Ontario Mental Health Reporting System Resource Manual, 2013–2014

Module 1—Clinical Coding

Types of Care

Canadian Institute for Health Information

Institut canadien d'information sur la santé

Our Vision

Better data. Better decisions. Healthier Canadians.

Our Mandate

To lead the development and maintenance of comprehensive and integrated health information that enables sound policy and effective health system management that improve health and health care.

Our Values

Respect, Integrity, Collaboration, Excellence, Innovation

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CIHI Background Information

The Canadian Institute for Health Information (CIHI) collects and analyzes information on health and health care in Canada and makes it publicly available. Canada's federal, provincial and territorial governments created CIHI as a not-for-profit, independent organization dedicated to forging a common approach to Canadian health information. CIHI's goal: to provide timely, accurate and comparable information. CIHI's data and reports inform health policies, support the effective delivery of health services and raise awareness among Canadians of the factors that contribute to good health.

For more information, visit our website at www.cihi.ca.

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. 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.

How to Use This Resource Manual

The *Ontario Mental Health Reporting System Resource Manual* is divided into two separate modules that are intended to provide comprehensive information to a broad range of partners and stakeholders who have key roles in the accurate coding and reporting of adult inpatient mental health episodes.

Module 1—Clinical Coding

Contains an overview and history of the Ontario Mental Health Reporting System (OMHRS) with explanations of the development, scope and basic principles of the RAI-MH. Included are an overview of the types of assessments, a listing of the mandatory and optional requirements for each data element, detailed coding and interpretation guidelines and a copy of the MDS 2.0© data set form with CIHI's added administrative elements.

This module is for clinicians and health records personnel responsible for coding the specified elements.

Module 2—Technical Specifications and Data Submission

Contains the relevant technical specifications, naming conventions, testing processes and file characteristics for use by facilities and vendors in the development of data collection software. The vendor and facility testing process is detailed, as are the record layouts for the various OMHRS assessment types. The edit tables are included with Appendix A, which provides the error numbers and descriptions that, if triggered by submitted data, will appear on a facility's submission report and a copy of the MDS 2.0 data set form with CIHI's added administrative elements.

This module is for IT and data submission personnel who are responsible for the submission.

Contact Information

The OMHRS team can be reached by email at omhrs@cihi.ca. Vendors can reach the vendor support department at vendors@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 and Long-Term Care (MOHLTC), serves to standardize the capture of mental health clinical and administrative data 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 data 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 MOHLTC, the Ontario Hospital Association (OHA), Statistics Canada, Health Canada, interRAI, researchers and the public. The OMHRS project is managed out of the Continuing and Specialized Care Information Services (CSCIS) Ottawa branch of CIHI.

Development of OMHRS

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

The Activity Measurement Working Group reported that

- The psychiatric Case Mix Groupers that were in use at the time were a poor measure of the variance in resource use between different populations served by various facilities;

- 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 important to prevent gaming (inappropriate or inaccurate coding of the instrument for secondary gains). In 1996, the JPPC partnered with interRAI to develop a mental health assessment that would be called RAI-MH, referring to the Resident Assessment Instrument—Mental Health (RAI-MH). The RAI-MH instrument would include a Minimum Data Set for Mental Health (MDS-MH)©, care-planning protocols, outcome measures, quality indicators and Case Mix Groups.

Phase one of the development of the RAI-MH occurred over approximately a two-year period and included the development of the version 1.0 RAI-MH assessment instrument and related triggers for care planning, quality indicators and outcome measures. Literature reviews, expert working groups, consultants, researchers and front-line clinicians contributed to the face and content validity of the instrument. Pilot study results using the version 1.0 assessment tool demonstrated acceptable or higher-than-average levels of inter-rater reliability and evidence of convergent validity among the elements.

In April 1999, during development of the instrument, a joint venture agreement was signed by the MOHLTC, the OHA and interRAI, which stipulated that the OHA and the MOHLTC would retain ownership of the RAI-MH within Canada and interRAI would retain ownership outside of Canada and continue with further research and development.

In phase two of the development, the RAI-MH version 1.0 instrument was piloted in more than 30 hospitals in Ontario, as well as two in Alberta and one in Manitoba. Criterion validity was assessed through comparisons of sub-scales against gold standards, for example, the Mini-Mental State Examination and the Cognitive Performance Scale. Research also began on the predictive validity of the care planning algorithms that lead to the triggering of various Mental Health Assessment Protocols (MHAPs). International efforts were also launched with pilot studies in the U.S. (Illinois), Iceland, Sweden, Germany and Spain.

In order to develop the case mix system, staff-time measurements were collected for time spent with persons in care as well as maintenance and administrative activities. The assessment information was linked to the staff-time measurement data to create the Case Mix Groups to be used in a per diem funding formula. Modifications made to the instrument were based on clinical input, extensive consultation within Canada and internationally, and the results of convergent validity testing. The new MDS-MH version 2.0 was 40 percent shorter than the first, with a simplified coding structure and increased clinical content. A final version 2.0 *Training and Resource Guide* was also completed, portions of which are included in this manual. Additional inter-rater reliability tests were conducted by 10 Ontario hospitals, as well as by facilities in Iceland and Sweden.

In 2002, the JPPC sponsored an independent review of the RAI-MH by three experts in evaluating assessment processes. The final report, submitted to the JPPC in July 2002, included short-, medium- and long-term recommendations and acknowledged that outstanding collaboration was demonstrated between research and clinical staff throughout the RAI-MH project.

In March 2003, the JPPC Psychiatric Working Group submitted the completed RAI-MH instrument to the joint owners of the instrument in Canada—the MOHLTC 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 MOHLTC 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, provincial psychiatric 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 and Care Planning System?

The Resident Assessment Instrument—Mental Health (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. This will be particularly important for specialized programs targeted at specific subpopulations of adults in inpatient mental health settings. 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. The Minimum Data Set for Mental Health (MDS-MH) is a standardized minimum-assessment tool for clinical use. It is not a questionnaire for analyzing the characteristics of the population, nor does it claim to include all of the information necessary to construct a comprehensive care plan. Mental health professionals should add supplemental processes as judged necessary. The items in this instrument describe the performance and capacity of the persons in care in several domains, with the majority of items serving as specific triggers for care planning. The MDS-MH is the form that enables a service provider to assess key domains of function, mental and physical health, social support and service use. Particular MDS-MH items also identify persons who could benefit from further evaluation of specific problems and risks for decline in health, well-being or function.

How Does the RAI-MH Work?

Completing the MDS-MH Assessment Form

The MDS-MH form is designed for use by mental health professionals (for example, nurses, social workers, psychiatrists, family physicians, and recreational and occupational therapists). It consists of items and definitions and should be used as a guide in structuring the 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.

The items on the MDS-MH flow in a reasonable sequence, and the sequence could be followed in the assessment. However, assessors are not bound by this sequence of items. Items may be reviewed in any sequence deemed appropriate for a given person.

The MDS-MH can be used as a guide in questioning the person in care or key family members. When answers are of dubious validity, further in-depth assessment using professional clinical judgment will be required. It is important to note that the MDS-MH questions seek information *about* the person, not necessarily *of* the person.

The presence of an accurate MDS-MH assessment lays the groundwork for all that will follow—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 rendered 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:

Full Admission	This assessment is completed when the net length of stay is greater than 72 hours (three days). It is a complete assessment inclusive of all the clinical and administrative items of the MDS-MH, including demographic information that is completed at intake only. A full admission assessment is required if (X80 Discharge Date – CC1 Date Stay Began – X130 Total Days Away From Bed) is greater than three days.
Short Stay	This assessment is completed whenever the net length of stay is less than or equal to 72 hours (three days). It is comprised of approximately 50 clinical and administrative items of the MDS-MH and includes the discharge information. Information for the items that are not mandatory may be collected if available. When calculating the length of stay for a short-stay assessment, count the admission date as day one and do not include service interruption days. For example, if, during a longer length of stay, a service interruption occurs such that the person is in the mental health bed for less than or equal to three days, a short-stay assessment is required. 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 three days.
Change in Status	This assessment type is completed at any time during a single episode of care for people who experience a significant, unexpected change in their clinical status. This assessment should not be completed when doing so would cause an overlap in assessment periods (that is, if it is less than 72 hours since the last assessment). A change in status assessment is a complete assessment inclusive of all the clinical and administrative items of the MDS-MH.
Quarterly	This assessment is completed for all longer-stay people within 92 days of the Assessment Reference Date (A1) of the most recent admission, quarterly or change in status assessment. This assessment is a complete assessment inclusive of all the clinical and administrative data elements of the MDS-MH.
Discharge (Full)	This assessment is completed for all planned discharges where the net length of stay is greater than six days and when there is no indication that the person will be returning. This assessment is a full assessment, inclusive of all the clinical and administrative items of the MDS-MH. A full discharge assessment is required if (X80 Discharge Date – CC1 Date Stay Began – X130 Total Days Away From Bed) is greater than six days and the discharge is planned (X90 Reason for Discharge = 1). 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.

Discharge (Short)	Under specific circumstances, it is acceptable to complete a shortened discharge assessment. This assessment is completed when one of the following two scenarios applies:
	1. The discharge is unplanned and the net length of stay is greater than or equal to four 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.
	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 four days.
	2. The discharge is planned or unplanned, and the net length of stay is greater than or equal to four days and less than or equal to six days. This assessment has a smaller set of mandatory items but should include the clinical items that are available.
	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 four days and less than or equal to six days, whether the discharge is planned or unplanned.
	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.

