITY DID NOT OCCUR — during entire period	
a	PERSONAL HYGIENE	How person manages hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (exclude baths and showers)
b	WALKING	How person walks between locations on same floor indoors
c	WHEELING	How person moves between locations on same floor indoors when using a wheelchair
d	TOILET USE	How person uses toilet room, commode, bedpan or urinal; cleans self after toilet use or incontinent episode(s); changes pad; manages ostomy or catheter; adjusts clothes (exclude transfer on/off toilet)
e	EATING	How person eats and drinks (regardless of skill); includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)
2	<b>IADL CAPACITY</b> CODE the person's IADL capacity based on his or her presumed ability to carry out the activity as independently as possible. In some cases this may require "speculation" by the assessor.	
	0. INDEPENDENT — no help, set-up or supervision	
	1. SET-UP HELP ONLY — article or device provided or placed within the person's reach 3 or more times	
	2. SUPERVISION — oversight, encouragement or cueing	
	3. LIMITED ASSISTANCE — help to complete task on some occasions; other times does on own	
	4. EXTENSIVE ASSISTANCE — assistance throughout the task but performs 50% or more of subtasks involved in the activity on own	
	5. MAXIMAL ASSISTANCE — person involved but completes less than 50% of subtasks involved in the activity on own	
	6. TOTAL DEPENDENCE — full performance of activity by others during entire period	
a	MEAL PREPARATION	How person prepares meals (e.g., planning meals, cooking, assembling ingredients, setting out food and utensils)
b	MANAGING MEDICATIONS	How person manages medications (e.g., remembering to take medications, opening bottles, taking correct drug dosages, giving injections, applying ointments)
c	TRANSPORTATION	How person travels by public transportation (navigating system, paying fare), arranges other transport or drives self (including getting out of house, into/out of vehicles)
d	MANAGING FINANCES	How person pays bills, balances cheque book, balances household expenses, monitors credit card account
e	PHONE USE	How person makes or receives telephone calls (with assistive devices such as large numbers on telephone, amplification as needed)
3	STAMINA	Hours of physical activity in the last 3 days (e.g., walking, outdoor gardening, shopping, cleaning house, exercise) 0. More than 2 hours      2. Less than 1 hour 1. 1 to 2 hours          3. None
4	ADL DECLINE	ADL status is worse than 90 days ago or since last assessment (if less than 90 days ago). 0. No or unsure          1. Yes, more impaired today

**SECTION H. COMMUNICATION/VISION PATTERNS**

1	HEARING	Ability to hear during the <b>last 3 days</b> with hearing appliance normally used 0. ADEQUATE — no difficulty in normal conversation, social interaction, TV, phone 1. MINIMAL DIFFICULTY — requires quiet setting to hear well 2. HEARS IN SPECIAL SITUATIONS ONLY — speaker has to increase volume and speak distinctly 3. HIGHLY IMPAIRED — absence of useful hearing
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**SECTION H. COMMUNICATION/VISION PATTERNS (cont'd)**

2	VISION	Ability to see in adequate light and with glasses or with other visual appliance normally used in the <b>last 3 days</b> 0. ADEQUATE — sees fine detail, including regular print in newspapers/books 1. IMPAIRED — sees large print but not regular print in newspapers/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
3	MAKING SELF UNDERSTOOD	Expressing information content (however able) 0. UNDERSTOOD — expresses ideas without difficulty 1. USUALLY UNDERSTOOD — difficulty finding words or finishing thoughts but if given time, little or no prompting required 2. OFTEN UNDERSTOOD — difficulty finding words or finishing thoughts, prompting usually required 3. SOMETIMES UNDERSTOOD — ability limited to concrete requests 4. RARELY/NEVER UNDERSTOOD

