

Running Head: DISRUPTIVE BEHAVIOUR IN COMPLEX CONTINUING CARE

Disruptive behaviour in an Ontario population of Complex Continuing Care Patients  
using the Minimum Data Set (2.0)

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## Abstract

The purpose of this study was to examine disruptive behaviour within a population of complex continuing care patients, and to identify the risk factors for such behavior. Data obtained from 14,023 residents upon admission into complex continuing care facilities were analyzed using the Minimum Data Set (2.0). Disruptive behavior was measured by the *Disruptive Behaviour Scale* developed by Stones, Stewart and Kirkpatrick (2003). The predictors of disruptive behaviour examined included demographic characteristics (gender, age), psychiatric diagnosis (anxiety, dementia, depression) use of medications (antianxiety, antidepressants, antipsychotics), restraint, functional status of the resident (Activities of Daily Living, recent and lasting delirium, incontinence, cognitive impairment), visual limitations, oral/dental status, pain, depressed affect, and withdrawal. The strongest predictors of disruptive behaviour included dementia, antipsychotic medication, bladder incontinence, tooth loss, depressed affect, recent and non recent delirium, withdrawal, restraint, vision impairment, antianxiety medication, activities of daily living, frequency of pain, and gender. The results are discussed in relation to proper detection and treatment of frequent conditions in care facilities that may help to reduce disruptive behaviour.



## Overview

A problem within care facilities that is receiving increasing attention in the literature concerns disruptive behaviour by residents. A review of the literature on disruptive behaviour showed it to be frequent within care facilities for the elderly. Although the literature provides a considerable amount of information on how residents' behaviors can affect quality of care, there has been little research investigating the underlying reasons for disruptive behaviour by elderly residents in care facilities.

Because disruptive behaviour can affect all members within care facilities, the purpose of this study was to investigate the reasons for disruptive behaviour by elderly residents throughout complex continuing care facilities in Ontario. This study intended to replicate previous research from long-term care facilities in Northwestern Ontario. The results from this previous study showed that disruptive behaviors predicted by delirium, depressed affect and urinary incontinence (Stones, Stewart, & Kirkpatrick, 2003). This research was important because disruptive behaviour related to treatable conditions, unlike irreversible cognitive impairment previously considered as the most frequent cause (Ryden, Bossenmaier & McLachlan, 1991).

The present research aimed to replicate the previous study with a larger sample from complex continuing care facilities. This population was chosen because many of these residents show behavioral problems (CIHI, 2004). Many residents receiving complex care are subsequently discharged from these facilities to their own homes, or placed in long-term care (CIHI, 2004).

The data were from the Minimum Data Set (MDS 2.0) provided to the author by the Canadian Institute for Health Information. The research hypotheses were that the predictors of disruptive behaviour by residents would include common and treatable conditions, such as untreated depression, delirium and urinary incontinence.

The data analyzed were admission data collected within 14 days from admission. Subsequent data (e.g. annual assessments) were not included because the reasons for disruptive behaviour may differ between admission and later assessment, with the immediately post-admission period providing the greater opportunities for detection and treatment.

### Literature Review

The terms aggressive, problematic, and disruptive behaviour used in the literature describe some elderly residents' conduct while under care (Bair, Toth, Johnson, Rosenberg & Hurdle, 1999). Examples of such behaviour include verbal and physical abuse (Everitt, Fields, Soumerai, & Avorn, 1991), social inappropriateness and care resisting behaviour (Stones, Stewart & Kirkpatrick, 2003).

The exact prevalence rates of these behaviours have been difficult to estimate because of the varying definitions (Bedford, Melzer & Guralnik, 2001), although researchers have found disruptive behaviour to be common. In an earlier study, Jackson, Drugovich, Fretwell, Spector, Sternburg, and Rosenstein (1989) examined the occurrences of disruptive behaviour over a two-week interval in a long-term care facility. Of the 3,351 residents sampled, approximately 26.4% of these residents showed some form of disruptive behaviour regardless of whether the resident was diagnosed as cognitively impaired. Similarly, Vollen (1996) found that approximately 23-79% of residents display disruptive behaviors. These behaviors are also more frequent in older residents (Bedford, Melzer, & Guralnik, 2001).

The following sections of the thesis review findings on the recipients of disruptive behaviour, impact of disruptive behaviour on residents and staff, implications for elder abuse and neglect, and the methods used to control disruptive behaviour.

#### *Recipients of Disruptive behaviour*

Over a one-year interval, Malone, Thompon and Goodwin (1993) examined 350 long-term care residents who had an incident of aggressive behavior. The most common

victims of the disruptive residents behaviour were other nursing home residents (62%), employees (37%) and visitors (1%). These results suggest that disruptive behaviour can affect the quality of life of all members within long-term care facilities.

*Impact on other residents: Staff time expenditure*

A recent study investigating the amount of time staff spent on intervening with disruptive residents provides one illustration on the adverse impacts on other resident's quality of life. Souder and O'Sullivan (2003) sampled 153 residents in eight institutional settings. Staff recorded the amount of time they spent on managing residents' disruptive behaviour over 21 shifts. The researchers determined that staff spent approximately "23 minutes to manage each disruptive episode" (p. 35). The researchers also calculated that on average, staff could spend "more than 80 minutes a day on each disruptive resident" (p.35). Clearly, time spent managing these behaviors and treating the victims' injuries, detracts from the time available to provide good quality care to all residents.

*Impact on other residents: Physical well-being*

The injuries resulting from physical aggression on the part of residents were recently reviewed in the literature. This provides another illustration of the impact on residents' quality of life. Shinoda, Leonard, Pontikas, McDonough, Allen and Dreyer (2004) assessed the types of injury between residents who were aggressive towards each other. Findings from this study determined that the most common injuries were

- fractures,
- dislocations,

- bruises or hematomas,
- lacerations,
- and reddened areas.

*Impact on other residents: Emotional well-being*

Disruptive behaviour has also been found to adversely affect other residents' emotional well being. Within care facilities, integration of both cognitively impaired and cognitively intact residents is common, with cognitively intact residents often required to share a room with someone who is consistently abusive towards them. For example, Ragneskog, Gerdner and Hellström (2001), examined this integration of cognitively intact and cognitively impaired individuals with disruptive behavior in hospitals, long-term care facilities, and residential homes. Findings showed that the cognitively intact residents viewed integration as a problem, often describing their "fears, anxieties, and aggravations" towards the disruptive resident (p. 735).

*Impact on Staff: Caregiver Distress*

Caring for the disruptive resident also has an impact on front line staff. Research cited by Evers, Tomic, and Browers (2001) has shown that caring for disruptive residents can lead to "depression, anxiety, absenteeism, and burnout" (p.441). However, not all staff report such distress. Everitt, Fields, Soumerai and Avorn (1991) asked front line staff in 12 long-term care facilities to record distress from residents' behaviour. Findings showed half of the staff members reported that residents' behaviour caused them to feel distressed whereas the other half reported no such distress. A likely reason for the differences among staff derives from findings by Meddaugh (1991) who noted in her

observational study, that some of the staff appeared to tolerate residents disruptive behaviour, believing that “its just part of the job” (p.115). However, this apparent acceptance of residents’ disruptive behaviour should not be taken lightly, considering the growing research on how residents’ behaviour can affect quality of care.

#### *Disruptive residents and Elder abuse*

Kilburn (1996) illustrated the potential impact of resident’s behaviour on quality of care by examining characteristics of caregivers and their feelings towards their care recipient. Of the 202 Alzheimer’s caregivers that were interviewed, one research finding that emerged implicated disruptive behavior by care recipients as a potential trigger for violent feelings in the caregiver. Other studies similarly implicated residents’ disruptive behaviors towards a caregiver as increasing the likelihood of abuse and neglect.

Pillmer and Bachman-Prehn (1991) recognized the problem of elder abuse and investigated the predictors of maltreatment in long-term care facilities. The researchers sampled 577 nurses and nursing aids in long term care facilities. The results indicated that the best predictors of abuse were caregiver burnout and conflicts with residents in the facility.

Hirst (2000) also examined the perceptions of abuse by members of the long-term care institution. Thirty-seven participants, including registered nurses, older residents, non-professional staff and significant others, were interviewed and participated in group discussions. One of the findings that emerged from the study was that both registered nurses and residents agreed that the idea of abuse should be judged within the context of

care (Hirst, 2000). One resident expressed an understanding of “why staff lose their tempers at times and shout” (p. 42). This implied that it was possible that resident behaviors may contribute to abuse by staff.

#### *Disruptive residents and Elder neglect*

Residents’ disruptive behaviour also has been speculated to lead to neglect by nursing staff. In observing interactions with disruptive residents in a long term care facility, Meddaugh (1991) noted that staff members felt “distressed” in caring for a disruptive resident, and “approached the patient cautiously” (p.116). Even assisting the resident with regular daily tasks (e.g. feeding) were approached with apprehension.

Reactions that staff can have towards the disruptive residents can also affect the residents’ emotional well being. Meddaugh (1991) noted that disruptive residents were often isolated from social activities even after “just one incident” (p.116). In the case of frequently disruptive residents, staff would only provide the “bed and body” care and would speak to the resident “only to give directions” (p.116). No effort was made for “small talk” (p.116). Generally, disruptive residents were labeled as “bad” with the staff making little effort to determine the “underlying reasons behind their behaviour” (p.116).

#### *Reasons for disruptive behaviour: External factors*

The literature also contains reports on possible triggers for disruptive behavior. Olson (2002) described external factors that are frequently found within long-term care institutions. These external factors included “noise pollution, such as loud talking, radios, bells, and alarms” (p.33). Disruptive behavior itself can contribute to noise pollution. Beck & Vogelpohl (1999) estimated that “20-30% of nursing home residents

scream, curse loudly, cry for help, or display other vocal behaviors that negatively affect other residents, staff, or visitors” (p.17).

Another external factor that Olson (2002) describes concerns consistent behaviour by the caregiver. Christenson, (as in Olson, 2002) reported that “lack of consistency in caregivers, abrupt or rushed approaches by staff members, even tenseness in personnel creates anxiety in residents” (p.33).

*Reasons for disruptive behaviour: Internal factors*

Staff members who do not respond to a resident’s needs in a timely manner may also trigger disruptive behaviour. Internal factors, according to Olson (2002), include unmet needs. If a resident “feels tired, has untreated pain, depression, sleep disturbances, unidentified acute medical problems, is dehydrated, constipated, and if they experience drug interactions” (p.33), the resulting discomfort or distress may potentially trigger disruptive behaviors.

A resident feeling loss of control may show increased agitation and aggression (Olson, 2002). The process of adjusting to a new environment may elicit feelings of loss of control and consequent distress (Hall & Bocksnick, 1995). Because residents are expected to behave in ways deemed appropriate by staff, Hall & Bocksnick (1995) suggested, in the context of recreation programming, the residents’ behaviors were externally controlled, and that their needs to have “self determination, control, and autonomy regarding program participation were undermined” (p.49).



*Reasons for Disruptive Behaviour**Cognitive Impairment*

Along with these external and internal factors, much of what is known about disruptive behaviors by residents relates to cognitive impairment. An estimated 63% of nursing home populations are comprised of residents with cognitive impairment and neuropsychiatric conditions (Vollen, 1996). Ryden, Bossenmair, and McLachlan (1991) studied cognitively impaired patients and found that 86% of these patients exhibit physically aggressive behaviors at some stage. Communication deterioration in dementia also contributes to verbal disruptive behaviour (Matteau, Landreville, Laplante, & Laplante, 2003).

*Impaired communication*

Impaired communication also received support as a potential reason for disruptive behaviors. Talerico, Evans and Strumpf (2002), investigated the reasons for verbally and physically disruptive behaviour in a long-term care facility. These researchers found that disruptive behaviour by residents related to depression, confusion, and communication difficulties.

*Reasons for disruptive behaviour: Emerging explanations*

Along with the earlier emphasis on cognitive triggers for disruptive behavior, there has been a recent emphasis on the importance of non-cognitive factors. Vision impairment possibly relates to disruptive behaviour (Horowitz, 1997). Stones, Stewart and Kirkpatrick (2003), examined disruptive behaviour in long-term care facilities in Northwestern Ontario using the Minimum Data Set (2.0), and found the strongest

predictors of disruptive behaviour related to delirium, untreated depression, and bladder incontinence.

### *Methods to control Disruptive Behaviour*

Research on the underlying reasons regarding disruptive behavior by residents is important because of the current methods used to control such behaviour. While new research on more positive interventions, such as engaging the resident in exercise (Beck, Modlin, Heithoff & Shue, 1992), and behavioral interventions for front line staff members (Beck, 2002; Fitwater & Gates, 2002) have been developed, the fact remains that the most common way to control disruptive behaviors is through either physical and/or chemical restraints. DeSantis, Engberg, and Rogers (1997) described the use of physical restraint to control disruptive behaviors as “common than previously reported” because staff may justify “the use the use of restraint for other reasons” (p.1517).

### *Present Research*

The purpose of this present investigation was to replicate and expand upon previous research on disruptive behaviors from a nursing home sample in Thunder Bay, Ontario (Stones, Stewart, & Kirkpatrick, 2003). That study determined by multivariate analysis, that delirium and symptoms of affective disorder, as well as urinary incontinence and withdrawal in the facility were the strongest predictors of disruptive behavior. This finding suggests that distress or discomfort may be predisposing factors. Therefore, the predictors for the present study included variables previously identified as related to disruptive behaviour in univariate or multivariate analysis, including

psychiatric diagnosis (anxiety, dementia, depression) use of medications (antianxiety, antidepressants, antipsychotics), restraint, functional status of the resident (Activities of Daily Living, recent and lasting delirium, incontinence, cognitive impairment), visual limitations, depressed affect, and withdrawal. Resident's oral/dental status and pain were also included because they relate to distress or discomfort. Finally, the predictors included demographic characteristics (gender, age). The sample used in the present study included all new admissions to complex continuing care in Ontario during a 1-year period.

## Method

### *Participants*

Data were obtained from the Canadian Institute for Health Information-Graduate Student Data Access Program (CIHI-GSDAP) for the period of 2000-2001. The data were from complex continuing care facilities that included acute care hospitals with wings assigned to complex continuing care, and complex continuing care beds in small hospitals (CIHI, 2004). The residents in these facilities are characterized by functional impairment along with clinical complexity, and comprise a more resource intensive case mix than is found in Ontario nursing homes and homes for the aged. Short-term rehabilitation patients constitute a significant proportion of admissions.

The participants consisted of 14,023 residents from complex continuing care facilities throughout Ontario. Residents were excluded from the study if they were younger than 65 years old and were comatose. All data were collected from new assessments into Complex Continuing Care Facilities, and were completed within

fourteen days of admission. Of the 14,023 residents, 58% were females, and 42% were males. The average age of the residents was 80.2 years, (SD=7.57).

### *Materials*

#### *Minimum Data Set 2.0.*

The MDS (2.0) is designed to monitor the individual status and progress of the medical, psychological and social characteristics of residents within care facilities (Lawton, Casten, Parmalee, Van Hartsma, Corn & Kleban, 1998). The MDS (2.0) is administered upon admission into a facility and in quarterly assessments thereafter by trained nursing staff, or if a resident has a significant change in status, or if there were significant corrections in the resident's assessment.

Although the MDS (2.0) is primarily a clinical instrument, it can provide valuable information for researchers. The reliability of the MDS has reported acceptable levels (Morris, Nonemaker, Murphy, Hawes, Fries, Mor, & Phillips, 1997) and studies such as Snowden and colleagues (1999) have examined the MDS's validity. These researchers concluded that the "cognitive performance scale, self performance of activities of daily living, and behavioral domains of the MDS have fair criterion validity when compared with other research instruments" (p.1003). The researchers continue to conclude that they "support the use of the MDS as a tool for cross sectional study of patients likely to have cognitive, behavioral, and functional impairment" (p.1003). Since this is, a cross-sectional study the use of the MDS is appropriate.

*Dependent variable*

The dependent variable consisted of the *Disruptive Behaviour Scale* (Stones, Stewart & Kirkpatrick, 2003). The scale consists of the behavioral symptom items on the MDS (2.0). These items include verbally abusive behaviour by residents (whether staff members or other residents were screamed at, threatened or cursed at), physically abusive behaviour by residents (others were hit, shoved, scratched or sexually abused), socially inappropriate behavior (resident was disruptive within the facility, self-abusive acts), and resistance to care (resident refused medications/assistance).

Each of these four items measures the frequency of the resident's behaviour within the last 7 days. Residents score based on a 4-point scale, where 0 means *behaviour not present*, 1 means *behaviour was present 1-3 days*, 2 means *behaviour occurred in 4-6 days*, and 3 means *behaviour occurred daily*.

The four behaviour items also measure the alterability of the behaviour in the last 7 days. These items are scored on a 2-point scale, such that, 0 means *residents' behaviour was easily altered, or not present*, and 1 means *behaviour was not easily altered*.