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)
X10	Country of Residence	M	M				
X20	Province/Territory Issuing Health Card Number	M	M				
X4	Health Card Number Status	M	M				
AA2	Health Card Number	O$*^0$	O$*^0$				
X30	Chart Number	M	M	M	M	M	M
AA3	Case Record Number	M	M	M	M	M	M
AA4	Facility Number	M	M	M	M	M	M
AA5	Unit Identifier	M	M	M	M	M	M
BB1	Sex	M	M				
BB2	Birthdate	M	M				
X40	Estimated Birthdate	M	M				
BB3	Marital Status	M	O				
BB4	Language	M	O				
BB5	Education	M	O				
BB6a–g	Income	M	O$*^1$				
X50a–i	Responsibility for Payment	M	M				
BB7	Aboriginal Origin	M	O				
CC1	Date Stay Began (Admission Date)	M	M				
CC2a–h	Reasons for Admission	M	M				
X60	Postal Code of Person's Residence	M	M				
CC3	Who Lived With at Admission	M	O				

Element ID	Element Name	Admission	Short Stay	Change in Status	Quarterly	Discharge (Full)	Discharge (Short)
CC4a–b	Admitted From and Usual Residential Status	M	M				
X65	Referred From Facility Number	O*[2]	O*[2]				
CC5	Residential Stability	M	O				
DD1	Number of Psychiatric Admissions (Recent)	M	O*[3]				
DD2	Number of Psychiatric Admissions (Lifetime)	M	O*[4]				
DD3	Time Since Last Discharge	M	O*[5]				
DD4	Amount of Time Hospitalized	M	O*[6]				
DD5	Contact With Community Mental Health	M	O				
DD6	Age at First Hospitalization	M	O				
A1	Assessment Reference Date	M	M	M	M	M	M
A2	Reason for Assessment	M		M	M	M	O
A3a	Status at Time of Admission	M	M				
A3b	Status at Time of Assessment	M	M	M	M	M	M
X9a	Forensic Status at Time of Admission	O*[7]	O*[7]				
X9b	Forensic Status at Time of Assessment	O*[7]	O*[7]	O*[7]	O*[7]	O*[7]	O*[7]
A4a–d	Capacity/ Competency	M	O	M	M	M	O
A5a–b	Police Intervention	M	M	M	M	M	M
B1a–gg	Mental State Indicators	M	M	M	M	M	M
B2	Insight Into Mental Health	M	M	M	M	M	M
C1	Alcohol	M	M	M	M	M	M
C2a–f	Substance Use	M	M	M	M	M	M
C3	Withdrawal Symptoms	M	M	M	M	M	M
C4a–d	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

Element ID	Element Name	Admission	Short Stay	Change in Status	Quarterly	Discharge (Full)	Discharge (Short)
I11a–g	Medical Diagnoses	M	M	M	M	M	M
I11h–m	Other Medical Diagnoses (ICD-10-CA Code)	O*[9]	O*[9]	O*[9]	O*[9]	O*[9]	O*[9]
J1a–l	Life Events	M	O	M	M	M	M
J1m–p	Life Events	M	M	M	M	M	M
J2	Life Event (J1) Causes Sense of Horror or Intense Fear	M	O*[10]	M	M	M	O*[10]
J3a–b	Other Indicators	M	O	M	M	M	O
K1	History of Medication Adherence	M	O				
K2	Medication Refusal	M	O	M	M	M	M
K3	Stopped Taking Psychotropic Medication	M	O	M	M	M	M
K4	Intentional Misuse of Medication	M	M	M	M	M	M
K5	Acute Control Medications	M	O	M	M	M	O
K6	Allergy to Drugs	M	O	M	M	M	O
L1a–h	Service Utilization—Formal Care	M	O	M	M	M	O
L2a–d	Nursing Interventions	M	O	M	M	M	O
L3a–d	Treatment Modalities	M	O	M	M	M	O
L4a–l	Focus of Intervention	M	O	M	M	M	O
L5	Adherence to Treatments, Therapies, Programs	M	O	M	M	M	O
L6	ECT	M	O	M	M	M	O
X6	Number of ECTs Since Last Assessment	O*[11]	O*[11]	M	M	M	M
M1a–f	Control Interventions	M	O	M	M	M	O
M2a–d	Observation Levels	M	O	M	M	M	O
M3	Psychiatric Intensive Care	M	O	M	M	M	O
M4	Authorized Activities Outside Facility	M	O	M	M	M	O
N1a–b	Height and Weight	M	O	M	M	M	O
N2a–d	Nutritional Problems	M	O	M	M	M	O

Element ID	Element Name	Admission	Short Stay	Change in Status	Quarterly	Discharge (Full)	Discharge (Short)
N3a–c	Eating Disorder Indicators	M	O	M	M	M	O
N4	Polydipsia	M	O	M	M	M	O
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
Q1a–q	DSM-IV Provisional Diagnostic Category	M	M	M	M	M	M
Q2a–c	Axis I— DSM-IV Code	O	O	O	O	O*13	O
Q2d–f	Axis II— DSM-IV Code	O	O	O	O	O*13	O
X7	Primary Diagnosis	O*14	O*14	O*14	O*14	O*14	O*14
Q3	Intellectual Disability	M	O	M	M	M	O
Q4	GAF Score	M	O	M	M	M	O
Q5	Patient Type	M	M	M	M	M	M
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
X75	Days in Alternate Level of Care Since Last Assessment			M	M	M	M

Element ID	Element Name	Admission	Short Stay	Change in Status	Quarterly	Discharge (Full)	Discharge (Short)
X80	Discharge Date		M			M	M
X90	Discharge Reason		M			M	M
X130	Total Days Away From Bed	M	M	M	M	M	M
X150	Total Service Interruptions	M	M	M	M	M	M
X131	Total Days Away From Bed in Q4	M	M	M	M	M	M
X151	Total Service Interruptions in Q4	M	M	M	M	M	M
X200 A, B	Project Code	O*[17]	O*[17]	O*[17]	O*[17]	O*[17]	O*[17]
X210 A, B	Project Data	O	O	O	O	O	O
X70	Drug Identification Number (DIN)	O	O	O	O	O	O
R2b–f	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:

O*0	• If X4 Health Card Number Status = 1, then AA2 Health Card Number must not be blank.
O*1	• 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.
O*2	• If CC4a Admitted From = any of 7, 9, 10 or 12, then X65 Referred From Facility Number must not be blank.
O*3	• 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.
O*4	• If DD3 Time Since Last Discharge = 8, then DD2 Number of Psychiatric Admissions (Lifetime) must = 0.
O*5	• If DD2 Number of Psychiatric Admissions (Lifetime) = 0, then DD3 Time Since Last Discharge must = 8.
O*6	• If DD1 Number of Psychiatric Admissions (Recent) = 0, then DD4 Amount of Time Hospitalized must = 0. • If DD1 Number of Psychiatric Admissions (Recent) does not = 0, then DD4 Amount of Time Hospitalized must not = 0. • If DD3 Time Since Last Discharge = 8, then DD4 Amount of Time Hospitalized must = 0.
O*7	• If A3 = 5 (Forensic), then corresponding X9a or X9b must not be blank.
O*8	• If I8a Pain Frequency = 0, then I8b Pain Intensity must = 0. • If I8b Pain Intensity = 0, then I8a Pain Frequency must = 0.
O*9	• If Q1q Psychiatric Diagnostic Category Not Applicable = 1 and CC2h Reason for Admission—Forensic Assessment does not = 1, then one of I11a–g Medical Diagnoses must be = 1 or one of I11h–m Other Medical Diagnoses must not be blank.
O*10	• If all of J1a–p = 0, then J2 Life Event Causes Sense of Horror or Intense Fear must = 0.
O*11	• If L6 ECT = 0, then X6 Number of ECTs Since Last Assessment must = 0.
O*12	• 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.
O*13	• On a full discharge assessment, an Axis I or Axis II DSM-IV code must be completed.
O*14	• If Axis I DSM-IV code Q2a and Axis II DSM-IV code Q2d are both reported, then X7 Primary Diagnosis must be coded.
O*15	• If X8a Admitted via ED = 1, then X8b Arrived on Inpatient Unit From ED must not be blank.
O*16	• If X8b Arrived on Inpatient Unit From ED = 1, then X8c Date Arrived on Inpatient Unit From ED must not be blank.
O*17	• 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.

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. The assessment is based on information collected from one or more of the following sources:

- Person interview and clinical observation
- Discussion with the person's family
- Discussion with other facility staff
- Medical records

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 one-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 two-letter code that represents the province or territory that issued the health card
number. Enter the letter codes in the first two spaces. See the table that follows for the codes.

NL   Newfoundland and Labrador

PE   Prince Edward Island

NS   Nova Scotia

NB   New Brunswick

QC   Quebec

ON   Ontario

MB   Manitoba

SK   Saskatchewan

AB   Alberta

BC   British Columbia

NT   Northwest Territories

YT   Yukon

NU   Nunavut

-70   Unknown

-90   Not Applicable

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.