**SECTION I. HEALTH CONDITIONS AND POSSIBLE MEDICATION SIDE EFFECTS**

1	SIGNS AND SYMPTOMS	Code for all problems present in the <b>last 3 days</b> 0. Indicator not exhibited in the last 3 days 1. Indicator exhibited on 1 to 2 of the last 3 days 2. Indicator exhibited on each of the last 3 days
	a. Headache	i. Nausea
	b. Dizziness/vertigo or light-headedness	j. Vomiting
	c. Shortness of breath	k. Constipation
	d. Chest pain/pressure	l. Diarrhea
	e. Blurred vision	m. Daytime drowsiness/sedation
	f. Dry mouth	n. Fatigue/weakness
	g. Increase or decrease in normal appetite	o. Impaired balance/ataxia
	h. Difficulty urinating/urinating 3 or more times a night/polyuria	p. Emergent conditions (e.g., itching, fever, rash)
		q. Edema
2	EXTRA-PYRAMIDAL SIGNS AND SYMPTOMS	Presence of extra-pyramidal signs and symptoms at any point during the <b>last 3 days</b> 0. No      1. Yes
	<b>INCREASE IN MOTOR ACTIVITY</b>	
	a. Akathisia	— reports subjective feeling of restlessness or need for movement
	b. Dyskinesia	— chewing, puckering movements of the mouth; abnormal irregular movements of lips; or rocking or writhing of trunk
	c. Tremor	— involuntary rhythmic movements of fingers, limbs, head, mouth or tongue
	<b>DECREASE IN MOTOR ACTIVITY</b>	
	d. Rigidity	— resistance to flexion and extension of muscles (e.g., continuous or cogwheeling rigidity)
	e. Slow, shuffling gait	— reduction in speed and stride length of gait, usually with a decrease in pendular arm movement
	f. Bradykinesia	— decrease in spontaneous movements (e.g., reduced body movement; poverty of facial expression, gestures, speech)
	<b>MUSCLE CONTRACTIONS</b>	
	g. Dystonia	— muscle hypertonicity (e.g., muscle spasms or stiffness, protruding tongue, upward deviation of the eyes)



**SECTION I. HEALTH CONDITIONS AND POSSIBLE MEDICATION SIDE EFFECTS (cont'd)**

3	SEXUAL FUNCTIONING	Reports persistent difficulty with sexual functioning during the <b>last 30 days</b> (e.g., loss of interest or drive, impaired erection or ejaculation, inhibited female orgasm). 0. No                      1. Yes	
4	SELF-REPORTED HEALTH	Ask, "In general, how would you rate your physical health over the <b>last 3 days</b> ." 0. Excellent    1. Good    2. Fair    3. Poor 8. Could not (would not) respond	
5	CHEWING/SWALLOWING	Any problem chewing or swallowing (e.g., pain while eating) 0. No                      1. Yes	
6	a. SKIN PROBLEMS	a. Major skin problems in the <b>last 3 days</b> (e.g., lesions, second- or third-degree burns, healing surgical wounds) 0. No                      1. Yes b. Other skin conditions or changes in skin condition (e.g., bruises, rashes, itching, mottling, herpes zoster, intertrigo, eczema) 0. No                      1. Yes	
	b. FOOT PROBLEMS	Presence of foot problems in the <b>last 3 days</b> (e.g., bunions, hammer toes, overlapping toes, structural problems, infections, ulcers) 0. No foot problems 1. Foot problems, no limitation in walking 2. Foot problems limit walking 3. Foot problems prevent walking 4. Foot problems, does not walk for other reasons	
7	a. FALLS	0. No fall in last 90 days 1. No fall in last 30 days, but fell 31 to 90 days ago 2. One fall in last 30 days 3. Two or more falls in last 30 days	
	b. RECENT FALLS	0. No                      1. Yes 8. Not applicable, first assessment or more than 30 days since last assessment	
8	PAIN	a. Frequency with which person complains of or shows evidence of pain in the <b>last 3 days</b> 0. No pain    1. Pain less than daily    2. Pain daily	
		b. Intensity of pain. Code for the most intense, distressful pain. 0. No pain                      3. Severe 1. Mild                              4. Sometimes 2. Moderate                      horrible or excruciating	
9	BLADDER CONTINENCE	Control of urinary bladder function (includes dribbling) in the <b>last 3 days</b> 0. CONTINENT — complete control; does not use any type of catheter or other urinary collection device 1. MANAGED WITH CATHETER OR OSTOMY — managed with any type of catheter or urinary collection device 2. INFREQUENT INCONTINENCE — not incontinent over the last 3 days but does have incontinent episodes 3. EPISODE OF INCONTINENCE — on 1 day 4. OCCASIONALLY INCONTINENT — on 2 days 5. FREQUENTLY INCONTINENT — tends to be incontinent daily, but some control present 6. INCONTINENT — inadequate control of bladder, multiple daily episodes all or almost all of the time 8. DID NOT OCCUR — no urine output from bladder	
10	BOWEL CONTINENCE	Control of bowel function in the <b>last 3 days</b> 0. CONTINENT — complete control; does not use ostomy device 1. CONTROL WITH OSTOMY — complete control with use of ostomy device that does not leak stool 2. INFREQUENT INCONTINENCE — not incontinent over the last 3 days but does have incontinent episodes 3. EPISODE OF INCONTINENCE — on 1 day 4. OCCASIONALLY INCONTINENT — on 2 days 5. FREQUENTLY INCONTINENT — tends to be incontinent daily but some control present (e.g., during day) 6. INCONTINENT — inadequate control of bowel, multiple daily episodes all or almost all of the time 8. DID NOT OCCUR — no bowel movement during the entire assessment period	