The scoring on the *Disruptive Behaviour Scale* is the sum of each of the frequency and alterability of resident's behaviour. Scores on the *Disruptive Behavior Scale* can range from 0 to 16. Internal consistency estimates of reliability for the *Disruptive Behavior Scale* has determined that the scale has good reliability (coefficient alpha= .835).

### *Predictors*

*Demographic Characteristics.* Resident's age and gender were included in analyses. Age was a continuous variable, and gender was coded such that 1 means *males* and 2 means *females*.

#### *Psychiatric Diagnosis.*

*Anxiety.* Diagnosis of anxiety on the Minimum Data Set (2.0) refers to resident's current diagnosis of anxiety. The anxiety item is coded such that 0 means *the resident has no anxiety disorder* and 1 means *resident has diagnosis of anxiety*.

*Depression.* Diagnosis of depression on the Minimum Data Set (2.0) is the resident's current diagnosis of depression at the time of assessment. Diagnosis was coded such that 0 means *the resident does not have depression* and 1 means *resident has diagnosis of depression*.

*Dementia.* Diagnosis of dementia refers to resident's present diagnosis of Alzheimer's disease or any other diagnosis of dementia other than Alzheimer's disease. Dementia other than Alzheimer's disease item on the Minimum Data Set (2.0) refers to dementia by "organic brain syndrome or chronic brain syndrome and dementia related to neurological disease" (RAI manual, 2002). The items were coded such that, 0 means *resident has no dementia*, and 1 means *resident has a diagnosis of dementia*.

#### *Medication Use.*

*Antipsychotic medication.* Antipsychotic medication use records the number of times in the last 7 days a resident has received this type of medication.

Antipsychotic medication use is recorded regardless what the medication was used for, and despite of how the medication was administered. The item is coded such that 0 means *the resident did not use the medication*, and 1 means *resident used medication daily*.

*Antidepressant medication.* Antidepressant medication use is recorded by the number of times in the last 7 days a resident has received this type of medication. Antidepressant medication use is recorded regardless what the medication was used for, and despite of how the medication was administered. The item is coded such that 0 means *the resident did not use the medication*, and 1 means *resident used medication daily*.

*Antianxiety medication.* Antianxiety medication use records the number of times in the last 7 days a resident has received this type of medication. Antianxiety medication use is recorded regardless what the medication was used for, and despite of how the medication was administered. The item is coded such that 0 means *the resident did not use the medication*, and 1 means *resident used medication daily*.

*Restraints.* Restraint on the Minimum Data Set (2.0) refers to frequency of physical restraint use within the last seven days. Restraint use on the MDS (2.0) was defined as trunk restraint, limb restraint, and any chair that prevents rising. Residents are assessed by direct observation and consulting other staff members and records. Restraint use was measured in the last 7 days, such that 0 means, *resident was not restrained*, 1 means, *restraint used less than daily*, and 2 means, *restraint used daily*.

*Functional Status.*

*Activities of daily living.* Activities of daily living refers to residents' self-performance on the MDS (2.0) in the last seven days. The items refer to how a resident moves in the facility (how a resident moves between locations in the facility), how a resident eats or drinks (includes diet by other means), the resident's toilet use (transfers on/ off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes), and how resident's maintain personal hygiene (includes combing hair, applying makeup, washing/ drying face, hands, perineum). Scores can range from 0 to 8, such that; 0 means *resident is independent*, 1 means, *resident needs supervision*, 2 means *limited assistance*, 3 means *extensive assistance*, 4 means *total dependence*, and 8 means *activity did not occur in the entire 7 days*.

Item consistency for the ADL scale is measured as good,  $\alpha = .90$  (Morris, Fries & Morris, 1999).

*Delirium.* Indicators of delirium on the Minimum Data Set (2.0) consists of whether the resident was easily distracted (e.g. problems with attention), if the resident had periods of altered perception or awareness of surroundings (e.g. talking to self or others that are not present), episodes of disorganized speech (e.g. losing train of thoughts), periods of restlessness (e.g. fidgeting), periods of lethargy (e.g. sluggishness), and mental function varying over the course of the day. Resident's delirious behavior is coded on a 3-point scale, such that zero means *the resident's behavior was not present in the last 7 days*, 1 means *behavior was present without recent onset*, and 2 means that *residents delirium is of recent onset, or different from the last 7 days*. For the present



study, delirium was coded to indicate delirium of recent onset, and delirium of non-recent onset.

*Urinary continence.* Resident's urinary continence measures in the last fourteen days, and refers to resident's continence regardless of programs and appliances. Staff members record continence through direct conversation, as well as referring to the resident's clinical record. Resident's urinary continence was coded such that 0 means, *the resident has complete control*, and 1 means *the resident was incontinent*.

*Cognitive Impairment.* The Minimum Data Set (2.0) items of cognition include a resident's short term and long term memory, designed to determine if the resident shows evidence of a memory problem. The cognition items extend to whether or not the resident was able to recall the current season, location of their room, recall staff members faces/names, recall that they are in a nursing home, and if the resident was able to make decisions regarding tasks of daily life. Checking off which items the resident was able to recall during the last 7 days completes these items. Staff members make assessments on the resident based on a 4-point scale, such that 0 means, *the resident is independent*, 1 means *modified independence*, 2 means *moderately impaired*, and 3 means *resident is severely impaired*.

In studies examining the validity of the MDS (2.0), Casten, Lawton, Parmelee and Kelban (1998) concluded that the MDS (2.0) was practical indicator of resident status in the areas of cognition. The measure used was a scale developed by Lawton and colleagues that had good reliability of  $\alpha = .89$ .

*Visual limitations.* Visual limitation items on the Minimum Data Set (2.0)

consist of whether the resident had side vision problems- decreased peripheral vision (leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) and if the resident experienced halos or rings around lights, sees flashes of light, sees curtains over eyes. These items were coded such that 0 means *resident did not have visual limitations*, and 1 means *resident had visual limitations*.

*Oral/dental Status.* Resident's oral/dental status items on the Minimum Data Set (2.0) consisted of debris present in mouth prior to going to bed at night; if the resident had dentures or removable bridge; if the resident had tooth loss or does not use dentures; if the resident had broken, loose, or carious teeth; if the resident had inflamed gums, swollen or bleeding gums, oral abscesses, ulcers or rashes; and daily cleaning for teeth/mouth care by resident or staff. These items were coded such that 0 means *absent*, 1 means *present*.

*Pain.* The pain items that were included on the MDS (2.0) referred to the frequency of pain in the last 7 days. The frequency of resident's pain is measured on a 3-point scale, such that 0 means *the resident had no pain*, 1 means, *the resident had pain less than daily*, and 2 means *the resident had pain daily*.

*Depressed Affect.* Depressed affect was measured using the Minimum Data Set Depression Rating Scale (MDS DRS). The MDS DRS developed by Burrows, Morris, Simon, Hirdes and Phillips (2000) screens for depression in nursing homes. The MDS DRS consists of a core set of 7 MDS mood items. Residents are scored on a three-point scale, regardless of the assumed cause, such that 0 means the *behaviour did not*

*occur during last 30 days, 1 means type was exhibited at least once in the last 30 days and up to 5 days a week, 2 means behaviour was exhibited daily or almost daily.*

Residents who score more than three are considered for further evaluation. The MDS DRS is administered by a staff member and is encouraged to consult with other direct care staff over all shifts, the resident's clinical records, and even family members whenever possible.

Because of the administering methods described above, MDS DRS has been applauded for its reliance on observations rather than diagnosis. This instrument also allows for the detection even of mild depression, which may be detrimental to elderly populations if left unnoticed. The scale's authors have reported MDS DRS's psychometric properties. The authors determined that the MDS DRS performs well when validated against the 17- item Hamilton Depression Rating Scale and the 9- item Cornell scale for Depression in patients with dementia, as well as the DSM IV (Burrows et al., 2000). However, the literature has shown a recent shift that questions the psychometric properties of the MDS DRS. Anderson and colleagues (2003), interviewed nursing home residents with the Minimum Data Set (2.0), Hamilton Depression Rating Scale, and Geriatric Rating Scale and determined that the MDS DRS failed to correlate highly with these scales.

The researchers who developed the MDS DRS state that the scale "may be important in the care of nursing home residents as well as targeting resources" (p. 172). Although the MDS DRS may have questionable psychometric properties, for the purpose of this study, it may be the best measure of symptomatology.

*Withdrawal.* The Minimum Data Set (MDS 2.0) items of withdrawal consist of resident's withdrawal from activities of interest (activities, family/friends), and reduced social interaction in the facility (less talkative, more isolated). These items refer to a resident's usual pattern of behaviour, as measured by staff across shifts and after consultation with family members if possible. These items are measured on a three-point scale, based on resident's behavior in the last 30 days, such that 0 means *the behavior did not occur in the last 30 days*, 1 means *behavior was present up to five days a week*, and 2 means *behavior was present daily*.

## Results

### *Distribution of Predictors*

Upon admission into the facility, 4.5% of residents had a diagnosis of anxiety, 15% had a diagnosis of depression, and 25% had a diagnosis of dementia. Of those residents, 16% were using antipsychotic medication, 31% were using antianxiety medication, and 22% were using antidepressants. Daily restraint occurred in 14% of residents.

Impairments in any activities of daily living occurred in 93% of residents. Recent delirium occurred in 47% of residents, and 61% of these residents had non-recent delirium. Bladder incontinence occurred in 55% of residents. Some form of cognitive impairment was present in 40% of residents. Residents with MDS DRS scores greater than 1 and displayed withdrawal were present in 51% and 32% of residents, respectively. Visual impairments were present in 25% of residents. Debris in mouth prior to bedtime occurred in 12% of residents, 56% of residents had dentures, 24% of residents had

tooth loss, 4% had dental caries, 3% of the residents had gingiva, 4.9% of residents did not clean their teeth before bedtime, and 70% of residents had experienced some pain.

*Distribution on the Disruptive Behaviour Scale*

Scores on the *Disruptive Behaviour Scale* determined that upon admission, 9,705 residents (71.7%) displayed no disruptive behavior while 3,078 (28.3%) showed varying degrees of disruptive behavior ( $M=1.35$ ,  $SD=2.93$ ). The scores on the *Disruptive Behaviour Scale* shown in Table 1, range from 0 to 16.

Table 1: *Frequency Distribution of the Disruptive Behaviour Scale (N=14,023)*

Score on Scale	Frequency
0	10058
1	499
2	848
3	540
4	709
5	125
6	279
7	139
8	226
9	92
10	80
11	71
12	140
13	48
14	40
15	29
16	100

*Reliability*

Internal consistency estimates of reliability were computed for each scale used in the study. The results determined that the *Disruptive Behavior Scale* had good reliability (coefficient alpha= .849). The Activity for Daily Living Scale also had good reliability (coefficient alpha=.814), as well as cognition scale (coefficient alpha=.849). The Depression Rating Scale had an adequate reliability (coefficient alpha=.734).

*Univariate Relationships between the Disruptive Behaviour Scale and its predictors*

Pearson *r* correlations computed between the binary *Disruptive Behavioral Scale*, (such as 0 means *no disruptive behaviour*, and 1 means *any disruptive behaviour*), and all of the predictors. These included a resident's sex, age, psychiatric diagnosis (anxiety, dementia, and depression), medication use (antianxiety, antidepressants, antipsychotic), restraint, functional status of the resident (activities of daily living, cognitive impairment, delirium, urinary incontinence) visual limitations, oral/dental status (debris in mouth prior to bedtime, use of dentures, tooth loss, broken, loose or carious teeth, gingiva or bleeding gums, ulcers or rashes, and daily cleaning of teeth), frequency of pain, depressed mood (measured by the MDS Depression Rating Scale), and withdrawal. The results of the significant correlations at the 0.01 level are presented in Table 2. All were significant except for age, and daily cleaning of teeth by staff or the resident.

Table 2  
*Correlation matrix with the predictors and the Disruptive Behaviour Scale*

	DBS	Age	Gender	Cognition	Antipsychotic	Antianxiety	Antidepressant	Dementia
DBS	_____	.024**	-.095**	.138**	.264**	.092**	.065**	.300**
Age	.024	_____	.150**	.010	-.025**	-.071**	-.097**	.132**
Gender	-.095**	.150**	_____	-.047**	-.062**	.029**	.002	-.044**
Cognition	.138**	.010	-.047**	_____	.098**	.021*	.085**	.157**
Antipsychotics	.264**	-.025**	-.062**	.098**	_____	.092**	.077**	.257**
Antianxiety	.092**	-.071**	.029**	.021*	.092**	_____	.088**	-.006
Antidepressant	.065**	.097**	.002	.085**	.077**	.088**	_____	.025**
Dementia	.300**	.132**	-.044**	.157**	.257**	-.006	.025**	_____
Depression	.072**	-.060**	.013	.092**	.075**	.059**	.392**	.059**
Anxiety	.063**	-.025**	.046**	.059**	.085**	.137**	.105**	.057**
Restraint	.148**	.010	-.059**	.083**	.102**	.023**	.016	.141**

Note. \*p<.05, \*\*p<.01

Table 2  
*Correlation matrix with the predictors and the Disruptive Behaviour Scale (con't..)*

	DBS	Age	Gender	Cognition	Antipsychotic	Antianxiety	Antidepressant	Dementia
ADLs	.211**	.035**	-.025**	.128**	.072**	.034**	-.011	.147**
Incontinence	.223**	.088**	-.054**	.176**	.122**	-.025**	.030**	.222**
MDS DRS	.392**	-.015	.026**	.201**	.228**	.182**	.159**	.161**
Withdrawal	.310**	-.008	-.054**	.113**	.164**	.078**	.077**	.162**
Pain	-.024**	-.034**	.092**	-.037**	-.035**	.143**	.038**	-.143**
Vision	.177**	.026**	-.030**	.078**	.100**	.008	.004	.176**
Debris	.080**	.004	-.026**	.029**	.052**	.021*	.021*	.075**
Denture	-.056**	.132**	.063**	-.007	-.011	.035**	.035**	-.062
Tooth Loss	.096**	-.033**	-.049**	.065**	.026**	-.028**	.002	.074**
Caries	.062**	-.007	-.031**	.048**	.030**	.001	.003	.006**
Gingiva	.035**	-.026**	.004	.021*	-.008	.031**	.017*	.012
Cleaning	.034*	.012	.017*	.050**	.018*	.031**	.019*	.017*
Recent Delirium	.345**	.043**	-.063**	.233**	.257**	.066**	.054**	.355**
Non recent Delirium	.217**	-.004	-.042**	.059**	.136**	.111**	.014	.084**

Note. \*p<.05, \*\*p<.01



### *Multivariate Predictors of Disruptive Behaviour*

A logistic regression analysis was conducted to investigate the multivariate predictors of disruptive behaviour. The predictor variables included all of the significant correlations from Table 2 and age. The dependant variable was the *Disruptive Behaviour Scale*, coded such that 0, means that the *resident had no disruptive behaviour*, and 1 means, *resident had varying degrees of disruptive behaviour*.

The results of the overall regression analysis was significant with the overall equation significant at  $\text{Chi Sq (23) = 4537.02 } p < .001$ . The standardized regression coefficients for the significant predictors of disruptive behaviour upon admission are reported in Table 3.