## 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.

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 one 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).

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

Validation
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.
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.

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 one-character provincial/territorial code plus a four-digit mental health master number. This number (including the provincial/territorial character) must contain a total of five characters. The provincial/territorial government assigns the four-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
N	Northwest Territories
Y	Yukon
V	Nunavut

Validation
AA4 Facility Number must match the facility number of the submission file name.
The four-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 four 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

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.

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 Unit: 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 two-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 (including hermaphrodites and transsexuals).

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 two digits each, using a leading zero ("0") as filler if needed. Use four 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 another language, refer to the ISO 693-3 Language Code table. This table may be available through your vendor software, or you can contact omhrs@cihi.ca for a copy. Enter the three-letter code that corresponds to the person's language in the set of boxes provided.

Coding

Refer to the ISO Language Codes. If unable to determine the correct ISO Language Code or First Nations' Language, contact CIHI at omhrs@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 eight 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 (for example, carpentry, plumbing, acupuncture, baking, secretarial, practical/vocational nursing or 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 (for example, 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 (for example, dealing in street drugs or 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 (for example, an outpatient therapist or 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**—RCMP, 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-identified Aboriginal status, when applicable.

Definition

Aboriginal status refers to self-identification as a member of an Aboriginal community, including Inuit, Métis or First Nations.

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 (that is, a status card) to report in the positive.

Coding

Code "0" if the person does not self-identify as a member of an Aboriginal community.

Code "1" if the person self-identifies as a member of an 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, a person admitted on March 20, 2002, should be coded as follows:

2	0	0	2		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 (for example, alcohol or drugs) or non-substance addiction (for example, gambling or 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. Two 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 six-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 six-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 three characters ANA.

Code "-70" if the postal code is unknown.

Code "-90" for Not Applicable if the person's prior residence was not in Canada.

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 (for example, a boarding home, long-term care home, group home or jail) or in shared accommodation with non-relatives (for example, 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 (for example, directly from the community or 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, for example, 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.

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 six 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 zeros 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.

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 four-digit facility number of the referring facility.

Process

Determine the four-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 one-character provincial/territorial code as in data element AA4 (page 22) and four-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
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 four 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 or 8, 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

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 (for example, a shelter or hostel).

Process

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

Coding

Code "0" if the person's last residence is not considered temporary.

Code "1" if the person's last residence is considered temporary.

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 two years.

Definition

The person was formally admitted as an inpatient for mental health services (either voluntary/ informal, involuntary or forensic) and stayed one 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 two years.

Code "1" if there have been one or two admissions in the last two years.

Code "2" if there have been three or more admissions in the last two 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 two 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 one, two or three admissions.

Code "2" if the total number of admissions has been four or five.

Code "3" if the total number of admissions has been six 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 one 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 two 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 one or more nights.

Process

Review prior psychiatric admissions for the last two 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 two years.

Code "1" if the person was hospitalized for a total of 30 days or less in the last two years.

Code "2" if the person was hospitalized for a total of 31 days to one year in the last two years.

Code "3" if the total number of days hospitalized exceeds one year.

Validation
DD4 Amount of Time Hospitalized must be coded as 0 (No other admissions in last two 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 two 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.

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 one 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 an 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.

Coding

Enter the Assessment Reference Date as follows: use four digits for the year and two 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, 2002, would usually be March 23, 2002, entered as follows:

2	0	0	2		0	3		2	3
Year					Month			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.
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 (for example, 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*, 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 (for example, 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 (for example, Form 3 or Form 4 of the *Ontario Mental Health Act*).

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 (that is, 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.

Validation
If A3b Inpatient Status at Time of Assessment = 5, then A3a Inpatient Status at Time of Admission must = 5.
If A3a Inpatient Status at Time of Admission = 5, then A3b Inpatient Status at Time of Assessment must = 5.
If Q5 Current Patient Type = 4, then A3b Inpatient Status at Time of Assessment must = 5.

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.

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

Coding Option	Description
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.

Coding Option	Description
6 Warrant of committal—NCR	The person is to be held in hospital pending a Review Board hearing.
7 *Mental Health Act*—involuntary	Admission to a forensic unit under the *Mental Health Act*, usually for behaviour management. Referral sources may include 1) a psychiatric unit of the same hospital; 2) a psychiatric unit of another hospital; and 3) a provincial or federal detention centre. Also includes a person who may have been a forensic patient of the hospital and has a discharge from the Review Board but remains in hospital for lack of another place to go.
8 *Mental Health Act*—voluntary	
9 Inter-hospital transfer—NCR	Person is either unfit to stand trial or NCR and is being moved from one forensic facility to another under Review Board order.
10 Inter-hospital transfer—unfit	
11 Other	Includes court-ordered disposition recommendations and holds.

Coding

X9a. Forensic Status at Time of Admission

Code for the person's forensic status at the time of admission to the unit/facility. Enter the corresponding number indicating the forensic status on the Date Stay Began (CC1).

X9b. Forensic Status at Time of Assessment

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

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 (for example, 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 (for example, arrests, police escort to hospital for psychiatric examination or 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.

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

Section B—Mental State Indicators

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

B1. Indicators of Mood Disturbance/Anxiety/Psychosis/Negative Symptoms and Other

Intent

To provide a profile of the person's mental state of the last three 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 five 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 (for example, 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 (for example, "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 (for example, "Let me die," "What's the use?").

e. **Self-deprecation**—Subjective reporting indicating a negative view of self (for example, "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 (for example, "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 (for example, "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 (for example, 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 (for example, 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 (for example, 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 (for example, 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 (for example, thoughts about being responsible for a tragedy, sinister thoughts about his or her children or 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 (for example, 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 one 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 (for example, 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 (for example, 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 (for example, 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 (for example, persistently seeking medical attention, excessive concern over bodily functions such as bowel movements).

dd. **Anger**—Persistent periods of anger with self or others (for example, 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 (for example, looking over to the side with no external stimulus to prompt such a gesture), peculiar motor behaviour or body posturing (for example, 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 one 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 one 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 three days, regardless of the number of times per day it occurred. For example, if a behaviour occurs only once in one of the last three days, code "2." If the behaviour is present on all three days and is persistent over that time frame **or** was observed to occur only once a day, but on all three days, code "3."

Code "0" if there is no indication that the indicator was present in the last three days.

Code "1" if there is no indication that the indicator was present in the last three 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 one or two of the last three days.

Code "3" if the indicator was present on all three of the last three 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 (that is, 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 (for example, at dinner, after work or 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 one drink at any given sitting in the last 14 days.

Code "2" if the person consumed two, three or four alcoholic drinks at any given sitting in the last 14 days.

Code "3" if the person consumed five 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.

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 (for example, 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.

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 three months.

Code "2" if the substance was used in the last three months, but not in the last month.

Code "3" if the substance was used in the last month, but not in the last seven days.

Code "4" if the substance was used in the last seven days, but not in the last three days.

Code "5" if the substance was used in the last three days.

Note: The examples above may serve as a good illustration of instances where the assessor must rely on his or her best clinical judgment. This may occur when the person is non-communicative or uncooperative. For example, the person may be unable or unwilling to provide information on his or her substance use. Family members, referral sources and/or other staff also cannot provide information related to substance use and the person's clinical records do not address this issue. In a situation like this, if you as the assessor have no reason to suspect that the person has used any of these substances in the past, code "0." Also, consider the situation where there are conflicting sources of information given about the person's use of these substances. For example, a person may not admit to having used these substances for fear of retribution. However, although the person may respond that no substance has been taken, other sources may indicate otherwise. This person may have admitted to another staff member that he or she has smoked marijuana recently, or clinical records may indicate that the person was known to use stimulants within the last year. Even though the person's response is in disagreement with these sources, the assessor must go with his or her clinical judgment in completing this section.

C3. Withdrawal Symptoms

Intent

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

Definitions

1. **Mild**—Symptoms that are typical of early stages of withdrawal from alcohol or drugs (for example, 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 three days are the best sources for information about withdrawal symptoms.

Coding

Code for the most severe stage observed in the last three 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 three months.

Definitions

a. **In the last three 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 three 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 three 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 three months, the person had to have a drink or use drugs first thing in the morning to steady his or her nerves (for example, 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, for example, "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 three 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 three 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 three days, but is a daily smoker.

Code "2" if the person has smoked or chewed tobacco in the last three days.

C6. Gambling

Intent

To determine if the person has been gambling excessively or uncontrollably in the last three 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 (for example, 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 three months.

Code "1" if the person has gambled excessively or uncontrollably in the last three 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 (for example, 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.

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 Himself/Herself

Intent

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

Definition

Intent—The self-injurious action was intentionally undertaken with the aim of ending the person's 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
If D1a Self-Injury—Most Recent Attempt = 0, then D1b Self-Injury—Intent must = 8.
If D1a Self-Injury—Most Recent Attempt does not = 0, then D1c Self-Injury—Considered must not = 0.

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 three 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 (for example, 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 (for example, those with dementia) would be identified in this item only.

d. **Socially inappropriate/disruptive behaviour**—This includes, but is not limited to, behaviours such as spitting, smearing 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 (for example, 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 (for example, 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 (for example, 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 three days and nights or if they are aware of past incidents.

Coding

Code "0" if the behavioural symptom was not exhibited in the last three days.