**SECTION I. HEALTH CONDITIONS AND POSSIBLE MEDICATION SIDE EFFECTS (cont'd)**

11	MEDICAL DIAGNOSES	0. Not present    1. Present    8. Unknown		
		a. Diabetes type 1		
		b. Diabetes type 2		
		c. Chronic obstructive pulmonary disease		
		d. Congestive heart failure		
		e. Chronic renal failure with dialysis		
		f. HIV+		
		g. Hepatitis C		
		<b>Other</b>		<b>ICD-10-CA</b>
		h. _____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
		i. _____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
		j. _____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
		k. _____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
l. _____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
m. _____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

**SECTION J. STRESSORS**

1	LIFE EVENTS	Code for the most recent time of the event. 0. Never                      3. 8 to 30 days 1. More than 1 year ago    4. 4 to 7 days 2. 31 days to 1 year        5. In last 3 days	
		a. Serious accident or physical impairment	
		b. Distress about health of another person	
		c. Death of close family member or friend	
		d. Child custody issues, birth or adoption of child	
		e. Conflict-laden or severed relationship, including divorce	
		f. Failed or dropped out of education program	
		g. Major loss of income or serious economic hardship due to poverty	
		h. Review hearing (e.g., forensic, certification, capacity hearing)	
		i. Immigration, including refugee status	
		j. Lived in war zone or area of violent conflict (includes combatants and civilians)	
		k. Witness to severe accident, disaster, act of terrorism, violence or abuse	
		l. Victim of crime (e.g., robbery). Exclude assault.	
		m. Victim of sexual assault/abuse	
		n. Victim of physical assault/abuse	
		o. Victim of emotional abuse	
		p. Parental abuse of alcohol or drugs	
2	LIFE EVENT (J1) CAUSES SENSE OF HORROR OR INTENSE FEAR	Describes 1 or more of these events (J1) as evoking a sense of horror or intense fear. 0. No or not applicable 1. Yes 8. Could not (would not) respond	
3	OTHER INDICATORS	Code for other indicators of abuse. 0. No                      1. Yes	
		a. Any history of physical/emotional/sexual abuse/sexual assault experienced by family member(s)	
		b. Fear of family member, friend, caregiver or staff	

SECTION K. MEDICATIONS			
1	HISTORY OF MEDICATION ADHERENCE	Adherent with prescribed medications during the <b>month prior to admission</b> 0. Always adherent 1. Adherent 80% or more of time 2. Adherent less than 80% of time, including failure to purchase prescribed medication 3. No medication prescribed 8. Unknown	
2	MEDICATION REFUSAL	Refused to take some or all of prescribed medication in the <b>last 3 days</b> . 0. No      1. Yes	
3	STOPPED TAKING PSYCHOTROPIC MEDICATION	In the <b>last 90 days</b> stopped taking psychotropic medication because of side effects. 0. No, or no psychotropic medication 1. Yes	
4	INTENTIONAL MISUSE OF MEDICATION	Misuse of prescription or over-the-counter medication in the <b>last 3 months</b> (e.g., uses medication for purpose other than intended). 0. No      1. Yes	
5	ACUTE CONTROL MEDICATIONS	Number of times psychotropic medication used as an immediate response to prevent harm to self or others in the <b>last 3 days</b> . Code the actual number; if 9 or more, code "9."	
6	ALLERGY TO DRUGS	Allergy to drugs 0. No      1. Yes	