Significant individual predictors of disruptive behaviour were

- dementia (OR= 1.98, 95% CI= 1.78-2.19)
- use of antipsychotic medication (OR=1.72, 95% CI=1.53-1.93)
- bladder incontinence (OR=1.51, 95% CI= 1.36-1.67)
- tooth loss (OR= 1.46, 95% CI= 1.31-1.63)
- Minimum Data Set Depression Rating Scale (OR=1.31, 95% CI= 1.28-1.34)
- recent delirium (OR=1.30, 95% CI= 1.25-1.34)
- non recent delirium (OR=1.28, 95% CI= 1.24-1.31)
- withdrawal (OR=1.17, 95% CI= 1.13-1.21)
- restraint (OR=1.23, 95% CI= 1.09-1.39)
- visual limitations (OR=1.19, 95% CI= 1.08-1.32)
- antianxiety medication (OR=1.12, 95% CI= 1.01-1.23)

- ADLs (OR=.1.01, 95% CI=1.01-1.02)
- frequency of pain (OR= .92, 95% CI= .87-.97)
- gender (OR=.67, 95% CI= .61-.74)

Table 3: Summary of logistic regression for variables predicting the Disruptive Behavior Scale

Variable	B	SE B	$\beta$
Age	.005	.003	1.00
Gender	-.388	.047	.678**
Anxiety	-.116	.109	.891
Dementia	.684	.052	1.98**
Depression	-.077	.067	.926
Antipsychotics	.545	.058	1.72**
Antianxiety	.114	.050	1.12**
Antidepressant	.055	.058	1.05
Restraint	.213	.061	1.23**
ADL	.019	.004	1.01**
Non recent delirium	.247	.013	1.28**
Recent delirium	.264	.018	1.30**
Incontinence	.416	.052	1.51**
Cognitive Impairment	-.013	.019	.987
Visual Limitations	.177	.051	1.19**
Debris	-.024	.066	.977
Dentures	-.050	.050	.952
Tooth loss	.380	.055	1.46**
Caries	.003	.103	1.03
Gingiva	.051	.117	1.05
Pain Frequency	-.084	.028	.920**
MDS DRS	.276	.012	1.31**
Withdrawal	.160	.017	1.17**

Note. \*\* P < 0.01

*Supplementary Analyses*

The overall results of the regression analysis replicated previous findings in that the Minimum Data Set Depression Rating Scale (MDS DRS), withdrawal and delirium emerged as strong significant predictors of disruptive behaviour. Consistent with the previous research study (Stones, Stewart and Kirkpatrick, 2003), these three predictors were explored more thoroughly because they relate to changeable conditions. Both withdrawal and depressed mood are aspects of affective disorder. Delirium is a reversible acute psychiatric condition, with both conditions common in older adults (Barlow & Durand, 1999). Therefore, withdrawal and depressed mood combined to produce four affect groups (withdrawal, depressed MDS DRS, both withdrawal and MDS DRS, and neither withdrawal nor MDS DRS). Because both recent and non-recent delirium were both significant, these items were summed into any delirium. The variable was recoded such as 0 means *delirium absent*, 1 means *delirium present*. The affect variable were coded such as 0 means *daily withdrawal*, 1 means *daily MDS DRS*, 3 means *both daily withdrawal and MDS DRS*, and 4 means *no withdrawal and no MDS DRS*. A 2 x 4 ANOVA was conducted to explore the effects of the four-affect groups and any delirium on the *Disruptive Behaviour Scale*.

The means and standard deviations for disruptive behavior as a function of delirium and affect are presented in Table 4, with a graphical depiction in Figure 1.

The ANOVA indicated a significant interaction between delirium and affect, (F [3,14015]=53.90,  $p < .01$ , partial  $\eta^2 = .011$ ), as well as significant main effects for

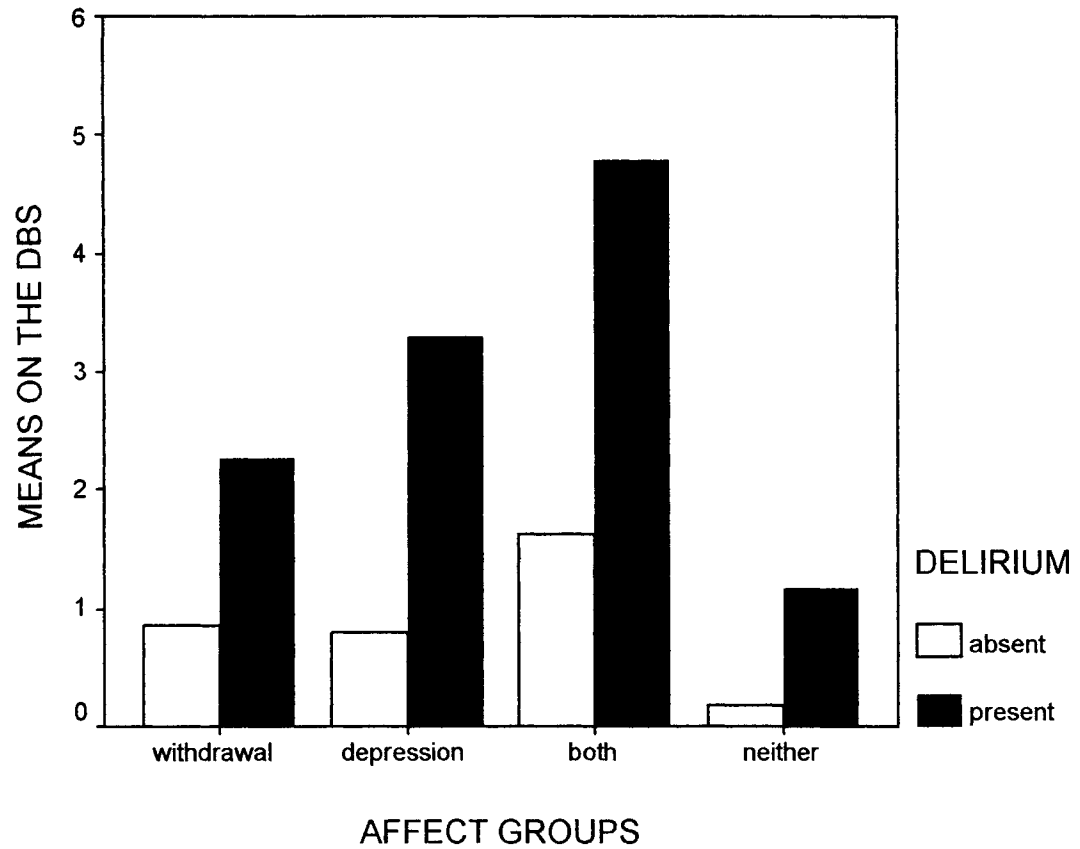
delirium, ( $F[1, 14015]= 490.87, p<.01, \text{partial } n^2=.034$ ), and affect, ( $F [3, 14015]=245.83, p<.01, \text{partial } n^2=.050$ ).

Table 4: Means and standard deviations on the *Disruptive Behavior Scale* by delirium and affect

Delirium	Affect	Mean	Standard Deviation
Absent	Withdrawal	.85	1.92
	MDS DRS	.79	1.72
	Both	1.63	2.93
	Neither	.17	.73
Present	Withdrawal	2.27	3.18
	MDS DRS	3.29	4.15
	Both	4.79	5.08
	Neither	1.17	2.36

Follow up tests were conducted to evaluate the four affect groups by post hoc Bonnfironi. The group with delirium, withdrawal, and depressed mood had significantly higher scores ( $p<.01$ ) on the *Disruptive Behaviour Scale* then any other group. The results are graphically presented in Figure 1.

Figure 1: Means on the Disruptive Behaviour Scale as a function of delirium and affect groups



Previous research also determined that untreated depression resulted in higher disruptive behaviour by residents. In order to determine if these results generalized from long-term care, to complex continuing care facilities, a 2 X 2 ANOVA was performed. Residents were divided into groups based on diagnosed depression and treatment by antidepressant medication.

The means and standard deviations for disruptive behavior as a function of untreated depression are presented in Table 5.

Table 5: Means and standard deviations for untreated depression and the *Disruptive Behaviour Scale*

Antidepressants	Diagnosis	Mean	Standard Deviation
Not Used	No	1.20	2.76
	Yes	1.87	3.40
Used	No	1.66	3.28
	Yes	1.74	3.22

The ANOVA indicated a significant interaction between diagnosis and treatment, ( $F[1, 14019]=16.29, p<.01$ , partial  $n^2=.01$ ), as well as a significant main effect for diagnosis, ( $F[1, 14019]=25.63, p<.01$  partial  $n^2=.02$ ). However, there was no significant main effect for antidepressant medication use, ( $F [1, 14019] =4.89, p=. 072$ , partial  $n^2=. 01$ ). The analyses failed to replicate that untreated depression related to higher scores on the disruptive behaviour scale.

However, since the Minimum Data Set Depression Rating Scale was a significant predictor of disruptive behaviour, analyses to determine if use of antidepressants would significantly reduce disruptive behaviour using scores on the Minimum Data Set Depression Rating Scale (MDS DRS) were conducted. Since scores on the MDS DRS greater than 3 indicate the presence of depression (Burrows, Morris, Simon, and Hirdes & Phillips, 2000), this cutoff score was used. The ANOVA indicated a non significant interaction between MDS DRS and treatment, ( $F [1, 14019] =3.16, p=. 076$ , partial

$n^2=.01$ ), as well as a non significant main effect for antidepressant use ( $F[1,14019]=.502$ ,  $p=.479$ , partial  $n^2=.01$ ). However, there was a significant main effect for MDS DRS ( $F [1, 14019]=1826.06$ ,  $p<.01$ , partial  $n^2=.11$ ).

Table 6. Means and standard deviations on the Disruptive Behaviour Scale by cut off scores on the MDS DRS and antidepressant medication.

Antidepressants	DRS +3	Mean	Standard Deviation
Not used	No	.72	1.94
	Yes	3.43	4.40
Used	No	.87	2.16
	Yes	3.36	4.30

Analyses determined that the untreated depression trend failed to replicate using the cut off scores on the MDS DRS.

Extended analyses were also conducted for resident dental status as tooth loss emerged as a significant predictor. Previous research by Stewart and Stones (2004) determined that resident's oral problems were also a predictor of disruptive behaviour. Thus, a 2 X 2 ANOVA was conducted using mouth pain (absent or present) and tooth loss (yes and no) by the score on the disruptive behaviour scale.

The means and standard deviations for disruptive behavior as a function of oral problems and tooth loss are presented in Table 6.

The ANOVA indicated a significant interaction between mouth pain and tooth loss, ( $F [1, 14019] = 5.52$ ,  $p=.007$ , partial  $n^2=.01$ ) as well as significant main effects for

tooth loss ( $F [1, 14019]=41.14, p<.01, \text{partial } n^2=.03$ ), and mouth pain, ( $F [3, 14019]=20.43, p<.01, \text{partial } n^2=.01$ ).

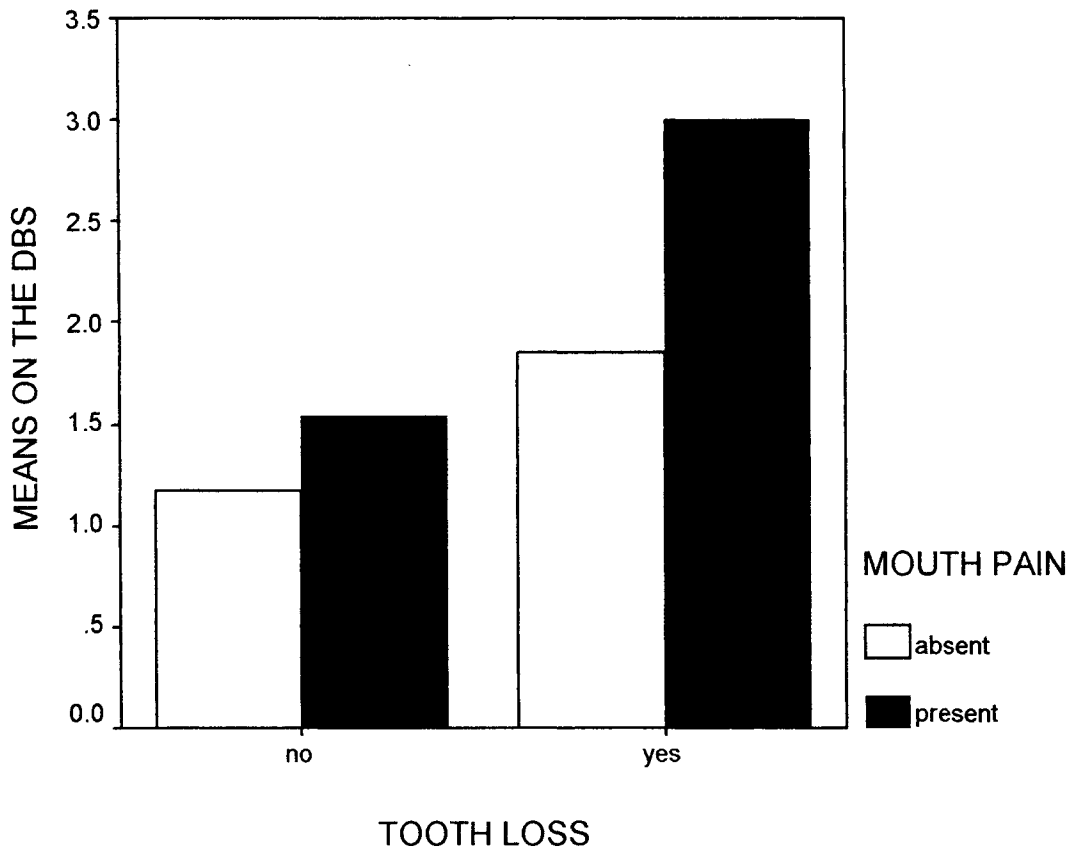
Follow up tests were also conducted to evaluate the pairwise differences among the means for tooth loss, and no tooth loss. The group with mouth pain and tooth loss had significantly higher scores on the *Disruptive Behavioral Scale* than any other group (mean=3.00). The results are presented graphically in Figure 2.

Table 7: Means and standard deviations on the *Disruptive Behaviour Scale* by mouth pain and residents' oral/dental status

Tooth loss	Mouth Pain	Mean	Standard Deviation
No	No	1.17	2.70
	Yes	1.53	3.36
Yes	No	1.85	3.41
	Yes	3.00	4.14



Figure 2: Means on the *Disruptive Behaviour Scale* as a function of tooth loss and dental pain



Discussion

This study intended to investigate disruptive behaviors within complex continuing care facilities, and to identify the predictors for such behaviour. The results indicated that the strongest predictors of residents' disruptive behaviour included dementia, antipsychotic medication, bladder incontinence, tooth loss, depressed affect, recent and non recent delirium, withdrawal, restraint, vision impairment, antianxiety medication, activities of daily living, frequency of pain, and gender. These results replicate previous research in long-term care facilities, in that indexes of affective disorder, delirium and

urinary incontinence were significant predictors of disruptive behavior. This research failed to replicate the trend of untreated depression relating to disruptive behaviour as found by Stones, Stewart, and Kirkpatrick (2003). As well, this research found that disruptive behaviour related to conditions such as visual limitations and tooth loss. These results partially support the hypothesis that disruptive behaviour by residents relates to common and treatable conditions in care facilities.

The previous study in long-term care determined that urinary incontinence strongly predicted disruptive behaviour. This was also a strong predictor in complex continuing care facilities. Incontinence cited in Brandeis and colleagues (1997) affects almost half of elderly nursing home residents. Given this frequency of incontinence, one could imagine that this could be very embarrassing and frustrating to the elderly resident. As well, incontinence is often under evaluated in nursing homes (as discussed in Brandeis et al., 1997). The process of adjusting to this new environment, as one gets older, could contribute to why the elderly residents act disruptively.

Reasons for the link between disruptive behaviour and urinary incontinence recently were illustrated. Stones and colleagues (2004, in preparation) determined that discomfort associated with incontinence related to resident's disruptive behaviour. These authors found that the discomfort associated with incontinence was predicting why residents were acting disruptively.

The findings also determined that delirium was again a significant predictor of disruptive behaviour within either care facilities. Delirium is common in older adults

because of normal physiologic changes, increased incidence of medical illnesses, and increased medication use in this population (Barlow & Durand, 1999). Delirium subsides quickly and full recovery is expected in most cases within several weeks (Barlow & Durand, 1999). The present findings showed that residents had consistently higher scores on the *Disruptive Behavioral Scale* when delirium was present. These findings are explainable since delirium often presents itself as confusion and disorientation (Berkow, Beers, Bogin, & Fletcher, 1997). If residents suddenly find themselves disorientated in their surroundings, this possibly could lead the resident to act disruptively, perhaps out of the confusion with this sudden change. Proper and prompt identification of delirium in residents may help to reduce the occurrence of disruptive behaviour.

Delirium can also occur three months after a move in the elderly (Lawlor, 1996). This study found that recent delirium could significantly predict why a resident is behaving disruptively. Since this study looked at reasons for disruptive behaviour upon admission into the facility, then it is possible that careful monitoring of newly admitted residents who are at risk of developing delirium may help to reduce disruptive behaviour.

Lasting delirium was also a significant predictor of disruptive behaviour. In recognizing the reasons that a resident is delirious upon entering a facility, and initiating treatment for these reasons, may offer hopes in reducing residents disruptive behaviors throughout the residents stay in the facility.

As well, higher scores on the *Disruptive Behaviour Scale* were found when residents had delirium and depressed affect. As these findings further imply, if one can

identify these underlying reasons for disruptive behaviour, it may be possible then to reduce these behaviors within care facilities.

Pain in this study appeared to have a protective effect, in that residents with more pain tended to have lower scores on the *Disruptive Behaviour Scale*. It is unclear as to why this may occur. Future research should address this issue.

This study also intended to investigate whether or not untreated depression related to disruptive behaviour. Previous research determined that residents' untreated depression was a significant predictor of the *Disruptive Behaviour Scale*, and in that treating residents' depression, might lead to a reduction in disruptive behaviour. The results from this study, investigating antidepressant medication either either with diagnosed depression, or cutoff scores with the MDS DRS, failed to replicate these results. These results may be due to the period upon admission, in that assessors may not recognize symptoms of depression, or be able to make an accurate diagnosis. Therefore, caution is necessary when interpreting these trends.