Code "1" if there is no indication that the behaviour was present in the last three 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 one or two days during the last three-day period, regardless of the number of times it occurred on each day. The behaviour did not occur on all three days.

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

Validation
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).

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 seven days suggests a current serious risk of harm to self or others.

Code "2" if the person demonstrated an extreme behaviour during the last seven 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 (for example, 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 (for example, "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 one 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 three 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 three unrelated items (for example, book, watch, table). After you have named all three 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 five minutes, ask the person to repeat the name of each item. If the person is unable to recall all three 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 (for example, 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 (for example, 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 two 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 two 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 (for example, 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 three days.

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 three 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 three 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 three days but is not of recent onset.

Code "2" if the behaviour was present over the last three days and appears different from the person's usual functioning of two weeks ago (for example, new onset or 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 (for example, 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 (that is, what the person actually did for himself or herself and/or how much help was required from staff members or others) during the last three 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 three 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 (for example, 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 (for example, 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 (for example, 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 three-day period, 24 hours a day (that is, not only how you see the person).

To accomplish this, you must gather information from multiple sources (for example, 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 one 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 one or two exceptions for the provision of heavier care. For example, a person may have received no help in eating on almost all occasions, but on one 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 one 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 Three Days)

Record the person's actual level of involvement in self-care and the type and amount of support actually received during the last three 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—that is, 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 three days in discussions regarding the person's ADL functional performance. Remind staff that the focus is on the last three 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 (for example, 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 three 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 three or more times.

Code "2" for **Supervision**—Oversight, encouragement or cueing was provided three or more times **or** supervision (one or more times) plus physical assistance was provided only once or twice during the period for a total of three 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 three or more times **or** a combination of non-weight-bearing help with more help was provided only one or two times during the period, for a total of three 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 one person three or more times:

1. Weight-bearing support (for example, 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 two-person assist) **or** received weight-bearing help or full performance of certain subtasks three 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 (for example, 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 three-day period**—Over the last three 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 three-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 one 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 three or more times during the last three days.

There will be times when not one type or level of assistance is provided to the person three or more times during a three-day period. However, the sum total of support of various types will be provided three 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 three or more times during the three-day period.

Validation
Assessment will be flagged as suspicious if G1d ADL—Toilet Use is coded as 8 (Activity did not occur in last three days).
Assessment will be flagged as suspicious if G1e ADL—Eating is coded as 8 (Activity did not occur in last three days).

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 (for example, planning meals, cooking, assembling ingredients, setting out food and utensils).

b. **Managing medications**—How the person manages medications (for example, 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 three 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 three 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, for example, 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 three 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 (for example, ADLs, walking, shopping) in the last three days.

Coding

Code "0" if the person has been involved in more than two hours of physical activity over the last three days.

Code "1" if the person has had one to two hours of physical activity over the last three days.

Code "2" if the amount of activity has been less than one hour in the last three days.

Code "3" if the person has not been involved in any activity in the last three 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 (for example, 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 three 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 (for example, one-on-one versus group situations). If possible, observe the person interacting with others (for example, family members). Always be mindful of environmental factors that may influence your assessment (for example, 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 (for example, glasses, magnifying glass) in last three 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 three days (for example, 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 (for example, 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 (for example, one-on-one, groups), circumstances (for example, 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 three 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 (for example, 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 (for example, 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 (for example, 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 (for example, 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 three 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 (for example, drug toxicity, influenza, psychogenic).

k. **Constipation**—No bowel movement in three days or difficult passage of stool.

l. **Diarrhea**—Frequent elimination of watery stools from any etiology (for example, 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 (for example, the person states "I feel so tired all the time.").

o. **Impaired balance/ataxia**—Objective observation of a balance problem (for example, 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 (for example, 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 (for example, 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 three days.

Code "1" if the indicator occurred on one or two days of the last three days, regardless of the number of times per day.

Code "2" if the indicator was present on each of the last three days.

I2.   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) (for example, 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 three 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 three days.

Code "1" if the item was present at any time in the last three days.

I3.   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.

I4. 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 three 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 (for example, 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 one 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.

I5.   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.

I6a.   Skin Problems

Intent

To document the presence of skin conditions or changes in the last three 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

I6aa. **Major skin problems**—For example, lesions, second- or third-degree burns, healing surgical wounds.

I6ab. **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 three days.

Code "0" if no skin problem was present in the last 3 days.

Code "1" if any one 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 three 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 three 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 one 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 one fall in the last 30 days.

Code "3" if there were two or more falls in the last 30 days.

I7b.   Recent Falls

Note: If the person was last assessed more than 30 days ago, or if this is the person's first assessment, skip this item and proceed to item I8.

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 two 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 one or more falls since the last assessment.

Code "0" if the person has not fallen.

Code "1" if the person has fallen one or more times.

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

I8. Pain

Intent

To record the frequency and intensity of the signs and symptoms of pain in the last three 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. **Frequently complains or shows evidence of pain**—The person reported *or was observed* to have pain. Observable signs of pain include, but are not limited to, moaning, crying and other vocalizations; wincing, frowning and other facial expressions; body posture, such as guarding or protecting an area of the body or lying very still; and a decrease in usual activities.

b. **Intensity of pain**—Measures the level of pain as the person perceives it (as described or manifested by the person).

Process

Ask the person if he or she has experienced any pain in the last three 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 three days.

Coding

a. Pain Frequency

Code "0" if no pain is reported.

Code "1" if pain has been present but less than daily over the last three days, regardless of the cause or intensity.

Code "2" if pain has been daily.

b. Pain Intensity

Code "0" if no pain is reported.

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.

Validation
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).

I9.   Bladder Continence

Intent

To determine and record the person's pattern of bladder continence (control) over the last three 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 (for example, 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 three-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 (for example, a family member of a newly admitted person or 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 three days.

Code for the actual bladder continence pattern—For example, the frequency with which the person is wet and dry during the three-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 **Control With Catheter**—The person has complete control with the use of any type of catheter or urinary collection device that does not leak urine.

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

Code "3" for **Episode of Incontinence**—An incontinent episode occurred on one day of the last three days.

Code "4" for **Occasionally Incontinent**—The person had incontinent episodes on two days, but not daily, in the last three days.

Code "5" for **Frequently Incontinent**—The person tends to be incontinent daily, but some control is present (for example, 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 three days).

I10.   Bowel Continence

Intent

To determine and record the person's pattern of bowel continence (control) over the last three 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 (for example, a primary family member of a newly admitted person or direct care staff). Remember to consider continence patterns over the last three-day period, 24 hours a day.

Coding

Code for bowel continence over the last three 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 three days but does have incontinent episodes.

Code "3" for **Episode of Incontinence**—The person had an incontinent episode on one day of the last three days.

Code "4" for **Occasionally Incontinent**—The person had an incontinent episode on two days of the last three days.

Code "5" for **Frequently Incontinent**—The person tends to be incontinent daily, but some control is present (for example, 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 three to six 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.
If Q1q Psychiatric Diagnostic Category Not Applicable = 1 and CC2h Reason for Admission—Forensic Assessment **does not** = 1, then one of I11a–g Medical Diagnoses must = 1 or one of I11h–m Other Medical Diagnoses must not be blank.

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

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**, for example, 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 (for example, 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 (for example, 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 (for example, any incident resulting in non-accidental injury, physical confinement, excessive physical discipline or 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**—One or more of the person's parents (for example, 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.

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 one 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 one of these life events is having on the person, as a potential indicator of post-traumatic stress.

Process

If the person acknowledges experiencing one 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.

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

J3. Other Indicators

Intent

The focus of this item is on two 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; that is, 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 three 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 one or more medications or has refused on one 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 three 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 three 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 (for example, 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 (for example, 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 three months.

Code "1" if the person has misused any medication in the last three months.

K5.   Acute Control Medications

Intent

To record the frequency with which an acute control medication was administered to the person over the last three 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 on a PRN basis to treat anxiety. If the person's behaviour escalates to a point where there is a risk of harm to self or others, either or both of these medications may be used as an acute control medication.

Process

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

Coding

Enter the actual number of times the person was given acute control medication in the last three days. If nine or more times, enter "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 seven 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 seven days (or since admission if less than seven days ago).

Definitions

Care or care management includes both the direct services provided to the person and the management of care received (for example, 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 (for example, 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 two of the last seven 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

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

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.

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 (for example, 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 (for example, supportive counselling, insight-oriented counselling). Teaching includes any health teaching provided directly to the person or to a family member (for example, medication side effects, nutrition, relaxation techniques).

c. **Crisis intervention**—Responding to a specific, unexpected occurrence that requires immediate nursing intervention that was otherwise unplanned (for example, 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 seven days (or since admission if less than seven days ago).

Coding

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

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 seven days (or since admission if less than seven days ago). Include those that are to be initiated in the next seven days.

Definitions

a. **Individual therapy**—Includes individual therapy with a mental health care worker (for example, 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 one 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 seven days (or since admission if less than seven days ago) and those that are scheduled to begin sometime in the next seven days.

Coding

Code "0" if the person was not involved in the treatment modality over the last seven days (or since admission if less than seven 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 seven 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 seven 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 (for example, 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 (for example, 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.