SECTION L. SERVICE UTILIZATION/TREATMENTS			
1	FORMAL CARE	Record the number of days of contact of at least 15 minutes per day in the <b>last 7 days or since admission</b> (if less than 7 days ago). Code 0 to 7 days.	
		a. Psychiatrist	
		b. Nurse practitioner or MD (non-psychiatrist)	
		c. Social worker	
		d. Psychologist or psychometrist	
		e. Occupational therapist	
		f. Recreation therapist	
		g. Addiction counsellor	
		h. Dietitian	
2	NURSING INTERVENTIONS	Record the number of days each of the following was provided for 15 minutes or more per day in the <b>last 7 days or since admission</b> (if less than 7 days ago). Code "0" if none or if less than 15 minutes per day.	
		a. Medical interventions	
		b. One-to-one counselling, teaching	
		c. Crisis intervention	
		d. Family support/consultation	
3	TREATMENT MODALITIES	Code for treatment modalities used in the <b>last 7 days or since admission</b> (if less than 7 days ago). 0. Not offered and not received 1. Offered but refused 2. Received in the last 7 days 3. Not received but scheduled to start within the next 7 days	
		a. Individual therapy	
		b. Group therapy	
		c. Family therapy, couple therapy	
		d. Self-help group	

SECTION L. SERVICE UTILIZATION/TREATMENTS (cont'd)					
4	FOCUS OF INTERVENTION	Code for types of issues that were a major focus of interventions in the <b>last 7 days or since admission</b> (if less than 7 days ago). 0. No intervention of this type 1. Offered but refused 2. Received in the last 7 days 3. Not received but scheduled to start within the next 7 days			
		a. Community reintegration			
		b. Social/family functioning			
		c. Psychosocial rehabilitation			
		d. Detoxification			
		e. Alcohol/drug treatment/smoking cessation			
		f. Vocational counselling			
		g. Anger management			
		h. Eating disorder			
		i. Behaviour management			
		j. Post-traumatic stress			
		k. Pain management			
5	ADHERENCE TO TREATMENTS, THERAPIES, PROGRAMS	Adherent all or most of the time with special treatments, therapies and programs in the <b>last 7 days or since admission</b> (if less than 7 days ago). 0. Always adherent 1. Adherent 80% or more of time 2. Adherent less than 80% of time 3. No treatments/programs			
		6	ECT	Received ECT. Code for the most recent instance. 0. Never 1. More than 1 month ago 2. During the last month 3. During the last 7 days 4. Scheduled to begin within 7 days	
		X6	NUMBER OF ECTS	Enter number of ECTs since last assessment (or since admission if this is an admission or short stay assessment): 0 to 99.	

SECTION M. CONTROL PROCEDURES/OBSERVATION					
1	CONTROL INTERVENTIONS	Code for the use of each device or intervention in the <b>last 3 days</b> . 0. Not used 1. Less than daily use 2. Daily use — night only 3. Daily use — day only 4. Night and day but not constant 5. Constant use for full 24 hours (may include periodic release)			
		a. Mechanical restraint			
		b. Chair prevents rising			
		c. Physical/manual restraint by staff			
		d. Confinement to unit			
		e. Confinement to room			
2	CLOSE OR CONSTANT OBSERVATION	Number of days of supervision of the following type in the <b>last 3 days</b> . If none, code "0." a. Checked at 15-minute intervals b. Checked at 5-minute intervals c. Constant observation for less than 1 hour d. Constant observation for more than 1 hour			
		3	PSYCHIATRIC INTENSIVE CARE UNIT	Number of days in psychiatric intensive care unit during the <b>last 3 days</b> . If none, code "0."	
		4	AUTHORIZED ACTIVITIES OUTSIDE OF FACILITY	Number of times in the <b>last 3 days</b> the person went out of facility (or locked unit, if applicable). 0. None      1. 1      2. 2 or more	
				a. Left accompanied by staff	
		b. Left not accompanied by staff			