This study found dementia was the strongest predictor of disruptive behaviour by residents. This result supports previous research indicating that dementia relates to disruptive behaviour (Matteau, Landreville, Laplante, & Laplante, 2003). However, dementia was the only psychiatric diagnosis to emerge as a significant predictor for disruptive behaviour in this study. Other psychiatric diagnosis, such as depression (Talerico, Evans & Strumpf, 2002) found in the literature, relates to disruptive behaviour. In this study however, depression did not emerge as a significant predictor of disruptive behaviour. In addition, a diagnosis of anxiety did not emerge as a significant

predictor of disruptive behaviour. These results probably reflect the time of assessment.

Despite a diagnosis of dementia, cognitive impairment did not emerge as a significant multivariate predictor of disruptive behaviour. These results contradict the literature in that cognitive impairment is a strong independent predictor for disruptive behavior (Ryden, Bossenmair, & McLachlan, 1991). These results support in part the hypothesis that disruptive behaviour relates to common but treatable conditions in care facilities.

Gender also emerged as a significant predictor for disruptive behaviour in this study, although it did not emerge significantly the previous study. Being male had a protective effect in this study. In examining the literature on disruptive behaviour and gender, this researcher has found mixed results for both males and females contributing to disruptive behaviour. These results further add to the uncertainty between gender and disruptive behaviour.

Age did not emerge as a significant predictor in this study. These results contradict those of Bedford, Melzer & Guralnik (2001) who found disruptive behaviour to increase in the later years. One reason for this finding might be because residents typically admitted into complex continuing care facilities will eventually be discharged to either the community or potentially be later admitted into long-term care (CIHI, 2004). The data may not support this finding from long-term care facilities.

Medication usage entered as a significant predictor for disruptive behaviour by residents in complex continuing care facilities. Both antianxiety medication and anti-psychotic medications were significant predictors of resident's disruptive behaviour. As

previously hypothesized by Stones and colleagues (2003), this trend is most likely related to treatment of disruptive behaviour rather than the underlying reasons. These results on medication use may further extend to why restraint use emerged as a significant predictor of resident's disruptive behaviour. These medications may possibly reflect chemical restraint.

Visual limitations also appeared as a significant predictor of disruptive behaviour in this study, which supports research examining vision impairment and disruptive behaviour. Horowitz (1997) found that elderly residents' visual functioning was significantly related to disruptive behaviour. Specific reasons are discussed in Horowitz's study. One of the hypothesis that Horowitz (1997) suggested was that the relationship between vision impairment and disruptive behaviour could be related to cognitive impairment, in that residents could be acting disruptive either because of their cognitive impairment however and being visually impaired. In this study, decreased peripheral vision and other visual limitations contributed to disruptive behaviour. Reasons for this finding may be that residents are being startled because of their decreased vision. Horowitz discusses that vision loss is often under evaluated in care facilities, and that unless an individual has significant vision loss, staff treat them as if they have full vision. In identifying these residents upon admission into the facility may help to correct this problem.

However, that this was just residents' visual limitation. This research lacked appropriate data to examine the visual acuity, as Horowitz (1997) study previously identified. Conversely, Horowitz (1997) study did not have access to multiple indicators

of visual limitations (i.e. side vision problems), something that this study investigated. While this research cannot replicate Horowitz (1997), in that vision impairment relates to disruptive behaviour, it adds to the literature that further support the hypothesis that disruptive behaviour is related to vision and thus opens the possibility of investigating other non-traditional reasons for residents' disruptive behaviour.

The present research also examined resident's dental status as predictor of disruptive behaviour. The only significant predictor to emerge in this study was tooth loss. Further exploration of these findings determined that if the resident had experienced mouth pain, it was an indicator of disruptive behaviour.

This is the first study this researcher could find that examined dental status and disruptive behaviors. However, dental pain contributing to disruptive behaviour is not surprising, considering the problems with dentistry in care facilities for the elderly, have been recently documented in the literature (Wyatt, 2002) .

Residents in care facilities; in particular, nursing homes have been illustrated in the literature to have considerable barriers to dental care (as discussed in Wyatt, 2002), meaning that either residents do not have dentists coming into the facility, or there is often difficulty in taking residents to their external appointments. Thus, research has shown that oral health in long-term care hospitals is poor, and that residents often suffer from dental caries, loose fitting dentures, and oral abscesses that can cause unnecessary pain for residents (Wyatt, 2002). However, treatment of any of these conditions can be routine practice for a dentist. This study found that resident's dental pain contributes to disruptive behaviour, with the former unnecessary with proper intervention or prevention

strategies. While the Ontario Dental Association recognizes this problem and is making a significant move for improvement, (ODA, 2004) with more elderly retaining teeth in older age, (as discussed in Wyatt, 2002), this issue is something that needs continued investigation.

### *Limitations*

The major limitations to this study included the cross sectional design. Because of this design, the presence or absence of the predictors and disruptive behaviour are determined at the same point (Tabachinick & Fidell, 2001). Because both predictors and disruptive behaviour are determined at the same time, it is impossible to determine which came first. Therefore, this research can only suggest associations between these predictors and disruptive behaviour, and cannot prove causality (Tabachinick & Fidell, 2001).

Another limitation in this study is the period in which the resident's assessments occur upon admission, which may be a contributing factor in why the trend of untreated depression did not replicate. Residents are assessed within 14 days of admission (CIHI, 2004), and this may not be a significant time period for staff members to know the resident well enough to provide an accurate assessment. As well, this is a relatively short period, and it is unlikely that a psychiatric diagnosis will occur. Examining the frequencies of these variables upon admission confirms this hypothesis. Future research will address this issue, examining the reasons for disruptive behaviour upon later assessments.



*Applications*

The purpose of this study was to examine the reasons for disruptive behaviour in Ontario's complex continuing care facilities. This research determined that the strongest predictors of resident's behaviour related to treatable conditions. These findings are important because of the current methods used to control disruptive behaviour.

As mentioned in the literature review, the most common approach to control residents who are acting abusive towards staff, display inappropriate behaviour in the facility, or resisting care provided to them by staff, was the use of physical or chemical restraints. This study found that treatable conditions including delirium, depressed affect, dental pain, incontinence, and visual impairment were among the underlying reasons for residents' disruptive behaviour.

Considering that this study replicates the original research in long-term care facilities, it is probable that identifying and treating the reasons for disruptive behaviour upon admission could reduce its frequency in later assessments. Is it time that we look at the underlying reasons for disruptive behavior for a long term solution other than using restraint as quick fix for this problem? In investigating the efficacy of restraint use in the literature, this common method to control disruptive behaviour may not actually work.

Werner, Cohen-Mansfield, Braun and Marx (1989), observed residents during and after restraints use controlling their disruptive behaviour. The study determined that restraint use did not significantly reduce disruptive behaviour. The authors

noted, residents' behaviour either remained the same or increased with the use of restraints, and that prolonged restraint use did nothing to ameliorate residents' behaviour. Since this study found that disruptive behaviour is treatable, would it make sense to look for long-term solutions rather than quick fixes? Possible consequences of restraint use include loss of dignity and sometimes death (Werner, Cohen-Mansfield, Braun & Marx, 1989). Conceivably, what this research found that treating could avoid these consequences, thereby improving quality of life within the facility.

The findings from this research are important not only from the perspective of restraint, but on much larger issues. The idea that disruptive behaviour could be treated and thus reduced in care facilities for the elderly, has promising implications for reducing behaviors that affect staff members, other residents and the residents themselves.

As previously mentioned in the literature review, residents' behaviour adversely affects other residents in care facilities (Ragneskog, Gerdner & Hellström, 2001; Shinoda, Leonard, Pontikas, McDonough, Allen & Dreyer, 2004). In identifying and treating residents' behaviors, this may help to reduce the amount of assaults and injuries caused by these disruptive residents, reduce the amount of anxiety or fear experienced, and therefore increasing the quality of life within these care facilities.

Reducing these disruptive behaviors by residents, may also help to boost staff morale. As Meddaugh (1991) found, some staff members believed that dealing with residents' behaviour was "part of the job". As Sounder and O'Sullivan's (2003) study suggests, with a lowering of disruptive behavior staff members could have more time to

spend with residents, and therefore help to improve the needed quality of life within these facilities.

Finally, a subtle implication arising from elder abuse research suggests that resident behaviors may contribute to abuse by staff members (Killburn, 1996). Reducing these behaviors may help to decrease elder abuse and neglect within care facilities. Traditional ways of thinking of elder abuse within long-term care has placed much emphasis on abuse by staff members. Only recently, has the concept of the abusive resident emerged in the literature, which may contribute to abuse by staff. “Aggressive” residents cited in the literature are four times more likely to be abused than “passive” residents (as in Conlin-Shaw, 1998). By reducing the behaviour as the “trigger”, this may help to reduce elder abuse and neglect within these facilities.

Overall, this research suggests that if appropriate interventions for disruptive behaviors implemented in care facilities, there may be a reduction in these behaviors, which could avoid the consequences formerly described. As previously mentioned, conventional efforts used to control disruptive behaviors simply are not effective. Even besides restraint use, the positive interventions developed are proving no more successful, and like restraints, these interventions either fail to decrease the behaviour, or may actually increase resident’s disruptive behaviour (as in Beck et al. 2002).

For instance, Beck and colleagues (2002) tested two interventions for disruptive behaviour in residents with dementia. These interventions consisted of improving the basic psychosocial needs to residents (territoriality, communication, self-esteem, safety

and security, autonomy, personal identity, and cognitive understanding), either using this method during activities of daily living (bathing), as a psychosocial activity or both.

Results compared residents with no intervention, and residents who received personal interaction for 30 minutes a day. Interventions were conducted five days a week for 12 weeks, with follow-ups for 2 months. One of the results from this study determined that there was no significant reduction in disruptive behaviour by residents using any of the interventions.

This study found that the strongest predictors of disruptive behaviour included dementia, antipsychotic medication, bladder incontinence, tooth loss, depressed affect, recent and non recent delirium, withdrawal, restraint, vision impairment, antianxiety medication, activities of daily living, frequency of pain, and gender. Obviously, dementia is not a treatable condition; however, the remaining predictors could develop effective interventions for disruptive behaviour.

Disruptive behaviors by residents are a concern within the care facilities, shown to affect staff members, other residents and the disruptive residents themselves. However, there has been less research directed on specifically identifying the risk factors. This study was able to determine that disruptive behaviors related to treatable conditions. Although caution is necessary, the findings may have some promising implications for the intervention of disruptive behaviors in care facilities.

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## ADMISSION BACKGROUND FORM

*Addressograph*

### SECTION AA & A: IDENTIFICATION INFORMATION

AA1	UNIQUE RESIDENT IDENTIFIER	
	RESIDENT NAME	
	ROOM NUMBER	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> a. Unit                      b. Room #
AA2	SEX	<input type="checkbox"/> M. Male <input type="checkbox"/> F. Female <input type="checkbox"/> O. Other
AA3a	BIRTH DATE	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year                      Month                      Day
AA3b	ESTIMATED BIRTH DATE?	Birth date is estimated. <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
AA4a	TREATY/BAND	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Band                      Treaty                      Placement
A5	MARITAL STATUS	1. Never married                      4. Separated 2. Married                                      5. Divorced 3. Widowed                                      9. Unknown
AA5a	HEALTH CARD NUMBER	a. Enter the resident's health card number, or enter "0" if unknown or "1" if not applicable. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
AA5b	PROVINCE/TERRITORY ISSUING HEALTH CARD NUMBER	b. Enter the Province/Territory code issuing health card number (See manual for province/territory abbreviations) <input type="text"/> <input type="text"/>
AA6	FACILITY NUMBER	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Prov/Terr                      Facility Number (See manual for province/territory codes)
A6a	HEALTH RECORD NUMBER	a. Enter the resident's assigned record number, or enter "0" if unknown or "1" if not applicable. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
A6b	HEALTH REGISTER NUMBER	b. Enter the resident's facility assigned register number, or enter "0" if unknown or "1" if not applicable. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
AA8	REASON FOR ASSESSMENT	Primary reason for assessment 01. Admission assessment (prior to full assessment by day 14)

### SECTION AB: DEMOGRAPHIC INFORMATION

AB1	ADMISSION DATE	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year                      Month                      Day
AB2a	ADMITTED FROM FACILITY/LEVEL OF CARE (at entry)	<b>a. Facility/Level of Care</b> 00 Ambulatory Health Service 01 Inpatient Acute Care Service 02 Inpatient Rehabilitation Service (General) 03 Inpatient Continuing Care Service 04 Residential Care Service (24-hour nursing care) 05 Inpatient Psychiatry Service 06 Other/Unclassified Service 07 Inpatient Rehabilitation Service (Specialized) 08 Home Care Service 09 Residential Care Service (board and care) 10 Private Home (no home care)
AB2b	FACILITY NUMBER ADMITTED FROM	<b>b. Facility from number</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Prov/Terr                      Facility Number
AB3	LIVED ALONE (prior to entry)	<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 9. Unknown
AB4	PRIOR PRIMARY RESIDENCE POSTAL CODE	Postal code. (See manual for homeless/missing codes) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
AB5	RESIDENTIAL HISTORY (5 years prior to entry)	<i>(Check all settings resident lived in during the 5 years prior to date of entry.) Use '9' if unknown.</i> a. Prior stay at this facility b. Prior stay in other similar level of care facility c. Prior stay in other board and care facility d. Prior stay in a psychiatric facility e. Prior stay in developmental disability facility f. <b>NONE OF ABOVE</b>
AB7	EDUCATION (Highest Completed)	1. No Schooling 2. 8 <sup>th</sup> Grade or less 3. 9 <sup>th</sup> to 11 <sup>th</sup> Grade 4. High School 5. Technical or Trade School 6. Some College 7. Bachelor's Degree 8. Graduate Degree 9. Unknown

= when box blank, must enter number or letter

a = when letter in box, or when instructed to do so, check if condition applies

AB/MDS 2.0  
June 2002

**SECTION AB: DEMOGRAPHIC INFORMATION (cont'd)**

<b>AB8</b>	<b>LANGUAGE</b>	Primary language <i>(See CCRS manual for additional codes)</i> eng. English      fra. French	
<b>AB9</b>	<b>MENTAL HEALTH HISTORY</b>	Does resident's RECORD indicate any history of mental illness, or developmental disability problem?  0. No      1. Yes	
<b>AB10</b>	<b>CONDITIONS RELATED TO DEVELOPMENTAL DISABILITY STATUS</b>	<i>(Check all conditions that are related to developmental disability)</i> a. Not applicable--no developmental disability <i>(Skip to item AC1)</i> <i>Development disability with organic condition:</i>	a
		b. Down's syndrome	b
		c. Autism	c
		d. Epilepsy	d
		e. Other developmental disability related to organic condition	e
		f. Development disability with no organic condition	f
		g. NONE OF ABOVE	g

**SECTION AC: CUSTOMARY ROUTINE (only at 1<sup>st</sup> admission)**

In the year prior to date of entry to this facility, or year last in community if now being admitted from another facility. <i>Check one response for each.</i>			
<b>AC1</b>	<b>CYCLE OF DAILY EVENTS</b>	a. Stays up late at night (e.g. after 9:00 pm) b. Naps regularly during day (at least 1 hour) c. Goes out 1+ days a week d. Stays busy with hobbies, reading or fixed daily routine e. Spends most of time alone or watching TV f. Moves independently indoors (with appliances, if used) g. Uses tobacco products at least daily	No Yes Unknown
	<b>EATING PATTERNS</b>	i. Distinct food preferences j. Eats between meals all or most days k. Use of alcoholic beverages at least weekly	
	<b>ADL PATTERNS</b>	m. In bedclothes much of the day n. Wakens to toilet all or most nights o. Has irregular bowel movement pattern p. Showers for bathing q. Bathing in the PM	
	<b>INVOLVEMENT PATTERNS</b>	s. Daily contact with relatives or close friends t. Usually attends church, temple, synagogue, etc. u. Finds strength in faith v. Daily animal companion or presence w. Involved in group activities	