   Smoking cessation—To assist the person in quitting smoking.

f. **Vocational counselling**—To assist the person in obtaining suitable employment.

g. **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.

h. **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.

i. **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.

j. **Post-traumatic stress**—To assist the person in dealing with the trauma of a specific event or ordeal.

k. **Pain management**—To help individuals deal with acute and/or chronic pain (for example, medications, relaxation therapy, transcutaneous electrical nerve stimulation [TENS]).

l. **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 seven days (or since admission if less than seven days ago).

Code "3" if intervention with the identified focus has not yet been initiated but is scheduled to start within the next seven 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 seven days (or since admission if less than seven 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 one month ago.

Code "2" if the person received ECT during the last month but more than seven days ago.

Code "3" if the person received ECT during the last seven days.

Code "4" if the person has not yet received ECT but is scheduled to begin it within the next seven days.

X6. Number of ECT Treatments Received Since Last Assessment

Intent

To document the number of ECT treatments received since last assessment.

Process

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

Coding

Code the actual number of ECT treatments received since previous assessment or admission.

0	2

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 listed below at any time during the day or night over the last three days.

Definitions

a. **Mechanical restraint**—The person is placed in mechanical restraints and is unable to ambulate (for example, restrained in bed), or the person is placed in mechanical restraints but is able to ambulate (for example, 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 (for example, a bean bag chair). This includes "comfort cushions" (for example, the "lap buddy" and "merry walker").

c. **Physical or manual restraint by staff**—Physically holding a person to restrict his or her movement. This refers to a technique where the person is manually held or restricted for a brief period of time in order to restore calm to the individual and he or she is released when calm. 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.

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 (for example, 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 in the last three days.

Code "0" if the device was not used in the last three days.

Code "1" if the device was used but less than daily in the last three days.

Code "2" if the device was used daily but at night only.

Code "3" if the device was used daily but during the day only.

Code "4" if the device was used during both the day and night but use was not constant.

Code "5" if the device was in constant use for a full 24 hours (with periodic release as applicable).

M2.   Close or Constant Observation

Intent

To document the level of supervision required over the last three 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 five-minute intervals**—The person is observed by staff at regular five-minute intervals.

c. **Constant observation for less than one hour**—The person is not left unattended at any time for a designated period of time that is less than one 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 one hour**—The person is not left unattended at any time, and this constant observation is in effect for more than one 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 three 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 three days.

Definition

The physical environment is such that people in the defined area can be observed at all times by at least one 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 three 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 give an indication of whether the person has left the facility or locked unit at any time in the last three days.

Process

Review the person's records.

Coding

Code for both M4a (accompanied by staff) and M4b (not accompanied by staff). Include instances of leaving the facility accompanied by family member or friend in M4b.

Code "0" if the person did not leave the facility or locked unit in the last three days.

Code "1" if the person left the facility or locked unit once.

Code "2" if the person left the facility two 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 (for example, 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.

Validation
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.).
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.).

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 a psychiatric 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 a psychiatric 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 four 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 six months previous (for example, "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 six 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 three months ago the person weighed 65 kilograms. Currently the person weighs 58 kilograms, which represents a loss of 7 kilograms over those three months.

$$7 \div 65 = 0.108$$
$$0.108 \times 100 = 10.8\%$$

The person has had a weight loss of nearly 11 percent in three 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:

   1. Loss of control over eating

   2. 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 three 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, for example, 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 three days.

Code "1" if any one or more of the indicators have been present in the last three 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 (for example, 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 (for example, family, staff, therapist) who have information about or observations of the relationship.

Coding

Code "0" if the belief is not present in 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.

O2.   Social Relations and Interpersonal Conflict

Intent

To describe several important features of a person's current social network.

Definitions

a. **Confidant**—The person identifies at least one 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 one 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**—One 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 one 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

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 (for example, 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 six 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 two 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 (for example, the person is not employed or is not attending school).

O5. 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 (for example, church group) or other activities that involve being with others (for example, 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 (for example, 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 one 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 three days.

Code "1" if the event occurred within the last week but more than three 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 one 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, co-workers 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 (for example, an acute exacerbation of symptoms or 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 (for example, 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 (for example, 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 (for example, "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; that is, 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

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; that is, 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.

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.

4. **Mental health residence** (for example, 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 six 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.

Validation
If X90 Discharge Reason = 2 or 3, then P5 Discharged To must = 15.

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 one-letter provincial/territorial character provided in data element AA4 (Facility Number) and the four-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.

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 four 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 Discharged To = any of 1–6, 8 or 15, then X140 Discharged to Facility Number must be blank.

Section Q—Psychiatric Diagnostic Information

The applicable diagnoses, as determined by the attending psychiatrist, are recorded in this category.

Q1.   DSM-IV Diagnostic Category

Intent

To provide up to three diagnoses (or provisional diagnoses if this is an initial assessment), according to broad *Diagnostic and Statistical Manual of Mental Disorders Text Revised* (DSM-IV TR) diagnostic categories, as determined by the psychiatrist or attending physician.

Diagnostic Categories

a. Disorders of childhood/adolescence
b. Delirium, dementia and amnestic and other cognitive disorders
c. Mental disorders due to general medical conditions
d. Substance-related disorders
e. Schizophrenia and other psychotic disorders
f. Mood disorders
g. Anxiety disorders
h. Somatoform disorders
i. Factitious disorders
j. Dissociative disorders
k. Sexual and gender identity disorders
l. Eating disorders
m. Sleep disorders
n. Impulse-control disorders not elsewhere classified
o. Adjustment disorders
p. Personality disorders
q. Not applicable—admitted to mental health bed for reasons not related to mental health

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 two 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.

Validation
Only one of Q1a–q may = 1.
Only one of Q1a–p may = 2.
Only one of Q1a–p may = 3.
If any of Q1a–p = 2, then one of Q1a–p must = 1.
If any of Q1a–p = 3, then one of Q1a–p must = 2.
If Q1q = 1, then all of Q1a to Q1p must be blank.
One of Q1a–q must be specified as 1 (most important).
Record will be flagged as suspicious if Z1 Record Type = 4 (Quarterly) and Q1q = 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 Q1q = 1.
Record will be flagged as suspicious if Q1q = 1 and the corresponding admission within the episode has a provisional psychiatric diagnosis.

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 three- to five-digit DSM-IV code in the space(s) provided for the specific psychiatric diagnosis for axes I and II. List the primary diagnosis first when it is an Axis I disorder or an Axis II disorder; the remaining disorders are listed in order of focus of attention and treatment. The DSM coding can be completed by the staff or referred to the health records department to complete.

Validation
On the full discharge assessments, an Axis I or Axis II DSM-IV code must be completed.
Q2a–f DSM-IV codes must be unique.
Q2a–f DSM-IV codes may contain three to five digits.
Q2a–f DSM-IV codes must not contain decimals.
The first character of the DSM-IV code must be one of the following: 2, 3, 6, 7, 9 or V.
If the first character of the DSM-IV code = 2, then the second character must = 9.
If the first character of the DSM-IV code = 3, then the second character must = 0, 1, 2, 3 or 4.
If the first character of the DSM-IV code = 6, then the second character must = 0 or 2.
If the first character of the DSM-IV code = 7, then the second character must = 8 or 9.
If the first character of the DSM-IV code = 9, then the second character must = 9.
If the first character of the DSM-IV code = V, then the second character must = 1, 6 or 7.
If the first character of the DSM-IV code = 2 AND the second character = 9, then the third character must be 0, 1, 2, 3, 4, 5, 6, 7, 8 or 9.
If the first character of the DSM-IV code = 3 AND the second character = 0, then the third character must be 0, 1, 2, 3, 4, 5, 6, 7, 8 or 9.
If the first character of the DSM-IV code = 3 AND the second character = 1, then the third character must be 0, 1, 2, 3, 4, 5, 6, 7, 8 or 9.
If the first character of the DSM-IV code = 3 AND the second character = 2, then the third character must be 7.
If the first character of the DSM-IV code = 3 AND the second character = 3, then the third character must be 2 or 3.
If the first character of the DSM-IV code = 3 AND the second character = 4, then the third character must be 7.
If the first character of the DSM-IV code = 6 AND the second character = 0, then the third character must be 7 or 8.
If the first character of the DSM-IV code = 6 AND the second character = 2, then the third character must be 5.
If the first character of the DSM-IV code = 7 AND the second character = 8, then the third character must be 0 or 7.
If the first character of the DSM-IV code = 7 AND the second character = 9, then the third character must be 9.
If the first character of the DSM-IV code = 9 AND the second character = 9, then the third character must be 5.
If the first character of the DSM-IV code = V AND the second character = 1, then the third character must be 5.
If the first character of the DSM-IV code = V AND the second character = 6, then the third character must be 1, 2 or 5.
If the first character of the DSM-IV code = V AND the second character = 7, then the third character must be 1.

X7. Primary Diagnosis

Intent

To indicate whether Axis I or Axis II is the primary diagnosis, when both Axis I and Axis II DSM-IV codes have been completed in Section Q2.

Process

Review the clinical record for this information.

Coding

Code "1" if Axis I—Q2a DSM-IV code is considered primary diagnosis.

Code "2" if Axis II—Q2d DSM-IV code is considered primary diagnosis.