**SECTION Q. PSYCHIATRIC DIAGNOSTIC INFORMATION**

1	DSM-5-TR DIAGNOSTIC CATEGORY	Select up to 3 DSM-5-TR diagnoses (or provisional diagnoses if this is an initial assessment) determined by the psychiatrist/attending physician and rank them in order of importance as factors contributing to this assessment. <b>Code "1" for the most important diagnosis, "2" for the second most important and "3" for the third most important.</b> (Note: Code 2 and 3 if applicable.)	
		a. Neurodevelopmental disorders	
		b. Schizophrenia spectrum and other psychotic disorders	
		c. Bipolar and related disorders	
		d. Depressive disorders	
		e. Anxiety disorders	
		f. Obsessive-compulsive and related disorders	
		g. Trauma- and stressor-related disorders	
		h. Dissociative disorders	
		i. Somatic symptoms and related disorders	
		j. Feeding and eating disorders	
		k. Elimination disorders	
		l. Sleep-wake disorders	
		m. Sexual dysfunctions	
		n. Gender dysphoria	
		o. Disruptive, impulse-control and conduct disorders	
		p. Substance-related and addictive disorders	
q. Neurocognitive disorders			
r. Personality disorders			
s. Paraphilic disorders			
t. Other mental disorders			
u. Medication-induced movement disorders and other adverse effects of medication			
v. Not applicable			
2	PSYCHI-ATRIC DIAGNOSIS	Enter DSM-5-TR diagnoses, if known. List codes in order of importance. This must be completed on discharge, but also complete with earlier assessments if a specific psychiatric diagnosis has already been determined.	
		a. DSM-5-TR CODE: <input type="text"/>	
		b. DSM-5-TR CODE: <input type="text"/>	
		c. DSM-5-TR CODE: <input type="text"/>	
		d. DSM-5-TR CODE: <input type="text"/>	
		e. DSM-5-TR CODE: <input type="text"/>	
		f. DSM-5-TR CODE: <input type="text"/>	
3	INTELLEC-TUAL DISABILITY	Has an intellectual disability (e.g., Down syndrome). 0. No                      1. Yes	
4	GAF SCORE	Global Assessment of Functioning. Code the current score. <input type="text"/>	
5	CURRENT PATIENT TYPE	Code for the most appropriate type. 1. Acute care                      3. Geriatric psychiatry 2. Longer term                      4. Forensic	

**SECTION Q. PSYCHIATRIC DIAGNOSTIC INFORMATION (cont'd)**

X160	SCHIZOPHR ENIA PRIMARY DIAGNOSIS	Has the physician determined that the person has a primary diagnosis of schizophrenia (DSM-5-TR = F20.9, F250 or F25.1)? 0. No                      1. Yes	
X161	LONG-ACTING INJECTABLE MEDICATION	Is the person receiving treatment with a long-acting injectable medication? 0. No 1. Yes, during hospital stay 2. Yes, prior to admission and not required during hospital stay	
X162	TREATMENT RESISTANT	Has it been determined by the physician that the person is treatment resistant? 0. No                      1. Yes	
X163	TREATMENT WITH CLOZAPINE	Has the person received treatment with clozapine (during this hospital stay)? 0. No, not during this hospital stay 1. Yes, during this hospital stay and is prescribed to continue at discharge	
X164	CARE PLAN SENT	Does the person have a documented care plan that will be available to the follow-up provider within 7 days (of discharge)? 0. No                      1. Yes	

**SECTION R. MEDICATIONS**

1	PRESCRIBED MEDICATIONS	Medication prescribed for use in the last 3 days. 0. No                      1. Yes	
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**SECTION S. SERVICE HISTORY**