**SIGNATURES OF PERSONS COMPLETING THESE ITEMS:**

Signature	Title	Date

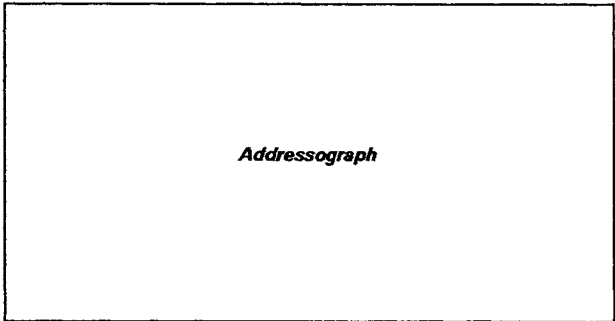
= when box blank, must enter number or letter

a = when letter in box, or when instructed to do so, check if condition applies

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## DEMOGRAPHIC CHANGES

### SECTION AA & A: IDENTIFICATION INFORMATION

AA1	UNIQUE RESIDENT IDENTIFIER		
	RESIDENT NAME		
AA2	SEX	M. Male	F. Female
		O. Other	
AA3a	BIRTH DATE	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
		Year	Month
			Day
AA3b	ESTIMATED BIRTH DATE?	Birth date is estimated.	0. No
			1. Yes
AA6	FACILITY NUMBER	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
		Prov/Terr	Facility Number
		(See manual for province/territory codes)	
AA5a	HEALTH CARD NUMBER	a. Enter the resident's health card number, or enter "0" if unknown or "1" if not applicable.	
		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
AA5b	PROVINCE/TERRITORY ISSUING HEALTH CARD NUMBER	b. Enter the Province/Territory code issuing health card number (See manual for province/territory abbreviations)	
		<input type="text"/> <input type="text"/>	
A6a	HEALTH RECORD NUMBER	a. Enter the resident's assigned record number, or enter "0" if unknown or "1" if not applicable.	
		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
A6b	HEALTH REGISTER NUMBER	b. Enter the resident's facility assigned register number, or enter "0" if unknown or "1" if not applicable.	
		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
AA8	REASON FOR ASSESSMENT	Primary reason for assessment	
		00. Change Demographics	
Z7	DATE OF CHANGE	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
		Year	Month
			Day

### SECTION AB: DEMOGRAPHIC INFORMATION

AB1	ADMISSION DATE	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
		Year	Month	Day

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## DISCHARGE TRACKING FORM

(Do not use for temporary visits home)

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### SECTION AA & A: DEMOGRAPHIC INFORMATION

AA1	UNIQUE RESIDENT IDENTIFIER			
	RESIDENT NAME			
AA2	SEX	M. Male	F. Female	O. Other
AA3a	BIRTH DATE	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Year	Month	Day
AA3b	ESTIMATED BIRTH DATE	Birth date is estimated. 0. No 1. Yes		
AA4a	TREATY/BAND	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Band	Treaty	Placement
AA6	FACILITY NUMBER	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Prov/Terr	Facility Number	
		(See manual for province/territory abbreviations)		
AA5a	HEALTH CARD NUMBER	a. Enter the resident's health card number, or enter "0" if unknown or "1" if not applicable.		
		<input type="text"/>		
AA5b	PROVINCE/TERRITORY ISSUING HEALTH CARD NUMBER	b. Enter the Province/Territory code issuing health card number (See CCRS manual for province/territory codes)		
		<input type="text"/>		
A6a	HEALTH RECORD NUMBER	a. Enter the resident's assigned record number, or enter "0" if unknown or "1" if not applicable.		
		<input type="text"/>		
A6b	HEALTH REGISTER NUMBER	b. Enter the resident's facility assigned register number, or enter "0" if unknown or "1" if not applicable.		
		<input type="text"/>		
AA8	REASON FOR ASSESSMENT	Primary reason for assessment 06. Discharged—return not anticipated 07. Discharged—return anticipated 08. Discharged prior to completing initial assessment		

### SECTION R: DISCHARGE STATUS

R3a	DISCHARGED TO: FACILITY/ LEVEL OF CARE	<p>a. Code for resident disposition upon discharge</p> <p>00 Ambulatory Health Service</p> <p>01 Inpatient Acute Care Service</p> <p>02 Inpatient Rehabilitation Service (General)</p> <p>03 Inpatient Continuing Care Service</p> <p>04 Residential Care Service (24-hour nursing care)</p> <p>05 Inpatient Psychiatry Service</p> <p>06 Other/Unclassified Service</p> <p>07 Inpatient Rehabilitation Service (Specialized)</p> <p>08 Home Care Service</p> <p>09 Residential Care Service (board and care)</p> <p>10 Private Home (no home care)</p> <p>11 Deceased</p>
R3b	DISCHARGED TO FACILITY NUMBER	<p>b. Facility number</p> <p><input type="text"/></p>
		Prov/Terr Facility Number (See manual for province/territory codes)
R4	DISCHARGE DATE	<input type="text"/>
		Year Month Day

### SIGNATURES OF PERSONS COMPLETING THESE ITEMS:

Signatures	Title	Date

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## FACILITY PROFILE

### SECTION AF: FACILITY PROFILE INFORMATION

AF1	FACILITY NAME	
AF2	SITE NAME	
AA6	FACILITY NUMBER	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> <span style="font-size: 8px;">Prov/Terr</span> </div> <div style="border: 1px solid black; width: 40px; height: 20px; display: flex; align-items: center; justify-content: center;"> <span style="font-size: 8px;">Facility Number</span> </div> </div> <p style="font-size: 8px;">(See manual for province/territory codes)</p>
AF5	ADDRESS	<p>a) Street Address 1</p> <hr/> <p>b) Street Address 2</p> <hr/> <p>c) City <span style="float: right;">d) Province/Territory</span></p> <div style="border: 1px solid black; width: 100%; height: 15px; margin-top: 5px;"></div> <p>e) Postal Code</p>
AF6a	FACILITY ADMINISTRATOR	
AF6b1	ADMINISTRATOR PHONE NUMBER	<input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 20px; height: 15px;" type="text"/>
AF6b2	ADMINISTRATOR PHONE NUMBER EXTENSION	<input style="width: 40px; height: 15px;" type="text"/>
AF6c	ADMINISTRATOR FAX NUMBER	<input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 20px; height: 15px;" type="text"/>
AF6d	ADMINISTRATOR E-MAIL ADDRESS	
AF7a	HEALTH RECORDS (HR) CONTACT	
AF7b1	HR CONTACT PHONE NUMBER	<input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 20px; height: 15px;" type="text"/>
AF7b2	HR CONTACT PHONE NUMBER EXTENSION	<input style="width: 40px; height: 15px;" type="text"/>
AF7c	HR CONTACT FAX NUMBER	<input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 20px; height: 15px;" type="text"/>

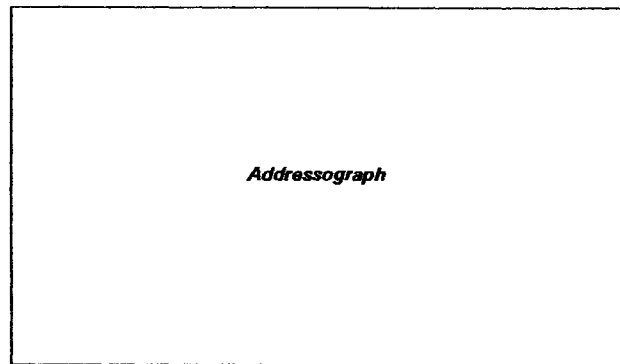
AF7d	HR CONTACT E-MAIL ADDRESS	
AF8a	DATABASE CONTACT	
AF8b1	DATABASE CONTACT PHONE NUMBER	<input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 20px; height: 15px;" type="text"/>
AF8b2	DATABASE CONTACT PHONE NUMBER EXTENSION	<input style="width: 40px; height: 15px;" type="text"/>
AF8c	DATABASE CONTACT FAX NUMBER	<input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 20px; height: 15px;" type="text"/> - <input style="width: 20px; height: 15px;" type="text"/>
AF8d	DATABASE CONTACT E-MAIL ADDRESS	
AF9a	VENDOR	
AF10	CODING CLASSIFICATION SYSTEM USED	<p>0. None</p> <p>1. ICD-9</p> <p>2. ICD-9-CM</p> <p>3. ICD-10-CA</p>
AF11	DESIGNATED NUMBER OF MOH BEDS	<input style="width: 20px; height: 15px;" type="text"/> Number
AF12	SUBMITTING FACILITY/LEVEL OF CARE	<p>03 Inpatient Continuing Care Service</p> <p>04 Residential Care Service (24-hour nursing care)</p> <p>06 Other/Unclassified Service</p> <p>09 Residential Care Service (board and care)</p>
AF13	OWNERSHIP	<p>1. Proprietary</p> <p>2. Religious</p> <p>3. Lay (not for profit, non-profit voluntary association, societies)</p> <p>4. Municipal</p> <p>5. Provincial/Territorial</p> <p>6. Federal</p>
AF14	PREFERRED COMMUNICATION	<p>a) Submission Media</p> <p>E. Electronic</p> <p>D. Diskette (default)</p> <p>b) Report Media</p> <p>E. Electronic</p> <p>F. Fax (default)</p>
AA13	DATE PROFILE UPDATED	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 40px; height: 15px; display: flex; align-items: center; justify-content: center;"> <span style="font-size: 8px;">Year</span> </div> <div style="border: 1px solid black; width: 30px; height: 15px; display: flex; align-items: center; justify-content: center;"> <span style="font-size: 8px;">Month</span> </div> <div style="border: 1px solid black; width: 30px; height: 15px; display: flex; align-items: center; justify-content: center;"> <span style="font-size: 8px;">Day</span> </div> </div>

# Minimum Data Set (MDS) 2.0<sup>®</sup> Canadian Version

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## FULL ASSESSMENT



### SECTION AA & A: IDENTIFICATION INFORMATION

AA1	UNIQUE RESIDENT IDENTIFIER			
	RESIDENT NAME			
	ROOM NUMBER	<input type="text"/>	<input type="text"/>	<input type="text"/>
		a. Unit	b. Room #	
AA2	SEX	M. Male	F. Female	O. Other
A3	ASSESSMENT REFERENCE DATE	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Year	Month	Day
AA3a	BIRTH DATE	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Year	Month	Day
AA3b	ESTIMATED BIRTH DATE	Birth date is estimated. 0. No 1. Yes		
AA4a	TREATY/BAND	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Band	Treaty	Placement
A5	MARITAL STATUS	1. Never married	4. Separated	
		2. Married	5. Divorced	
		3. Widowed	9. Unknown	
AA6	FACILITY NUMBER	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Prov/Terr	Facility Number	
		(See manual for province/territory codes)		
AA5a	HEALTH CARD NUMBER	a. Enter the resident's health card number, or enter "0" if unknown or "1" if not applicable.		
		<input type="text"/>		
AA5b	PROVINCE/TERRITORY OF ISSUE	b. Enter the Province/Territory code issuing health card number. (See CCRS manual for province/territory codes)		
		<input type="text"/>		
A6a	HEALTH RECORD NUMBER	a. Enter the resident's assigned record number, or enter "0" if unknown or "1" if not applicable.		
		<input type="text"/>		
A6b	HEALTH REGISTER NUMBER	b. Enter the resident's facility assigned register number, or enter "0" if unknown or "1" if not applicable.		
		<input type="text"/>		

A7	RESPONSIBILITY FOR PAYMENT	(Check all that apply in LAST 30 DAYS.)	
		a. Provincial/territory government plan (for resident of province/territory)	a
		b. Other province/territory (resident of Canada)	b
		c. Federal government—Department of Veteran Affairs (DVA)	c
		d. Federal government—First Nations and Inuit Health Branch (FNIHB)	d
		e. Federal government—other (RCMP, Canadian Armed Forces, federal penitentiary inmate, refugee)	e
		f. Worker's compensation board (WCB/WSIB)	f
		g. Canadian resident, private insurance pay	g
		h. Canadian resident, public trustee pay	h
		i. Canadian resident, self pay	i
		j. Other country resident, self pay	j
		k. Responsibility for payment unknown/unavailable	k
AA8	REASON FOR ASSESSMENT	Primary reason for assessment	
		01. Admission assessment (before day 14)	
		02. Full annual assessment	
		03. Significant change in status assessment	
		04. Significant correction of prior full assessment	
A9	RESPONSIBILITY/LEGAL GUARDIAN	(Check all that apply. Use '9' if unknown on admission only.)	
		a. Legal guardian	a
		b. Durable power of attorney/financial	b
		c. Other legal oversight	c
		d. Family member responsible	d
		e. Endurable power of attorney/health care	e
		f. Resident responsible for self	f
		g. NONE OF ABOVE	g
A10	ADVANCED DIRECTIVES	(For those items with supporting documentation in the medical record, check all that apply. Use '9' if unknown on admission only.)	
		a. Living will	a
		b. Do not resuscitate	b
		c. Do not hospitalize	c
		d. Organ donation	d
		e. Autopsy request	e
		f. Feeding restrictions	f
		g. Medication restrictions	g
		h. Other treatment restrictions	h
		i. NONE OF ABOVE	i



= when box blank, must enter number or letter



= when letter in box, or when instructed to do so, check if condition applies

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 ○ - indicates variable used in RUG calculation

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**SECTION AB: DEMOGRAPHIC INFORMATION**

<b>ADMISSION DATE</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
	Year	Month	Day

**SECTION B: COGNITIVE PATTERNS**

<b>B1</b>	<b>COMATOSE</b> *O	<i>(Persistent vegetative state or no discernible consciousness)</i> 0. No      1. Yes (Skip to item G1)	
<b>B2</b>	<b>MEMORY</b>	<i>(Recall of what was learned or known)</i> a. Short-term memory OK—seems or appears to recall after 5 minutes 0. Memory OK    1. Memory problem *O b. Long-term memory OK—seems or appears to recall long past 0. Memory OK    1. Memory problem	
<b>B3</b>	<b>MEMORY/ RECALL ABILITY</b>	<i>(Check all that resident was normally able to recall during the LAST 7 DAYS.)</i> a. Current season b. Location of own room c. Staff names/faces d. That he/she is in a facility e. <i>NONE OF ABOVE</i> are recalled	a b c d e
<b>B4</b>	<b>COGNITIVE SKILLS FOR DAILY DECISION MAKING</b> *O	<i>(Made decisions regarding tasks of daily life.)</i> 0. INDEPENDENT—decisions consistent and reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues or supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions	
<b>B5</b>	<b>INDICATORS OF DELIRIUM-PERIODIC DISORDERED THINKING/AWARENESS</b>	<i>(Code for behaviour in LAST 7 DAYS.) Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behaviour over this time.</i> 0. Behaviour not present 1. Behaviour present, not of recent onset 2. Behaviour present, over last 7 days appears different from resident's usual functioning (e.g. new onset or worsening) a. EASILY DISTRACTED (e.g. difficulty paying attention, gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS (e.g. moves lips or talks to someone not present; believes he or she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH (e.g. speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS (e.g. fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY (e.g. sluggishness; staring into space; difficult to arouse; little bodily movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY (e.g. sometimes better, sometimes worse; behaviours sometimes present, sometimes not)	
<b>B6</b>	<b>CHANGE IN COGNITIVE STATUS</b>	Resident's cognitive status, skills or abilities have changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No change    1. Improved    2. Deteriorated	

**SECTION C: COMMUNICATION/HEARING PATTERNS**

<b>C1</b>	<b>HEARING</b>	<i>(With hearing appliance, if used)</i> 0. HEARS ADEQUATELY—normal talk, TV, phone 1. MINIMAL DIFFICULTY—when not in quiet setting 2. HEARS IN SPECIAL SITUATION ONLY—speaker has to adjust tonal quality and speak distinctly 3. HIGHLY IMPAIRED or absence of useful hearing	
<b>C2</b>	<b>COMMUNICATION DEVICES/ TECHNIQUES</b>	<i>(Check all that apply during LAST 7 DAYS.)</i> a. Hearing aid, present and used regularly b. Hearing aid, present and not used regularly c. Other receptive communication techniques used (e.g. lip reading) d. <i>NONE OF ABOVE</i>	a b c d
<b>C3</b>	<b>MODES OF EXPRESSION</b>	<i>(Check all used by resident to make needs known.)</i> a. Speech b. Writing messages to express or clarify needs c. American sign language or Braille d. Signs or gestures or sounds e. Communication board f. Other g. <i>NONE OF ABOVE</i>	a b c d e f g
<b>C4</b>	<b>MAKING SELF UNDERSTOOD</b> O	<i>(Expressing information content—however able)</i> 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY OR NEVER UNDERSTOOD	
<b>C5</b>	<b>SPEECH CLARITY</b>	<i>(Code for speech in LAST 7 DAYS.)</i> 0. CLEAR SPEECH—distinct, intelligible words 1. UNCLEAR SPEECH—slurred, mumbled words 2. NO SPEECH—absence of spoken words	
<b>C6</b>	<b>ABILITY TO UNDERSTAND OTHERS</b>	<i>(Understanding verbal information content—however able)</i> 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part or intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY OR NEVER UNDERSTANDS	
<b>C7</b>	<b>CHANGE IN COMMUNICATION/ HEARING</b>	Resident's ability to express, understand, or hear information has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No Change    1. Improved    2. Deteriorated	

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**SECTION D: VISION PATTERNS**