Validation
If Axis I DSM-IV code Q2a and Axis II DSM-IV code Q2d are both reported, then X7 Primary Diagnosis must be coded.
If Axis I DSM-IV code Q2a or Axis II DSM-IV code Q2d is blank, then X7 Primary Diagnosis must be blank.

Q3. Intellectual Disability

Intent

To document conditions associated with intellectual disabilities.

Definition

A confirmed diagnosis of mental retardation as described in the DSM-IV TR: a disorder, present before the age of 18, that involves diminished cognitive ability (intelligence quotient [IQ] less than 70) and significant impairment in conceptual, social and practical skills.

Note: Other disorders usually diagnosed in infancy, childhood or adolescence (such as autism, Rhett's, Tourette's and learning disability) should be listed in section Q2 Psychiatric Diagnosis.

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. **Psychogeriatric**—Regardless of the length of stay, the person has a chronic condition typically associated with aging (for example, Alzheimer's disease or 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.

Section R—Medications

The medications section comprises the indicator for the presence of medications within the last three 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 three days.

Process

Check the medical record.

Coding

Code "0" if no medication has been prescribed.

Code "1" if there has been one 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 three 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 eight-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 one pill or tablet is used to make up the dose, document the total dose taken [for example, if the person is taking two 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 three 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 eight-digit drug identification number of all medication taken in the last three 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 three days, place a check mark in the "PRN" column; otherwise leave it blank. If the medication was discontinued during the last three 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, for example, if the person was admitted through the emergency department, the discharge date, time spent away from the bed and 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 person who arrived on the mental health inpatient unit on March 20, 2002, should be coded as follows:

2	0	0	2		0	3		2	0
Year					Month			Day	

X75.   Days of Alternate Level of Care (ALC) Since Last Assessment

Intent

The designation of alternate level of care (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 one 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, that is, the attending psychiatrist.

Coding

Enter the total number of days that the person spent in ALC since the last assessment during this episode of care.

Validation
X75 Days in Alternate Level of Care Since Last Assessment must be between 0 and 999.
X75 Days in Alternate Level of Care Since Last Assessment must be less than or equal to 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.

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 two digits each using a leading zero ("0") as filler if needed. Use four digits for the year.

Example

February 17, 2006

2	0	0	6		0	2		1	7
Year					Month			Day	

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 three 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. (For example, the person was transferred for a service interruption but did not return.)

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).

Service Interruption

Intent

To capture those occasions when a person leaves the mental health bed for a period of time and returns to the mental health bed to continue treatment.

Definitions

Service interruptions are equal to or greater than 24 hours and less than or equal to 92 calendar days in duration. Instances in which the person is away from the mental health bed for longer than 92 days or does not return as expected should not be counted as service interruptions. In these instances, a discharge assessment should be completed, with the discharge date being the last day the person occupied the mental health bed.

Please note that the definition of what is to be included as a service interruption may vary from jurisdiction to jurisdiction. Contact CIHI at omhrs@cihi.ca for further information.

Figure 1: Service Interruption Example
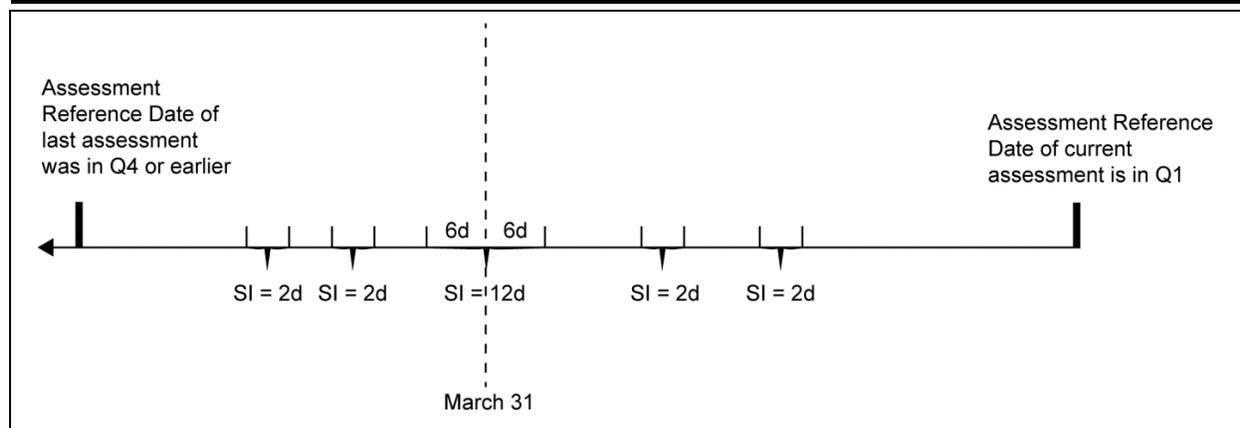
X130. Total Days Away From Bed

Intent

To capture the total number of qualified service interruption days the person was away from the mental health bed.

Process

Determine the total number of days the person was away from the bed for any service interruptions that occurred since the last assessment (or since admission if this is a full admission or short stay assessment). Please note that what is to be included as a service interruption day may vary from jurisdiction to jurisdiction.

Coding

Enter the total number of days the person was away from the bed. Code "0" if no qualified days away from bed occurred.

Example (see Figure 1)

X130	Enter the total number of days the person was away from the bed since the last assessment.	Code 20

X150. Total Service Interruptions

Intent

To capture the number of service interruptions (when the person left the mental health bed for greater than or equal to 24 hours and returned in less than or equal to 92 days).

Process

Determine the number of times since the last assessment (or since admission if this is a full admission or short stay assessment) that the person left the mental health bed for greater than or equal to 24 hours and returned in less than or equal to 92 days. Please note that the definition of what is to be included as a service interruption may vary from jurisdiction to jurisdiction.

Coding

Enter the total number of service interruptions that occurred since the last assessment or since admission. **Code "0"** if no service interruptions occurred.

Example (see Figure 1)

X150	Enter the total number of service interruptions that occurred since the last assessment or since admission.	Code 5

X131. Total Days Away From Bed in Quarter 4

Intent

To capture the total number of qualified service interruption days that occurred in quarter 4.

Definitions

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 record to determine the total number of days since the last assessment (or since admission if this is an admission or short stay assessment) the person was away from the bed for service interruptions in quarter 4. Include all service interruption days up to and including March 31, even if the person remained away from the bed on March 31.

Coding

Enter the total number of qualified service interruption days that occurred in quarter 4.

Code "0"   if the time since last assessment includes any part of quarter 4 but no qualified service interruption days occurred in quarter 4.

Code "99" (not applicable) if the time since last assessment does **not** include any part of quarter 4.

For assessments with an Assessment Reference Date in quarter 1, count all qualified service interruption days that occurred in quarter 4 **even if** the person remained away from the bed on March 31.

Example (see Figure 1)

X131	Enter the total number of qualified service interruption days that occurred in Quarter 4.	Code 10

X151. Total Service Interruptions in Quarter 4

Intent

To capture those service interruptions from which the person returned to the mental health bed during quarter 4.

Definition

Quarter 4—The months of January, February and March in any year of the mental health reporting cycle. Quarter 4 begins on January 1 and ends on March 31.

Process

Determine how many service interruptions ended in quarter 4. Do not count service interruptions from which the person had not returned before April 1.

Coding

Enter the number of service interruptions that ended in quarter 4.

Code "0"   if the time since last assessment includes any part of quarter 4 but no service interruptions ended in quarter 4.

Code "99" (not applicable) if the time since last assessment does not include any part of quarter 4.

For assessments with an Assessment Reference Date in quarter 1, count only those service interruptions that ended in quarter 4 (that is, from which the person had returned on or before March 31).

Example (see Figure 1)

X151	Enter the number of service interruptions that ended in Quarter 4.	Code 2

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

Definition

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.

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.

X210A–B.   Project Data

Definition

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 omhrs@cihi.ca.

Facility Data Elements

It is the facility's responsibility to provide updated facility profile information to CIHI. All communication between CIHI and facilities submitting data will be based on the contact information in this file.

In order to promote accurate and up-to-date contact information and other facility details, facilities must submit the record at the beginning of each fiscal year prior to live data submissions and when changes are warranted.

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 two-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

NT   Northwest Territories

YT   Yukon

NU   Nunavut

FP3e. Postal Code

Coding

Enter the six-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 mental health beds at the facility.

FP5.   Ownership

Coding

Code the ownership as per the legend below. If more than one code applies to the facility, choose the one 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 five-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, for example, 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 one 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.

Validation
Email address must contain only one "@" symbol, at least one "." (period) and no "," (comma) and must be at least 5 bytes long (a@b.c).

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

Reference

1. J.P.Hirdes, E.Pérez, N.Curtin-Telegdi, et al. RAI-MH Training Manual and Resource Guide for Version 2.0. Toronto: Ontario Joint Policy and Planning Committee; 2003.