X8A	ADMITTED THROUGH EMERGENCY DEPARTMENT	Person admitted through this organization's emergency department? 0. No or not applicable                      1. Yes	
X8B	ARRIVED ON INPATIENT UNIT	Person arrived on inpatient unit from this organization's emergency department? 0. No                      1. Yes	
X8C	DATE ARRIVED ON INPATIENT UNIT	Enter the date the person arrived on inpatient unit from this organization's emergency department. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year                      Month                      Day	
X75	DAYS IN ALTERNATE LEVEL OF CARE	Enter the total number of days of alternate level of care since last assessment (or since admission if this is an admission or short stay assessment) for this person. <input type="text"/> <input type="text"/> <input type="text"/>	
X80	DISCHARGE DATE	Enter the date of discharge <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year                      Month                      Day	
X90	REASON FOR DISCHARGE	Code the most appropriate reason for discharge. 1. Planned discharge 2. Death due to suicide 3. Death not due to suicide 4. Transferred (unplanned) 5. AWOL 6. LOA to community >92 days 7. Discharged against medical advice 8. Other	
X130	TOTAL DAYS AWAY FROM BED	Enter the total number of days away from the mental health bed since last assessment (or since admission if this is an admission or short stay assessment). <input type="text"/> <input type="text"/>	
X131	DAYS AWAY FROM BED IN PREVIOUS FISCAL YEAR	Enter the number of days away from the mental health bed that occurred in the previous fiscal year since the last assessment (or since admission if this is an admission or short stay assessment). <input type="text"/> <input type="text"/>	

**SECTION T. ASSESSOR IDENTIFICATION**

1	SIGNATURE OF PERSON COORDINATING THE ASSESSMENT																
a. _____ Signature of Assessment Coordinator	b. Date Assessment Coordinator signed as complete																
	<table style="display: inline-table; border: 1px solid black; margin-right: 20px;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td colspan="4" style="text-align: center; font-size: 8px;">Year</td></tr> </table> <table style="display: inline-table; border: 1px solid black; margin-right: 20px;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td colspan="2" style="text-align: center; font-size: 8px;">Month</td></tr> </table> <table style="display: inline-table; border: 1px solid black;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td colspan="2" style="text-align: center; font-size: 8px;">Day</td></tr> </table>					Year						Month				Day	
Year																	
Month																	
Day																	

**Medication Record**

List all medications prescribed for use in the **last 3 days**.

**Name** — Record the name of the medication.

**DIN** — Drug Identification Number. Be sure to enter the correct DIN for the drug name, strength and form. The DIN must match the drug dispensed by the pharmacy.

**Dose** — Record the dose of the medication.

**Form/Route** — Code the route of administration using the following table:

<b>PO</b> By mouth	<b>SL</b> Sublingual	<b>IM</b> Intramuscular	<b>TOP</b> Topical	<b>ET</b> Enteral tube
<b>IV</b> Intravenous	<b>SQ</b> Subcutaneous	<b>R</b> Rectal	<b>NH</b> Inhalation	<b>OTH</b> Other

**Freq.** — Code the number of times per day, week or month the medication is administered, using the following list:

<b>QH</b> Every hour	<b>QD</b> Once daily	<b>QW</b> Once each week	<b>QOD</b> Every other day
<b>Q2H</b> Every two hours	<b>BID</b> Two times daily (include every 12 hours)	<b>2W</b> Two times each week	<b>QHS</b> At bedtime
<b>Q3H</b> Every three hours	<b>TID</b> Three times daily	<b>3W</b> Three times each week	<b>1M</b> Once every month
<b>Q4H</b> Every four hours	<b>QID</b> Four times daily	<b>4W</b> Four times each week	<b>2M</b> Twice every month
<b>Q6H</b> Every six hours	<b>5D</b> Five times daily	<b>5W</b> Five times each week	<b>C</b> Continuous
<b>Q8H</b> Every eight hours		<b>6W</b> Six times each week	<b>O</b> Other

**PRN** — Check if the medication was given on a PRN basis at any time in the last 3 days.      **D/C** — Check if the medication has now been discontinued.

	Name	X70 DIN (Drug Identification Number)	R2 b. Dose	R2 c. Form/ Route	R2 d. Freq.	R2 e. PRN (L)	R2 f. D/C (L)
a.		<input style="width: 100%; height: 20px;" type="text"/>					
b.		<input style="width: 100%; height: 20px;" type="text"/>					
c.		<input style="width: 100%; height: 20px;" type="text"/>					
d.		<input style="width: 100%; height: 20px;" type="text"/>					
e.		<input style="width: 100%; height: 20px;" type="text"/>					
f.		<input style="width: 100%; height: 20px;" type="text"/>					
G		<input style="width: 100%; height: 20px;" type="text"/>					
h.		<input style="width: 100%; height: 20px;" type="text"/>					
i.		<input style="width: 100%; height: 20px;" type="text"/>					

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