D1	<b>VISION</b>	<p>(Able to see in adequate light and with glasses, if used)</p> <p>0. <b>ADEQUATE</b>—sees fine detail, including regular print in newspapers or books</p> <p>1. <b>IMPAIRED</b>—sees large print, but not regular print in newspapers or books</p> <p>2. <b>MODERATELY IMPAIRED</b>—limited vision; not able to see newspaper headlines, but can identify objects</p> <p>3. <b>HIGHLY IMPAIRED</b>—object identification in question, but eyes appear to follow objects</p> <p>4. <b>SEVERELY IMPAIRED</b>—no vision or sees only light, colours or shapes; eyes do not appear to follow objects</p>	
D2	<b>VISUAL LIMITATIONS/DIFFICULTIES</b>	<p>a. Side vision problems—decreased peripheral vision (e.g. leaves food on one side of tray, difficulty travelling, bumps into people and objects, misjudges placement of chair when seating self)</p> <p>0. No 1. Yes</p> <p>b. Experiences any of the following: sees halos or rings around lights, sees flashes of light, sees “curtains” over eyes</p> <p>0. No 1. Yes</p>	
D3	<b>VISUAL APPLIANCES</b>	<p>Glasses; contact lenses; magnifying glass</p> <p>0. No 1. Yes</p>	

**SECTION E: MOOD AND BEHAVIOUR PATTERNS**

E1	<b>INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD</b> ⊙	<p>(Code for indicators observed in LAST 30 DAYS, irrespective of the assumed cause.)</p> <p>0. Indicator not exhibited in last 30 days</p> <p>1. Indicator of this type exhibited up to 5 days a week</p> <p>2. Indicator of this type exhibited daily or almost daily (6, 7 days)</p> <p><b>VERBAL EXPRESSIONS OF DISTRESS</b></p> <p>a. Resident made negative statements (e.g. “Nothing matters; Would rather be dead; What’s the use; Regrets having lived so long; Let me die.”) *</p> <p>b. Repetitive questions: (e.g. “Where do I go? What do I do?”)</p> <p>c. Repetitive verbalizations (e.g. Calling out for help; “God help me.”)</p> <p>d. Persistent anger with self or others (e.g. easily annoyed, anger at placement in facility; anger at care received)</p> <p>e. Self deprecation (e.g. “I am nothing, of no use to anyone.”)</p> <p>f. Expressions of what appear to be unrealistic fears (e.g. fear of being abandoned, left alone, being with others)</p> <p>g. Recurrent statements that something terrible is about to happen (e.g. believes is about to die, have a heart attack) *</p> <p>h. Repetitive health complaints (e.g. persistently seeks medical attention, obsessive concern with body functions)</p> <p>i. Repetitive anxious complaints or concerns—non-health (e.g. persistently seeks attention or reassurance regarding schedules, meals, laundry or clothing, relationship issues)</p> <p><b>SLEEP-CYCLE ISSUES</b></p> <p>j. Unpleasant mood in morning *</p> <p>k. Insomnia or change in usual sleep pattern</p> <p><b>SAD, APATHETIC, ANXIOUS APPEARANCE</b></p> <p>l. Sad, pained, worried facial expressions (e.g. furrowed brows)</p> <p>m. Crying, tearfulness</p> <p>n. Repetitive physical movements (e.g. pacing, hand wringing, restlessness, fidgeting, picking) *</p>	
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		<b>LOSS OF INTEREST</b>																
		<p>o. Withdrawal from activities of interest (e.g. no interest in longstanding activities or being with family, friends) *</p> <p>p. Reduced social interaction *</p>																
E2	<b>MOOD PERSISTENCE</b> *	<p>One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to “cheer up”, console, or reassure the resident in LAST 7 DAYS.</p> <p>0. No mood indicators</p> <p>1. Indicators present, easily altered</p> <p>2. Indicators present, not easily altered</p>																
E3	<b>CHANGE IN MOOD</b>	<p>Resident’s mood status has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days).</p> <p>0. No change 1. Improved 2. Deteriorated</p>																
E4	<b>BEHAVIOURAL SYMPTOMS</b> ⊙	<p>(Code for behaviour in LAST 7 DAYS.)</p> <p>A. Behavioural symptom frequency in last 7 days</p> <p>0. Behaviour not exhibited in last 7 days</p> <p>1. Behaviour of this type occurred on 1 to 3 days in last 7 days</p> <p>2. Behaviour of this type occurred 4 to 6 days, but less than daily</p> <p>3. Behaviour of this type occurred daily</p> <p>B. Behavioural symptom alterability in last 7 days</p> <p>0. Behaviour not present—OR—behaviour was easily altered</p> <p>1. Behaviour was not easily altered</p>	<table border="1"> <tr> <td></td> <td>A</td> <td>B</td> </tr> <tr> <td>*</td> <td></td> <td></td> </tr> <tr> <td>*</td> <td></td> <td></td> </tr> <tr> <td>*</td> <td></td> <td></td> </tr> <tr> <td>*</td> <td></td> <td></td> </tr> </table>		A	B	*			*			*			*		
	A	B																
*																		
*																		
*																		
*																		
E5	<b>CHANGE IN BEHAVIOURAL SYMPTOMS</b>	<p>Resident’s behavioural status has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days).</p> <p>0. No change 1. Improved 2. Deteriorated</p>																

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**SECTION F: PSYCHOSOCIAL WELL-BEING**

F1	<b>SENSE OF INITIATIVE/ INVOLVEMENT</b>	a. At ease interacting with others	a		
		b. At ease doing planned or structured activities	b		
		c. At ease doing self-initiated activities	c		
		d. Establishes own goals	d		
		e. Pursues involvement in life of facility (e.g. makes and keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e		
		f. Accepts invitations into most group activities	f		
		g. <i>NONE OF ABOVE</i>	g		
		F2	<b>UNSETTLED RELATIONSHIPS</b>	a. Covert/open conflict with or repeated criticism of staff	a
				b. Unhappy with roommate	b
c. Unhappy with residents other than roommate	c				
d. Openly expresses conflict/anger with family/friends	d				
e. Absence of personal contact with family or friends	e				
f. Recent loss of close family member or friend	f				
g. Does not adjust easily to change in routines	g				
h. <i>NONE OF ABOVE</i>	h				
F3	<b>PAST ROLES</b>			a. Strong identification with past roles and life status 0. No 1. Yes 9. Unknown (admission only)	
		b. Expresses sadness, anger or empty feeling over lost roles or status 0. No 1. Yes 9. Unknown (admission only)			
		c. Resident perceives that daily life (customary routine, activities) is very different from prior pattern in the community 0. No 1. Yes 9. Unknown (admission only)			

**SECTION G: PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS**

G1	<b>A. ADL SELF-PERFORMANCE</b> (Code for resident's PERFORMANCE OVER ALL SHIFTS during LAST 7 DAYS, not including setup)		A	B
	0. <b>INDEPENDENT.</b> No help or oversight—OR—help/oversight provided only 1 or 2 times during last 7 days.			
	1. <b>SUPERVISION.</b> Oversight, encouragement or cueing provided 3 or more times during last 7 days—OR—Supervision plus physical assistance provided only 1 or 2 times during last 7 days.			
	2. <b>LIMITED ASSISTANCE.</b> Resident highly involved in activity; received physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3 or more times—OR—More help provided only 1 or 2 times during last 7 days.			
	3. <b>EXTENSIVE ASSISTANCE.</b> Although resident performed part of activity, over last 7-day period, help of the following type(s) was provided 3 or more times: <ul style="list-style-type: none"> <li>• weight-bearing support</li> <li>• full staff performance during part (but not all) of last 7 days.</li> </ul>			
	4. <b>TOTAL DEPENDENCE.</b> Full staff performance of activity during entire 7 days.			
	8. <b>ACTIVITY DID NOT OCCUR</b> during entire 7 days.			
	<b>B. ADL SUPPORT PROVIDED</b> (Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during LAST 7 DAYS; code regardless of resident's self-performance classification.)			
	0. No setup or physical help from staff			
	1. Setup help only			
	2. One-person physical assist			
	3. Two + persons physical assist			
	8. ADL activity did not occur during entire 7 days			
G1a	<b>BED MOBILITY</b> * ○	How resident moves to and from lying position, turns from side to side, and positions body while in bed		
G1b	<b>TRANSFER</b> * ○	How resident moves between surfaces—to and from: bed, chair, wheelchair, standing position (EXCLUDE to and from bath and toilet)		
G1c	<b>WALK IN ROOM</b>	How resident walks between locations in own room		
G1d	<b>WALK IN CORRIDOR</b>	How resident walks in corridor on unit		
G1e	<b>LOCOMOTION ON UNIT</b> *	How resident moves between locations in own room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
G1f	<b>LOCOMOTION OFF UNIT</b>	How resident moves to and returns from off-unit locations (e.g. areas set aside for dining, activities or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
G1g	<b>DRESSING</b>	How resident puts on, fastens, and takes off all items of street clothing, including donning and removing prosthesis		
G1h	<b>EATING</b> * ○	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition)		
G1i	<b>TOILET USE</b> * ○	How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
G1j	<b>PERSONAL HYGIENE</b>	How resident maintains personal hygiene, including combing hair; brushing teeth; shaving; applying makeup; washing and drying face, hands, and perineum (EXCLUDE baths and showers)		

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**SECTION G: PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS (cont'd)**

G2	<b>BATHING</b>	How resident takes full-body bath or shower, sponge bath, and transfers in and out of tub or shower (EXCLUDE washing of back and hair). (Code for most dependent in self-performance and support.) Bathing self-performance codes are: 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Bathing did not occur during the entire 7 days  (Bathing support codes are as defined in item G1aB, "support provided" above)	A	B
G3	<b>TEST FOR BALANCE</b>	(Code for ability during test in the LAST 7 DAYS.) 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test or doesn't follow directions 3. Not able to attempt test without physical help a. Balance while standing b. Balance while sitting—position, trunk control		
G4	<b>FUNCTIONAL LIMITATION IN RANGE OF MOTION *</b>	(Code for limitations during LAST 7 DAYS that interfered with daily functions or put resident at risk of injury.) A. RANGE OF MOTION      B. VOLUNTARY MOVEMENT 0. No limitation              0. No loss 1. Limitation on 1 side      1. Partial loss 2. Limitation on both sides      2. Full loss a. Neck b. Arm—including shoulder or elbow c. Hand—including wrist or fingers d. Leg—including hip or knee e. Foot—including ankle or toes f. Other limitation or loss	A	B
G5	<b>MODES OF LOCOMOTION</b>	(Check all that apply during LAST 7 DAYS.) a. Cane, walker, or crutch b. Wheeled self c. Other person wheeled d. Wheelchair primary mode of locomotion e. NONE OF ABOVE		a b c d e
G6	<b>MODES OF TRANSFER</b>	(Check all that apply during LAST 7 DAYS.) a. Bedfast all or most of the time * b. Bed rails used for bed mobility or transfer c. Lifted manually d. Lifted mechanically e. Transfer aid (e.g. slide board, trapeze, cane, walker, brace) f. NONE OF ABOVE		a b c d e f
G7	<b>TASK SEGMENTATION</b>	Some or all of ADL activities were broken into sub-tasks during LAST 7 DAYS so that resident could perform them. 0. No                              1. Yes		
G8	<b>ADL FUNCTIONAL REHAB. POTENTIAL</b>	(Check all that apply during LAST 7 DAYS.) a. Resident believes self to be capable of increased independence in at least some ADLs b. Direct care staff believe resident is capable of increased independence in at least some ADLs c. Resident able to perform tasks/activity but is very slow d. Difference in ADL self-performance or ADL support, comparing mornings to evenings e. NONE OF ABOVE		a b c d e
G9	<b>CHANGE IN ADL FUNCTION</b>	Resident's ADL Self-Performance status has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No change    1. Improved    2. Deteriorated		

**SECTION H: CONTINENCE IN LAST 14 DAYS**

H1	<b>CONTINENCE SELF-CONTROL CATEGORIES (Code for performance over all shifts.)</b> 0. CONTINENT—Complete control 1. USUALLY CONTINENT—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. OCCASIONALLY INCONTINENT—BLADDER, 2+ times a week but not daily; BOWEL, once a week 3. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g. on day shift); BOWEL, 2 or 3 times a week 4. INCONTINENT—Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time		
H1a	<b>BOWEL CONTINENCE *</b>	Control of bowel movement, with appliance or bowel continence programs, if used	
H1b	<b>BLADDER CONTINENCE *</b>	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g. foley) or continence programs, if used	
H2	<b>BOWEL ELIMINATION PATTERN</b>	(Check all that apply in LAST 14 DAYS.) a. Bowel elimination pattern regular—at least 1 movement every 3 days b. Constipation c. Diarrhea d. Fecal impaction * e. NONE OF ABOVE	a b c d e
H3	<b>APPLIANCES AND PROGRAMS</b>	(Check all that apply in LAST 14 DAYS.) a. Any scheduled toileting plan * b. Bladder retraining program * c. External (condom) catheter d. Indwelling catheter * e. Intermittent catheter f. Did not use toilet, commode, urinal g. Pads or briefs used h. Enemas, irrigation i. Ostomy present * j. NONE OF ABOVE	a b c d e f g h i j
H4	<b>CHANGE IN URINARY CONTINENCE</b>	Resident's urinary continence has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No change    1. Improved    2. Deteriorated	

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**SECTION I: DISEASE DIAGNOSES**

*(Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behaviour status, medical treatments, nurse monitoring, or risk of death. Do not list inactive diagnoses.)*

<b>I1</b>	<b>DISEASES</b>	<i>(If none of I1a-I1uu apply, CHECK item I1vv)</i>	
		<b>ENDOCRINE/METABOLIC/NUTRITIONAL</b>	
		a. Diabetes mellitus <input checked="" type="checkbox"/>	a
		b. Hyperthyroidism	b
		c. Hypothyroidism	c
		<b>HEART/CIRCULATION</b>	
		d. Arteriosclerotic heart disease (ASHD)	d
		e. Cardiac dysrhythmia	e
		f. Congestive heart failure	f
		g. Deep vein thrombosis	g
		h. Hypertension	h
		i. Hypotension	i
		j. Peripheral vascular disease	j
		k. Other cardiovascular disease	k
		<b>MUSCULOSKELETAL</b>	
		l. Arthritis	l
		m. Hip fracture	m
		n. Missing limb (e.g. amputation)	n
		o. Osteoporosis	o
		p. Pathological bone fracture	p
		<b>NEUROLOGICAL</b>	
		q. Amyotrophic lateral sclerosis (ALS)	q
		r. Alzheimer's disease	r
		s. Aphasia <input checked="" type="checkbox"/>	s
		t. Cerebral palsy <input checked="" type="checkbox"/>	t
		u. Cerebrovascular accident (stroke)	u
		v. Dementia other than Alzheimer's disease	v
		w. Hemiplegia/hemiparesis <input checked="" type="checkbox"/>	w
		x. Huntington's chorea	x
		y. Multiple sclerosis <input checked="" type="checkbox"/>	y
		z. Paraplegia	z
		aa. Parkinson's disease	aa
		bb. Quadriplegia <input checked="" type="checkbox"/>	bb
		cc. Seizure disorder	cc
dd. Transient ischemic attack (TIA)	dd		
ee. Traumatic brain injury	ee		
<b>PSYCHIATRIC/MOOD</b>			
ff. Anxiety disorder	ff		
gg. Depression	gg		
hh. Manic depressive (bipolar disease) *	hh		
ii. Schizophrenia *	ii		
<b>PULMONARY</b>			
jj. Asthma	jj		
kk. Emphysema/ COPD	kk		
<b>SENSORY</b>			
ll. Cataracts	ll		
mm. Diabetic retinopathy	mm		
nn. Glaucoma	nn		
oo. Macular degeneration	oo		
<b>OTHER</b>			
pp. Allergies	pp		
qq. Anemia	qq		
rr. Cancer	rr		
ss. Gastrointestinal disease	ss		
tt. Liver disease	tt		
uu. Renal failure	uu		
vv. NONE OF ABOVE	vv		
<b>I2</b>	<b>INFECTIONS</b>	<i>(If none of I2a-I2m apply, CHECK item I2n.)</i>	
	a. Antibiotic resistant infection (e.g. Methicillin resistant staph)		a
	b. Cellulitis		b
	c. Clostridium difficile		c
	d. Conjunctivitis		d
	e. HIV infection		e
	f. Pneumonia <input checked="" type="checkbox"/>		f

		g. Respiratory infection	g
		h. Septicemia <input checked="" type="checkbox"/>	h
		i. Sexually transmitted diseases	i
		j. Tuberculosis (active)	j
		k. Urinary tract infection in LAST 30 DAYS *	k
		l. Viral hepatitis	l
		m. Wound infection	m
		n. NONE OF ABOVE	n
<b>I3</b>	<b>OTHER CURRENT DIAGNOSIS AND ICD-10-CA CODES</b>	a	
		b	
		c	
		d	
		e	
		f	

**SECTION J: HEALTH CONDITIONS**

*(Check all problems present in LAST 7 DAYS UNLESS OTHER TIME FRAME IS INDICATED.)*