Minimum Data Set For Mental Health (MDS-MH)©

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Addressograph

SECTION AA. NAME AND IDENTIFICATION NUMBERS

1	NAME	_____ a. (Last/Family Name) b. (First Name) c. (Middle Name/Initial)
X10	COUNTRY OF RESIDENCE	1. Canada 3. Other 2. U.S.A. 4. Unknown
X20	PROV./TERR. ISSUING HEALTH CARD NO.	☐☐☐
X4	HEALTH CARD NUMBER STATUS	Indicate Health Card Number status. 1. Known 8. Unknown 9. Not applicable
2	HEALTH CARD NUMBER	☐☐☐☐☐☐☐☐☐☐
X30	CHART NUMBER	☐☐☐☐☐☐☐☐☐☐
3	CASE RECORD NUMBER	☐☐☐☐☐☐☐☐☐☐
4	FACILITY NUMBER	☐ ☐☐☐ Prov./Terr. Facility Number (See manual for provincial/territorial codes.)
5	UNIT IDENTIFIER	25 Mental Health—Acute Unit 45 Mental Health—Addiction Unit 55 Mental Health—Forensic Unit 90 Mental Health—Psychiatric Crisis Unit 20 Mental Health—Longer Term Dual Diagnosis 30 Mental Health—Longer Term Combined 81 Mental Health—Longer Term Rehabilitation 96 Mental Health—Longer Term Geriatric 99 Mental Health—Other Longer Term ☐☐

SECTION BB. PERSONAL ITEMS *(Complete at intake only.)*

1	SEX	M. Male F. Female O. Other
2	BIRTHDATE	☐☐☐☐ ☐☐ ☐☐ Year Month Day
X40	ESTIMATED BIRTHDATE	If the person's birthdate is an estimate, code "1." 0. No 1. Yes
3	MARITAL STATUS	1. Never married 4. Widowed 2. Married 5. Separated 3. Partner/significant other 6. Divorced
4	LANGUAGE	Primary language eng = English fra = French ☐☐☐
5	EDUCATION	1. No schooling 6. Some college/university 2. 8 grades or less 7. Diploma/bachelor's degree 3. 9–11 grades 8. Graduate degree 4. High school 9. Unknown 5. Technical or trade school

SECTION BB. PERSONAL ITEMS (cont'd) *(Complete at intake only.)*

6	SOURCES OF INCOME	0. No 1. Yes	
		a. Employment	d. Social assistance
		b. Employment insurance	e. Disability insurance
			f. Other
		c. Pension (CPP, ODSP, etc.)	g. No income
X50	RESPON-SIBILITY FOR PAYMENT	0. No 1. Yes	
		a. Provincial/territorial responsibility	
		b. Workers' compensation (WCB/WSIB)	
		c. Other province/territory (if resident of Canada)	
		d. Veterans Affairs Canada (VAC)	
		e. First Nations and Inuit Health Branch (FNIHB)	
		f. Other federal government (RCMP, Canadian Forces, federal penitentiary, department responsible for refugee claims)	
		g. Self-pay—Canadian resident	
		h. Self-pay—Other country	
		i. Unknown	
7	ABORIGINAL ORIGIN	Person's origin is Inuit, Métis or First Nations. 0. No 1. Yes	

SECTION CC. REFERRAL ITEMS *(Complete at intake only.)*

1	DATE STAY BEGAN	☐☐☐☐ ☐☐ ☐☐ Year Month Day
2	REASONS FOR ADMISSION	0. No 1. Yes
		a. Threat or danger to self
		b. Threat or danger to others
		c. Inability to care for self due to mental illness
		d. Problem with addiction/dependency
		e. Specific psychiatric symptoms (e.g. depression, hallucinations, medication side effects)
		f. Involvement with criminal justice system, forensic admission
		g. Other
		h. Forensic assessment
X60	POSTAL CODE OF PERSON'S RESIDENCE	☐☐☐ ☐☐☐ Postal Code

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	☐ 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 **recent (last 2 years)** 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 **lifetime** 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 **last 2 years**. 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 **last year** 0. No contact in the last year 1. 31 days or more 2. 30 days or less	
6	AGE AT FIRST HOSPITAL-IZATION	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	☐☐☐☐ 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. *Mental Health Act*—involuntary 8. *Mental Health Act*—voluntary 9. Inter-hospital transfer—NCR 10. Inter-hospital transfer—unfit 11. 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 INTERVEN-TION	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 STATE INDICATORS

1	Code for indicators observed in the **last 3 days**.	0. Indicator not exhibited in the **last 3 days** 1. Indicator not exhibited in the last 3 days but is **reported to be present** 2. Indicator exhibited on **1 to 2 of the last 3 days** 3. Indicator exhibited **daily in the last 3 days**	

	INDICATORS OF MOOD DISTURBANCE	
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.")	
g. Hopeless-ness	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 Hyper-sexuality	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	

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 **last 14 days**. 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)	
		f. Cannabis	
3	WITH-DRAWAL SYMPTOMS	Severity of signs or symptoms possibly indicative of withdrawal from alcohol or drugs. Code for the most severe level in the **last 3 days**. 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 **last 3 months** 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 had 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 **last 3 months.** 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 3. 8 to 30 days ago 1. More than 1 year ago 4. 4 to 7 days ago 2. 31 days to 1 year ago 5. In last 3 days	
		b. Intent of any self-injurious attempt was to kill himself/herself 0. No 1. Yes 8. No attempt	
		c. Considered performing a self-injurious act 0. Never 3. 8 to 30 days ago 1. More than 1 year ago 4. 4 to 7 days ago 2. 31 days to 1 year 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 3. 8 to 30 days ago 1. More than 1 year ago 4. 4 to 7 days ago 2. 31 days to 1 year ago 5. In last 3 days	
		a. Violent to others—acts **with purposeful, malicious** or **vicious** 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 **last 3 days** 0. Indicator not exhibited in the last 3 days 1. Indicator not exhibited in the last 3 days but is **reported to be present** 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 DISTUR-BANCE	Prior history of extreme behaviours that suggests **serious** 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 **last 7 days** 2. Yes, and exhibited in the **last 7 days**	

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 **over the last 3 days**.

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

	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 IADL CAPACITY
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 PREP-ARATION	How person prepares meals (e.g. planning meals, cooking, assembling ingredients, setting out food and utensils)	
b	MANAGING MEDICA-TIONS	How person manages medications (e.g. remembering to take medications, opening bottles, taking correct drug dosages, giving injections, applying ointments)	
c	TRANS-PORTATION	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 **last 3 days** 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 | |

| 2 | VISION | Ability to see in adequate light and with glasses or with other visual appliance normally used in the **last 3 days**
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 UNDER-STOOD | 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 **last 3 days**
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 **last 3 days**
0. No 1. Yes | |
|---|---|---|---|

INCREASE IN MOTOR ACTIVITY	
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	
DECREASE IN MOTOR ACTIVITY	
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)	
MUSCLE CONTRACTIONS	
g. **Dystonia**—muscle hypertonicity (e.g. muscle spasms or stiffness, protruding tongue, upward deviation of the eyes)	

3	SEXUAL FUNCTIONING	Reports persistent difficulty with sexual functioning during the **last 30 days** (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 **last 3 days**." 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 **last 3 days**—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 **last 3 days**—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, more than 30 days since last assessment	
8	PAIN	a. Frequently complains or shows evidence of pain in the **last 3 days** 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 **last 3 days** 0. CONTINENT—complete control; does not use any type of catheter or other urinary collection device 1. CONTROL WITH CATHETER—complete control with any type of catheter or urinary collection device that does not leak urine 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 **last 3 days** 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	

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	

Other	ICD-10-CA
h. _____	☐☐☐.☐☐☐
i. _____	☐☐☐.☐☐☐
j. _____	☐☐☐.☐☐☐
k. _____	☐☐☐.☐☐☐
l. _____	☐☐☐.☐☐☐
m. _____	☐☐☐.☐☐☐

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 **month prior to admission** 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 **last 3 days**. 0. No 1. Yes	
3	STOPPED TAKING PSYCHO-TROPIC MEDICATION	In the **last 90 days** 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 **last 3 months** (e.g. uses medication for purpose other than intended). 0. No 1. Yes	
5	ACUTE CONTROL MEDICA-TIONS	Number of times psychotropic medication used as an immediate response to prevent harm to self or others in the **last 3 days.** 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 **last 7 days or since admission** (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 INTERVEN-TIONS	Record the number of days each of the following was provided for 15 minutes or more per day in the **last 7 days or since admission** (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 **last 7 days or since admission** (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 INTER-VENTION	Code for types of issues that were a major focus of interventions in the **last 7 days or since admission** (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	
		l. Alternative/non-traditional therapy	
5	ADHERENCE TO TREAT-MENTS, THERAPIES, PROGRAMS	Adherent all or most of the time with special treatments, therapies and programs in the **last 7 days or since admission** (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:.0 to 99.	