<b>J1</b>	<b>PROBLEM CONDITIONS</b>	<b>INDICATORS OF FLUID STATUS</b>	
		a. Weight gain or loss of 1.5 or more kilograms in last 7 days (3 lbs.)	a
		b. Inability to lie flat due to shortness of breath	b
		c. Dehydrated; e.g. output exceeds intake * <input checked="" type="checkbox"/>	c
		d. Insufficient fluid; did NOT consume all or almost all liquids provided during LAST 3 DAYS	d
		<b>OTHER</b>	
		e. Delusions <input checked="" type="checkbox"/>	e
		f. Dizziness/vertigo	f
		g. Edema	g
		h. Fever <input checked="" type="checkbox"/>	h
		i. Hallucinations * <input checked="" type="checkbox"/>	i
		j. Internal bleeding <input checked="" type="checkbox"/>	j
k. Recurrent lung aspirations in LAST 90 DAYS	k		
l. Shortness of breath	l		
m. Syncope (fainting)	m		
n. Unsteady gait	n		
o. Vomiting <input checked="" type="checkbox"/>	o		
p. NONE OF ABOVE	p		
<b>J2</b>	<b>PAIN SYMPTOMS</b>	<i>(Code for the highest level of pain present in LAST 7 DAYS.)</i>	
	a. <b>FREQUENCY</b> with which resident complains or shows evidence of pain: 0. No pain <i>(Skip to J4)</i> 1. Pain less than daily      2. Pain daily		
	b. <b>INTENSITY</b> of pain: 1. Mild pain      2. Moderate pain 3. Times when pain is horrible or excruciating		
<b>J3</b>	<b>PAIN SITE</b>	<i>(Check all sites where pain was present in LAST 7 DAYS.)</i>	
	a. Back pain	a	
	b. Bone pain	b	
	c. Chest pain during usual activities	c	
	d. Headache	d	
	e. Hip pain	e	
	f. Incisional pain	f	
	g. Joint pain (other than hip)	g	
	h. Soft tissue pain (e.g. lesion, muscle)	h	
	i. Stomach pain	i	
	j. Other site	j	
<b>J4</b>	<b>ACCIDENTS</b>	<i>(CHECK all that apply.)</i>	
	a. Fell in PAST 30 DAYS *		a
	b. Fell in PAST 31 to 180 DAYS		b
	c. Hip fracture in LAST 180 DAYS *		c
	d. Other fracture in LAST 180 DAYS *		d
	e. NONE OF ABOVE		e

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**SECTION J: HEALTH CONDITIONS (cont'd)**

J5	STABILITY OF CONDITIONS	<i>(Check all that apply.)</i> a. Conditions or diseases make resident's cognitive, ADL, mood, or behaviour patterns unstable (fluctuating, precarious, or deteriorating) b. Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem c. End-stage disease; 6 months or less to live * d. NONE OF ABOVE	<input type="checkbox"/>	a
			<input type="checkbox"/>	b
			<input type="checkbox"/>	c
			<input type="checkbox"/>	d

**SECTION K: ORAL/NUTRITIONAL STATUS**

K1	ORAL PROBLEMS	<i>(Check all that apply in LAST 7 DAYS.)</i> a. Chewing problem b. Swallowing problem	a b	c. Mouth pain d. NONE OF ABOVE	c d
K2	HEIGHT AND WEIGHT	a. <i>(Record height in centimetres)</i> b. <i>(Record weight in kilograms)</i> Base weight on most recent measure in LAST 30 DAYS; measure weight consistently in accord with standard facility practice (e.g. in AM after voiding, before meal, with shoes off, and in nightclothes).	a. HEIGHT (cm.) b. WEIGHT (kg.)		
K3	WEIGHT CHANGE	a. Weight loss—5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS. b. Weight gain—5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS	0. No 1. Yes 9. Unknown (admission only)		
K4	NUTRITIONAL PROBLEMS	<i>(Check all that apply in LAST 7 DAYS.)</i> a. Complains about the taste of many foods b. Regular or repetitive complaints of hunger c. Leaves 25% or more of food uneaten at most meals d. NONE OF ABOVE	a b c d		
K5	NUTRITIONAL APPROACHES	<i>(Check all that apply in LAST 7 DAYS.)</i> a. Parenteral/IV b. Feeding tube c. Mechanically altered diet d. Syringe (oral feeding) e. Therapeutic diet	a b c d e	f. Dietary supplement between meals g. Plate guard, stabilized built-up utensil, etc. h. On a planned weight change program i. NONE OF ABOVE	f g h i
K6	PARENTERAL OR ENTERAL INTAKE	<i>(Skip to Section L if neither 5a nor 5b is checked.)</i> a. Code the proportion of total calories the resident received through parenteral or tube feedings in the LAST 7 DAYS b. Code the average fluid intake per day by IV or tube in the last 7 days	0. None 1. 1% to 25% 2. 26% to 50% 3. 51% to 75% 4. 76% to 100%		

**SECTION L: ORAL/DENTAL STATUS**

L1	ORAL STATUS AND DISEASE PREVENTION	<i>(Check all that apply in LAST 7 DAYS.)</i> a. Debris (soft, easily removable substances) present in mouth prior to going to bed at night b. Has dentures and/or removable bridge c. Some or all natural teeth lost—does not have or does not use dentures (or partial plates) d. Broken, loose, or carious teeth e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses, ulcers or rashes f. Daily cleaning of teeth or dentures, or daily mouth care—by resident or staff g. NONE OF ABOVE	a b c d e f g
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**SECTION M: SKIN CONDITION**

M1	ULCERS (due to any cause)	<i>(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply in LAST 7 DAYS. Code 9 for 9 or more.) Requires a full body exam.</i> a. Stage 1—A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved b. Stage 2—A partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater c. Stage 3—A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue d. Stage 4—A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone	
M2	TYPE OF ULCER	<i>(For each type of ulcer, code for the highest stage in LAST 7 DAYS using scale in item M1—i.e., 0 = none; stages 1, 2, 3, 4.)</i> a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	* *
M3	HISTORY OF RESOLVED ULCERS	Resident has had a pressure ulcer that was resolved or cured in last 90 days. 0. No 1. Yes	
M4	OTHER SKIN PROBLEMS OR LESIONS PRESENT	<i>(Check all that apply during LAST 7 DAYS.)</i> a. Abrasions, bruises b. Burns (second or third degree) c. Open lesions other than ulcers, rashes or cuts (e.g. cancer lesions) d. Rashes (e.g. intertrigo, eczema, drug/heat rash, herpes) e. Skin desensitized to pain or pressure f. Skin tears or cuts (other than surgery) g. Surgical wounds h. NONE OF ABOVE	a b c d e f g h
M5	SKIN TREATMENTS	<i>(Check all that apply during LAST 7 DAYS.)</i> a. Pressure relieving device(s) for chair b. Pressure relieving device(s) for bed c. Turning or repositioning program d. Nutrition or hydration intervention to manage skin problems e. Ulcer care f. Surgical wound care g. Application of dressings (with or without topical medications) other than to feet h. Application of ointments or medications (except to feet) i. Other preventative or protective skin care (except to feet) j. NONE OF ABOVE	a b c d e f g h i j
M6	FOOT PROBLEMS AND CARE	<i>(Check all that apply during LAST 7 DAYS.)</i> a. Resident has one or more foot problems (e.g. corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems) b. Infection of the foot (e.g. cellulitis, purulent drainage) c. Open lesions on the foot d. Nails or callouses trimmed during LAST 90 DAYS e. Received preventative or protective foot care (e.g. used special shoes, inserts, pads, toe separators) f. Application of dressings (with or without topical meds) g. NONE OF ABOVE	a b c d e f g

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**SECTION N: ACTIVITY PURSUIT PATTERNS**

N1	TIME AWAKE * $\odot$	(Check appropriate time periods over LAST 7 DAYS.) Resident awake all or most of the time (i.e. naps no more than 1 hour per time period) in the: a. Morning b. Afternoon c. Evening d. NONE OF ABOVE	a b c d
(If resident is comatose, skip to Section O.)			
N2	AVERAGE TIME INVOLVED IN ACTIVITIES *	(When awake and not getting treatment or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None	
N3	PREFERRED ACTIVITY SETTINGS	(Check all settings in which activities are preferred.) a. Own room b. Day or activity room c. Inside facility/off unit d. Outside facility e. NONE OF ABOVE	a b c d e
N4	GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)	(Check all PREFERENCES whether or not activity is currently available to resident.) a. Cards, other games b. Crafts or arts c. Exercise or sports d. Music e. Reading, writing f. Spiritual or religious activities g. Trips or shopping h. Walk/wheeling outdoors i. Watching TV j. Gardening or plants k. Talking or conversing l. Helping others m. NONE OF ABOVE	a b c d e f g h i j k l m
N5	PREFERS CHANGE IN DAILY ROUTINE	(Code for resident preferences in daily routine.) 0. No change 1. Slight change 2. Major change a. Type of activities in which resident is currently involved b. Extent of resident involvement in activities	

**SECTION O: MEDICATIONS**

O1	NUMBER OF MEDICATIONS	(Record the NUMBER of different MEDICATIONS used in the LAST 7 DAYS. Enter "00" if none used.)	
O2	NEW MEDICATIONS	Resident currently receiving medications that were initiated during the LAST 90 DAYS. 0. No 1. Yes 9. Unknown (admission only)	
O3	INJECTIONS $\odot$	(Record the NUMBER OF DAYS injections of any type were received during the LAST 7 DAYS. Enter "0" if none used.)	
O4	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the NUMBER OF DAYS during LAST 7 DAYS; enter "0" if not used. N.B. Enter "1" for long-acting medications used less than weekly.) a. Antipsychotic * b. Antianxiety * c. Antidepressant * d. Hypnotic * e. Diuretic f. Analgesic	* * * *  *

**SECTION P: SPECIAL TREATMENTS AND PROCEDURES**

P1a	SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS	<b>SPECIAL CARE</b> —(Check treatments or programs received in LAST 14 DAYS.) <b>TREATMENTS</b> a. Chemotherapy $\odot$ b. Dialysis $\odot$ c. IV medication $\odot$ d. Intake/output e. Monitoring acute medical condition f. Ostomy care g. Oxygen therapy $\odot$ h. Radiation $\odot$ i. Suctioning $\odot$ j. Trach. Care $\odot$ k. Transfusions $\odot$ l. Ventilator or respirator $\odot$ <b>PROGRAMS</b> m. Alcohol or drug treatment program n. Alzheimer's or dementia special care unit o. Hospice care p. Pediatric care q. Respite care r. Training in skills to return to the community (e.g. taking medications, house-work, shopping, transportation, ADLs) s. NONE OF ABOVE	a b c d e f g h i j k l	m n o p q r s
P1b		<b>THERAPIES</b> —(Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the LAST 7 DAYS. Enter "0" if none or less than 15 minutes daily.) Note: Count only post-admission therapies. Box A = # of days administered for 15 minutes or more Box B = total # of minutes provided in last 7 days		A B
P2	INTERVENTION PROGRAMS FOR MOOD, BEHAVIOUR, COGNITIVE LOSS	(Check all interventions or strategies used in the LAST 7 DAYS, no matter where received.) a. Special behaviour symptom evaluation program b. Evaluation by a licensed mental health specialist in LAST 90 DAYS c. Group therapy d. Resident-specific deliberate changes in the environment to address mood or behaviour patterns (e.g. providing bureau in which to rummage) e. Reorientation (e.g. cueing) f. NONE OF ABOVE		a b c d e f
P3	NURSING REHABILITATION/ RESTORATIVE CARE $\odot$	(Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the LAST 7 DAYS. Enter "0" if none or less than 15 minutes daily.) a. Range of motion (passive) b. Range of motion (active) c. Splint or brace assistance <b>Training and skill practice in:</b> d. Bed mobility e. Transfer f. Walking g. Dressing or grooming h. Eating or swallowing i. Amputation or prosthesis care j. Communication k. Other		

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**SECTION P: SPECIAL TREATMENTS AND PROCEDURES**

<b>P4</b>	<b>DEVICES AND RESTRAINTS</b>	<i>(Use the following codes for the LAST 7 DAYS:)</i> 0. Not used    1. Used less than daily    2. Used daily	
	a. Full bed rails on all open sides of bed		
	b. Other types of side rails used (e.g. half rail, 1 side)		
	c. Trunk restraint	*	
	d. Limb restraint	*	
	e. Chair prevents rising	*	
<b>P5</b>	<b>HOSPITAL STAY(s)</b>	Record number of times resident was admitted to hospital in the LAST 90 DAYS (or since last assessment). Enter "00" if no admission.	
<b>P6</b>	<b>EMERGENCY ROOM (ER) VISIT(s)</b>	Record number of times resident visited ER in the LAST 90 DAYS (or since last assessment if less than 90 days). Enter "00" if no ER visits.	
<b>P7</b>	<b>PHYSICIAN VISITS</b> ⊙	In the LAST 14 DAYS (or since admission, if less than 14 days in facility), how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter "00" if none.)	
<b>P8</b>	<b>PHYSICIAN ORDERS</b> ⊙	In the LAST 14 DAYS (or since admission, if less than 14 days in facility), on how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter "00" if none.)	
<b>P9</b>	<b>ABNORMAL LAB VALUES</b>	Has the resident had any abnormal lab values during the LAST 90 DAYS (or since admission)? 0. No                                  1. Yes	

**SECTION Q: DISCHARGE POTENTIAL AND OVERALL STATUS**

<b>Q1</b>	<b>DISCHARGE POTENTIAL</b>	a. Resident expresses or indicates preference to return to the community. 0. No                                  1. Yes	
		b. Resident has a support person who is positive towards discharge. 0. No                                  1. Yes	
		c. Stay projected to be of a short duration – Discharge projected WITHIN 90 DAYS. (Do not include expected discharge due to death.) 0. No                                  2. Within 31–90 days 1. Within 30 days                  3. Discharge status uncertain	
<b>Q2</b>	<b>OVERALL CHANGE IN CARE NEEDS</b>	Resident's overall level of self-sufficiency has changed significantly as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support	

**SECTION R: ASSESSMENT INFORMATION**

<b>R1</b>	<b>PARTICIPATION IN ASSESSMENT</b>	a. Resident:    0. No    1. Yes	
		b. Family:      0. No    1. Yes    2. No family	
		c. Significant other: 0. No.    1. Yes    2. None	

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**SECTION R: ASSESSMENT INFORMATION (cont'd)**

SIGNATURES OF THOSE COMPLETING THE ASSESSMENT					Provider Type	Assessor ID #
_____ Signature of RN Assessment Coordinator (sign on above line)					<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>R2b. Date RN Assessment Coordinator signed as complete</b>						
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>						
Year		Month		Day		
Other Signatures	Title	Sections	Date	_____ _____ _____ _____ _____ _____ _____ _____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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**SECTION U: MEDICATION LIST**

List all medications that the resident received during the LAST 7 DAYS. Include scheduled medications that are used regularly, but less than weekly

1. **Medication name and dose ordered.**
2. **Route of administration (RA).** Code the route of administration using the following codes:  
 01 = by mouth (PO)    02 = sublingual (SL)    03 = intramuscular (IM)    04 = intravenous (IV)    05 = subcutaneous (SC)  
 06 = rectally (PR)    07 = topical    08 = inhalation    09 = enteral tube    10 = other
3. **Frequency.** Code the number of times per day, week or month that the medication is administered using the following list:  
 prn = as necessary    q1h = every 1 hour    q2h = every 2 hours    q3h = every 3 hours    q4h = every 4 hours  
 q6h = every 6 hours    q8h = every 8 hours    od = once a day    hs = at bedtime    bid = two times daily  
 tid = three times daily    qid = four times daily    eod = every other day    1wk = once a week    2wk = twice a week  
 3wk = three times a week    4wk = four times a week    5wk = five times a week    1mo = once a month    2mo = twice a month  
 cont = continuous    othr = other
4. **Amount Administered.** Record the number of tablets, capsules, suppositories, or liquid (any route) per dose administered to the resident. Code 999 for topicals, eyedrops, inhalants and oral medications that need to be dissolved in water.
5. **PRN – number of doses.** If the frequency code for the medication is "PRN" record the number of times during the last 7 days that each PRN medication was given. Code "99" for STAT medications given once.
6. **DIN Number—Drug Information Number** for each medication given. Be sure to enter the correct DIN for the drug name, strength and form. The DIN must match the drug dispensed by the pharmacy.