SECTION M. CONTROL PROCEDURES/OBSERVATION

1	CONTROL INTERVEN-TIONS	Code for the use of each device in the **last 3 days**. 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 (with periodic release)	
		a. Mechanical restraint	
		b. Chair prevents rising	
		c. Physical/manual restraint by staff	
		d. Confinement to unit	
		e. Confinement to room	
		f. Seclusion room	
2	CLOSE OR CONSTANT OBSERVA-TION	Number of days of supervision of the following type in the **last 3 days**. 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 **last 3 days**. If none, code "0."	
4	AUTHORIZED ACTIVITIES OUTSIDE OF FACILITY	Number of times in the **last 3 days** 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 N. NUTRITION

1	HEIGHT AND WEIGHT	Enter the actual number.		
		a. Height in centimetres	☐☐☐	(cm)
		b. Weight in kilograms	☐☐☐	(kg)

2	NUTRI-TIONAL PROBLEMS	0. No 1. Yes	
		a. Weight loss of 5% or more in the **last 30 days** or 10% or more in the **last 180 days.**	
		b. Weight gain of 5% or more in the **last 30 days** or 10% or more in the **last 180 days**	
		c. Insufficient fluid—less than 1,000 cc per day or less than four 8-oz cups per day	
		d. In the **last 3 days**, noticeable decrease in the amount of food or fluid usually consumed	
3	INDICATORS OF EATING DISORDERS	Presence of potential signs of eating disorders in the **last month.** 0. No 1. Yes	
		a. Any instances of binge eating, purging or bulimia	
		b. Unrealistic fear of weight gain, statements that suggest a distorted body image	
		c. Fasting or major restriction of diet (excluding religious practices)	
4	POLYDIPSIA	In the **last 3 days**, inappropriate or excessive fluid consumption (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). 0. No 1. Yes	

SECTION O. ROLE FUNCTIONING AND SOCIAL RELATIONS

1	FAMILY ROLES	Belief that relationship(s) with immediate family members is disturbed or dysfunctional. 0. Belief not present 1. Only person believes 2. Family/friends/others believe 3. Both person and family/friends/others believe	
2	SOCIAL RELATIONS AND INTER-PERSONAL CONFLICT	Presence of potential problems with social relations. 0. No 1. Yes	
		a. Reports having no confidant.	
		b. Family/close friends report feeling overwhelmed by person's illness.	
		c. Is persistently hostile towards or critical of family/friends.	
		d. Is persistently hostile towards or critical of others or staff.	
		e. Family/friends are persistently hostile towards or critical of person.	
		f. Staff reports persistent frustration in dealing with person.	
		g. Family/friends require unusual amounts of facility staff time.	
3	EMPLOY-MENT STATUS	Current employment status 0. Employed 1. Unemployed, seeking employment 2. Unemployed, NOT seeking employment 3. Other 4. Unknown	
4	RISK OF UNEMPLOY-MENT/ DISRUPTED EDUCATION	Factors that increase current risk of unemployment or disruption of education. 0. No 1. Yes 8. Not applicable	
		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	

SECTION O. ROLE FUNCTIONING AND SOCIAL RELATIONS (cont'd)

5	TRADE-OFFS	During the **last month**, because of limited funds, made trade-offs to purchase any of the following: prescribed medications, sufficient home heat, necessary health care, adequate food. 0. No 1. Yes	
6	SOCIAL RELATION-SHIPS	0. Occurred within the last 3 days 1. Occurred within the last week 2. Occurred within the last month 3. Last occurred more than 1 month ago	
		a. Participation in social activities of long-standing interest	
		b. Visit by long-standing social relation/family member	
		c. Telephone or email contact with long-standing social relation/family member	

SECTION P. RESOURCES FOR DISCHARGE

1	AVAILABLE SOCIAL SUPPORTS (family/close friends)	Presence of 1 or more family members (or close friends) able to provide the following types of support after discharge. 0. Not needed 1. Regular 2. Occasional 3. No	
		a. Help with child care, other dependants	
		b. Supervision for personal safety	
		c. Crisis support	
		d. Support with ADL or IADL	
2	DISCHARGE READINESS	Presence of indicators of discharge readiness 0. No 1. Yes	
		a. Expresses/indicates preference to return to/remain in the community.	
		b. Has a support person who is positive towards discharge/maintaining residence in the community.	
3	PROJECTED TIME TO PLANNED DISCHARGE	How long person is expected to stay in current setting or under the care of this service prior to planned discharge. 0. 1–7 days 3. 31–90 days 1. 8–14 days 4. 91 or more days 2. 15–30 days	
4	OVERALL CHANGE IN CARE NEEDS	Change in psychiatric symptoms as compared to 30 days ago or since admission/last assessment (if less than 30 days ago). 1. Deteriorated—symptoms are more frequent and/or severe 2. No change 3. Improvement 4. Marked improvement	
5	DISCHARGED TO	Code for the **living** arrangement at discharge. 1. Private home/apartment/rented room 2. Board and care 3. Assisted living or semi-independent living 4. Mental health residence 5. Group home for persons with physical disabilities 6. Setting for persons with intellectual disabilities 7. Psychiatric hospital 8. Homeless (with or without shelter) 9. Long-term care facility (nursing home) 10. Rehabilitation hospital/unit 11. Hospice facility/palliative care unit 12. Acute care hospital 13. Correctional facility 14. Other 15. Deceased	
X140	DISCHARGED TO FACILITY NUMBER	☐ Prov./Terr. ☐☐☐☐ Facility Number	

SECTION Q. PSYCHIATRIC DIAGNOSTIC INFORMATION

1	DSM-IV DIAGNOSTIC CATEGORY	Select **up to 3** DSM-IV 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. **Code "1" for the most important diagnosis, "2" for the second most important and "3" for the third most important.** (Note: Code 2 and 3 if applicable.)	
		a. Disorders of childhood/adolescence	
		b. Delirium, dementia and amnestic and other cognitive disorders	
		c. Mental disorders due to general medical conditions	
		d. Substance-related disorders	
		e. Schizophrenia and other psychotic disorders	
		f. Mood disorders	
		g. Anxiety disorders	
		h. Somatoform disorders	
		i. Factitious disorders	
		j. Dissociative disorders	
		k. Sexual and gender identity disorders	
		l. Eating disorders	
		m. Sleep disorders	
		n. Impulse-control disorders not classified elsewhere	
		o. Adjustment disorders	
		p. Personality disorders	
		q. Not applicable—admitted to mental health bed for reasons not related to mental health	
2	PSYCHIATRIC DIAGNOSIS	Enter Axis I and Axis II DSM-IV diagnoses, if known. This must be completed on discharge, but also complete with earlier assessments if a specific psychiatric diagnosis has already been determined. AXIS I: a. DSM-IV CODE: b. DSM-IV CODE: c. DSM-IV CODE: AXIS II: d. DSM-IV CODE: e. DSM-IV CODE: f. DSM-IV CODE:	
X7	PRIMARY DIAGNOSIS	If both Axis I and Axis II DSM-IV diagnoses are completed, indicate which is the primary diagnosis. 1. Axis I – Q2a 2. Axis II – Q2d	
3	INTELLECTUAL DISABILITY	Has an intellectual disability (e.g. Down's syndrome). 0. No 1. Yes	
4	GAF SCORE	Global Assessment of Functioning. Code the current score.	
5	CURRENT PATIENT TYPE	Code for the most appropriate type. 1. Acute care 3. Geriatric psychiatry 2. Longer term 4. Forensic	

SECTION R. MEDICATIONS

1	PRESCRIBED MEDICATIONS	Medication prescribed for use in the **last 3 days**. 0. No 1. Yes	

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. Year Month Day	
X75	TOTAL DAYS OF ALTERNATE LEVEL OF CARE	Enter the total number of days of alternate level of care since last assessment for this person.	
X80	DISCHARGE DATE	Enter the date of discharge 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 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 service interruption days away from the mental health bed since last assessment or admission.	
X150	TOTAL SERVICE INTERRUPTIONS	Enter the total number of service interruptions that occurred since last assessment or admission.	
X131	TOTAL DAYS AWAY FROM BED IN QUARTER 4	Enter the total number of service interruption days away from the mental health bed that occurred in Quarter 4.	
X151	TOTAL SERVICE INTERRUPTIONS IN QUARTER 4	Enter the total number of service interruptions that ended in Quarter 4.	

SECTION T. ASSESSOR IDENTIFICATION

1	SIGNATURE OF PERSON COORDINATING THE ASSESSMENT		
	a. _____ Signature of Assessment Coordinator	b. Date Assessment Coordinator signed as complete	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:

PO	By mouth	**SL**	Sublingual	**IM**	Intramuscular	**TOP**	Topical	**ET**	Enteral tube
IV	Intravenous	**SQ**	Subcutaneous	**R**	Rectal	**NH**	Inhalation	**OTH**	Other

Freq.—Code the number of times per day, week or month the medication is administered, using the following list:

QH	Every hour	**QD**	Once daily	**QW**	Once each week	**QOD**	Every other day
Q2H	Every two hours	**BID**	Two times daily (include	**2W**	Two times each week	**QHS**	At bedtime
Q3H	Every three hours		every 12 hours)	**3W**	Three times each week	**1M**	Once every month
Q4H	Every four hours	**TID**	Three times daily	**4W**	Four times each week	**2M**	Twice every month
Q6H	Every six hours	**QID**	Four times daily	**5W**	Five times each week	**C**	Continuous
Q8H	Every eight hours	**5D**	Five times daily	**6W**	Six times each week	**O**	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 ([)	R2 f. D/C ([)
a.						
b.						
c.						
d.						
e.						
f.						
g						
h.						
i.						

The *Ontario Mental Health Reporting System Resource Manual* is composed
of two modules:
Module 1—Clinical Coding
Module 2—Technical Specifications and Data Submission

OMHRS incorporates the Resident Assessment Instrument—Mental Health
(RAI-MH)©. The authors of the *RAI-MH© Training Manual and Resource Guide
for Version 2.0* are John P. Hirdes, Edgardo Pérez, Nancy Curtin-Telegdi, Peter
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