	1. Medication Name and Dose Ordered	2. RA	3. Frequency	4. Amount Administered	5. PRN Number of Doses	6. DIN Number
A						
B						
C						
D						
E						
F						
G						
H						
I						
J						
K						
L						
M						
N						
O						
P						
Q						
R						
S						
T						

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## QUARTERLY ASSESSMENT

*Addressograph*

### SECTION AA & A: IDENTIFICATION INFORMATION

AA1	UNIQUE RESIDENT IDENTIFIER	
	RESIDENT NAME	
	ROOM NUMBER	<input type="text"/> <input type="text"/> a. Unit                      b. Room #
AA2	SEX	M. Male    F. Female    O. Other
A3	ASSESSMENT REFERENCE DATE	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year                      Month                      Day
A3a	BIRTH DATE	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year                      Month                      Day
A3b	ESTIMATED BIRTH DATE?	Birth date is estimated    0. No    1. Yes
A4a	TREATY/BAND	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Band                      Treaty                      Placement
A5	MARITAL STATUS	1. Never married                      4. Separated 2. Married                                      5. Divorced 3. Widowed                                      9. Unknown
AA6	FACILITY NUMBER	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Prov/Terr                      Facility Number (See manual for province/territory codes)
AA5a	HEALTH CARD NUMBER	a. Enter the resident's health card number, or enter "0" if unknown or "1" if not applicable. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
AA5b	PROVINCE/TERRITORY ISSUING HEALTH CARD NUMBER	b. Enter the Province/Territory code issuing health card number (See manual for province/territory abbreviations) <input type="text"/> <input type="text"/>
A6a	HEALTH RECORD NUMBER	a. Enter the resident's assigned record number, or enter "0" if unknown or "1" if not applicable. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
A6b	HEALTH REGISTER NUMBER	b. Enter the resident's facility assigned register number, or enter "0" if unknown or "1" if not applicable. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

AA8	REASON FOR ASSESSMENT	Primary reason for assessment 05. Quarterly review assessment 10. Significant correction of prior quarterly assessment	
A9	RESPONSIBILITY/LEGAL GUARDIAN	(Check all that apply.) a. Legal guardian b. Durable power of attorney/financial c. Other legal oversight d. Family member responsible e. Endurable power of attorney/health care f. Resident responsible for self g. NONE OF ABOVE	a b c d e f g
A10	ADVANCED DIRECTIVES	(For those items with supporting documentation in the medical record, check all that apply.) a. Living will b. Do not resuscitate c. Do not hospitalize d. Organ donation e. Autopsy request f. Feeding restrictions g. Medication restrictions h. Other treatment restrictions i. NONE OF ABOVE	a b c d e f g h i

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**SECTION B: COGNITIVE PATTERNS**

B1	COMATOSE * 0	(Persistent vegetative state or no discernible consciousness) 0. No 1. Yes (Skip to item G1)	
B2	MEMORY	(Recall of what was learned or known) a. Short-term memory OK—seems or appears to recall after 5 minutes 0. Memory OK 1. Memory problem * 0 b. Long-term memory OK—seems or appears to recall long past 0. Memory OK 1. Memory problem	
B3	MEMORY/ RECALL ABILITY	(Check all that resident was normally able to recall during the LAST 7 DAYS.) a. Current season b. Location of own room c. Staff names and faces d. That he/she is in a facility e. NONE OF ABOVE recalled	a
			b
			c
			d
			e
B4	COGNITIVE SKILLS FOR DAILY DECISION MAKING * 0	(Made decisions regarding tasks of daily life.) 0. INDEPENDENT—decisions consistent and reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues or supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions	
B5	INDICATORS OF DELIRIUM-PERIODIC DISORDERED THINKING/AWARENESS	(Code for behaviour in LAST 7 DAYS.) Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behaviour over this time. 0. Behaviour not present 1. Behaviour present, not of recent onset 2. Behaviour present, over last 7 days appears different from resident's usual functioning (e.g. new onset or worsening) a. EASILY DISTRACTED (e.g. difficulty paying attention, gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS (e.g. moves lips or talks to someone not present; believes he or she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH (e.g. speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS (e.g. fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY (e.g. sluggishness; staring into space; difficult to arouse; little bodily movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY (e.g. sometimes better, sometimes worse; behaviours sometimes present, sometimes not)	
B6	CHANGE IN COGNITIVE STATUS	Resident's cognitive status, skills or abilities have changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No change 1. Improved 2. Deteriorated	

**SECTION C: COMMUNICATION/HEARING PATTERNS**

C4	MAKING SELF UNDERSTOOD 0	(Expressing information content—however able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY OR NEVER UNDERSTOOD
C6	ABILITY TO UNDERSTAND OTHERS	(Understanding verbal information content—however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part or intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY OR NEVER UNDERSTANDS
C7	CHANGE IN COMMUNICATION/HEARING	Resident's ability to express, understand, or hear information has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No Change 1. Improved 2. Deteriorated

**SECTION E: MOOD AND BEHAVIOUR PATTERNS**

E1	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD 0	(Code for indicators observed in LAST 30 DAYS, irrespective of the assumed cause.) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to 5 days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days)
		<p><b>VERBAL EXPRESSIONS OF DISTRESS</b></p> <p>a. Resident made negative statements (e.g. "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die.") *</p> <p>b. Repetitive questions ("Where do I go? What do I do?")</p> <p>c. Repetitive verbalizations (e.g. Calling out for help "God help me.")</p> <p>d. Persistent anger with self or others (e.g. easily annoyed, anger at placement in facility; anger at care received)</p> <p>e. Self deprecation (e.g. "I am nothing, of no use to anyone.")</p> <p>f. Expressions of what appear to be unrealistic fears (e.g. fear of being abandoned, left alone, being with others)</p> <p>g. Recurrent statements that something terrible is about to happen (e.g. believes is about to die, have a heart attack) *</p> <p>h. Repetitive health complaints (e.g. persistently seeks medical attention, obsessive concern with body functions)</p> <p>i. Repetitive anxious complaints or concerns—non-health (e.g. persistently seeks attention or reassurance regarding schedules, meals, laundry or clothing, relationship issues)</p> <p><b>SLEEP-CYCLE ISSUES</b></p> <p>j. Unpleasant mood in morning *</p> <p>k. Insomnia or change in usual sleep pattern</p> <p><b>SAD, APATHETIC, ANXIOUS APPEARANCE</b></p> <p>l. Sad, pained, worried facial expressions (e.g. furrowed brows)</p> <p>m. Crying, tearfulness</p> <p>n. Repetitive physical movements (e.g. pacing, hand wringing, restlessness, fidgeting, picking) *</p> <p><b>LOSS OF INTEREST</b></p> <p>o. Withdrawal from activities of interest (e.g. no interest in longstanding activities or being with family, friends) *</p> <p>p. Reduced social interaction *</p>

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**SECTION E: MOOD AND BEHAVIOUR PATTERNS (cont'd)**

E2	<b>MOOD PERSISTENCE</b> *	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident in LAST 7 DAYS.  0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered		
E3	<b>CHANGE IN MOOD</b>	Resident's mood status has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days).  0. No change 1. Improved 2. Deteriorated		
E4	<b>BEHAVIOURAL SYMPTOMS</b> ○	(Code for behaviour in LAST 7 DAYS.) A. Behavioural symptom frequency in last 7 days 0. Behaviour not exhibited in last 7 days 1. Behaviour of this type occurred on 1 to 3 days in last 7 days 2. Behaviour of this type occurred 4 to 6 days, but less than daily 3. Behaviour of this type occurred daily B. Behavioural symptom alterability in last 7 days 0. Behaviour not present —OR—behaviour was easily altered 1. Behaviour was not easily altered	A	B
	*	a. <b>WANDERING</b> (moved with no rational purpose, seemingly oblivious to needs or safety)		
	*	b. <b>VERBALLY ABUSIVE BEHAVIOURAL SYMPTOMS</b> (others were threatened, screamed at, cursed at)		
	*	c. <b>PHYSICALLY ABUSIVE BEHAVIOURAL SYMPTOMS</b> (others were hit, shoved, scratched, sexually abused)		
	*	d. <b>SOCIALLY INAPPROPRIATE or DISRUPTIVE BEHAVIOURAL SYMPTOMS</b> (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behaviour or disrobing in public, smeared or threw food or feces, hoarding, rummaged in others' belongings)		
	*	e. <b>RESISTS CARE</b> (resisted taking meds or injections, ADL assistance, or eating)		
E5	<b>CHANGE IN BEHAVIOURAL SYMPTOMS</b>	Resident's behavioural status has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days).  0. No change 1. Improved 2. Deteriorated		

**SECTION F: PSYCHOSOCIAL WELL-BEING**

F1	<b>SENSE OF INITIATIVE/ INVOLVEMENT</b>	a. At ease interacting with others	a
		b. At ease doing planned or structured activities	b
		c. At ease doing self-initiated activities	c
		d. Establishes own goals	d
		e. Pursues involvement in life of facility (e.g. makes and keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e
		f. Accepts invitations into most group activities	f
		g. <b>NONE OF ABOVE</b>	g

**SECTION G: PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS**

G1	<b>A. ADL SELF-PERFORMANCE</b> (Code for resident's PERFORMANCE OVER ALL SHIFTS during LAST 7 DAYS, not including setup.) 0. <b>INDEPENDENT.</b> No help or oversight—OR—help/oversight provided only 1 or 2 times during last 7 days. 1. <b>SUPERVISION.</b> Oversight, encouragement or cueing provided 3 or more times during last 7 days—OR—Supervision plus physical assistance provided only 1 or 2 times during last 7 days. 2. <b>LIMITED ASSISTANCE.</b> Resident highly involved in activity; received physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3 or more times—OR—More help provided only 1 or 2 times during last 7 days. 3. <b>EXTENSIVE ASSISTANCE.</b> Although resident performed part of activity, over last 7-day period, help of the following type(s) was provided 3 or more times: • weight-bearing support • full staff performance during part (but not all) of last 7 days. 4. <b>TOTAL DEPENDENCE.</b> Full staff performance of activity during entire 7 days.  8. <b>ACTIVITY DID NOT OCCUR</b> during entire 7 days.			
	<b>B. ADL SUPPORT PROVIDED</b> (Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during LAST 7 DAYS; code regardless of resident's self-performance classification.)			
	0. No setup or physical help from staff 1. Setup help only 2. One-person physical assist 3. Two+ persons physical assist 8. ADL activity did not occur during entire 7 days			
			<b>A</b>	<b>B</b>
			<b>SELF-PERFORMANCE</b>	<b>SUPPORT PROVIDED</b>
G1a	<b>BED MOBILITY</b> * ○	How resident moves to and from lying position, turns from side to side, and positions body while in bed		
G1b	<b>TRANSFER</b> * ○	How resident moves between surfaces—to and from: bed, chair, wheelchair, standing position (EXCLUDE to and from bath and toilet)		
G1c	<b>WALK IN ROOM</b>	How resident walks between locations in own room		
G1d	<b>WALK IN CORRIDOR</b>	How resident walks in corridor on unit		
G1e	<b>LOCOMOTION ON UNIT</b> *	How resident moves between locations in own room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
G1f	<b>LOCOMOTION OFF UNIT</b>	How resident moves to and returns from off-unit locations (e.g. areas set aside for dining, activities or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
G1g	<b>DRESSING</b>	How resident puts on, fastens, and takes off all items of street clothing, including donning and removing prosthesis		
G1h	<b>EATING</b> * ○	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition)		
G1i	<b>TOILET USE</b> * ○	How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
G1j	<b>PERSONAL HYGIENE</b>	How resident maintains personal hygiene, including combing hair; brushing teeth; shaving; applying makeup; washing and drying face, hands, and perineum (EXCLUDE baths and showers)		

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**SECTION G: PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS**

G2	<b>BATHING</b>	How resident takes full-body bath or shower, sponge bath, and transfers in and out of tub or shower (EXCLUDE Washing of back and hair). <i>Code for most dependent in self-performance.</i> Bathing self-performance codes are: 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Bathing did not occur during the entire 7 days	A		SELF-PERFORMANCE
G3	<b>TEST FOR BALANCE</b>	(Code for ability during test in the LAST 7 DAYS.) 0. Maintained position as required in test 1. Unsteady, but able to rebalance without physical support 2. Partial physical support during test or doesn't follow directions 3. Not able to attempt test without physical help a. Balance while standing b. Balance while sitting—position, trunk control			
G4	<b>FUNCTIONAL LIMITATION IN RANGE OF MOTION *</b>	(Code for limitations during LAST 7 DAYS that interfered with daily functions or put resident at risk of injury.) <b>A. RANGE OF MOTION</b> <b>B. VOLUNTARY MOVEMENT</b> 0. No limitation                      0. No loss 1. Limitation on 1 side              1. Partial loss 2. Limitation on both sides      2. Full loss	A	B	
G6	<b>MODES OF TRANSFER</b>	(Check all that apply during LAST 7 DAYS.) a. Bedfast all or most of the time * b. Bed rails used for bed mobility or transfer f. NONE OF ABOVE	a	b	f
G7	<b>TASK SEGMENTATION</b>	Some or all of ADL activities were broken into sub-tasks during LAST 7 DAYS so that resident could perform them. 0. No                      1. Yes			
G9	<b>CHANGE IN ADL FUNCTION</b>	Resident's ADL Self-Performance status has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No change    1. Improved    2. Deteriorated			

**SECTION H: CONTINENCE IN LAST 14 DAYS**

CONTINENCE SELF-CONTROL CATEGORIES (Code for performance over all shifts.)	
0. CONTINENT—Complete control	3. FREQUENTLY INCONTINENT-BLADDER, tended to be incontinent daily, but some control present (e.g. on day shift); BOWEL, 2 or 3 times a week
1. USUALLY CONTINENT-BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly	4. INCONTINENT—Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time
2. OCCASIONALLY INCONTINENT-BLADDER, 2+ times a week but not daily; BOWEL, once a week	
H1a	<b>BOWEL CONTINENCE *</b> Control of bowel movement, with appliance or bowel continence programs, if used
H1b	<b>BLADDER CONTINENCE *</b> Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g. foley) or continence programs, if used

**SECTION H: CONTINENCE IN LAST 14 DAYS (cont'd)**

H2	<b>BOWEL ELIMINATION PATTERN</b>	(Check all that apply in LAST 14 DAYS.) c. Diarrhea d. Fecal impaction * e. NONE OF ABOVE	c	d	e			
H3	<b>APPLIANCES AND PROGRAMS</b>	(Check all that apply in LAST 14 DAYS.) a. Any scheduled toileting plan * b. Bladder retraining program * c. External (condom) catheter d. Indwelling catheter * i. Ostomy present * j. NONE OF ABOVE	a	b	c	d	i	j
H4	<b>CHANGE IN URINARY CONTINENCE</b>	Resident's urinary continence has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No change    1. Improved    2. Deteriorated						

**SECTION I: DISEASE DIAGNOSES**

(Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behaviour status, medical treatments, nurse monitoring, or risk of death. Do not list inactive diagnoses.)	
I1	<b>DISEASES</b> (If none of I1a–I1t apply, CHECK item I1vv.) <b>ENDOCRINE/METABOLIC/NUTRITIONAL</b> a. Diabetes mellitus * <b>MUSCULOSKELETAL</b> m. Hip fracture <b>NEUROLOGICAL</b> q. Amyotrophic lateral sclerosis (ALS) s. Aphasia * t. Cerebral palsy * u. Cerebrovascular accident (stroke) v. Dementia other than Alzheimer's disease w. Hemiplegia/Hemiparesis * x. Huntington's chorea y. Multiple sclerosis * bb. Quadriplegia * <b>PSYCHIATRIC/MOOD</b> gg. Depression hh. Manic depressive (bipolar disease) * ii. Schizophrenia * <b>OTHER</b> ss. Gastrointestinal disease tt. Liver disease vv. NONE OF THE ABOVE

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**SECTION I: DISEASE DIAGNOSES (cont'd)**

I2	INFECTIONS	<i>(If none of I2a-I2m apply, CHECK item I2n.)</i>										
		a. Antibiotic resistant infection (e.g. Methicillin resistant staph)										a
		b. Cellulitis										b
		c. Clostridium difficile										c
		d. Conjunctivitis										d
		e. HIV infection										e
		f. Pneumonia										f
		g. Respiratory infection										g
		h. Septicemia										h
		i. Sexually transmitted diseases										i
		j. Tuberculosis (active)										j
		k. Urinary tract infection in last 30 days	*									k
		l. Viral hepatitis										l
		m. Wound infection										m
n. NONE OF ABOVE										n		
I3	OTHER CURRENT DIAGNOSIS AND ICD-10-CA CODES	a										
		b										
		c										
		d										
		e										
		f										

**SECTION J: HEALTH CONDITIONS (cont'd)**

J2	PAIN SYMPTOMS	<i>(Code for the highest level of pain present in LAST 7 DAYS)</i>		
		a. FREQUENCY with which resident complains or shows evidence of pain:		
		0. No pain <i>(Skip to J4)</i>		
		1. Pain less than daily		
		2. Pain daily		
		b. INTENSITY of pain:		
		1. Mild pain		
		2. Moderate pain		
		3. Times when pain is horrible or excruciating		
J4	ACCIDENTS	<i>(CHECK all that apply.)</i>		
		a. Fell in past 30 days	*	a
		b. Fell in past 31 to 180 days		b
		c. Hip fracture in last 180 days	*	c
		d. Other fracture in last 180 days	*	d
		e. NONE OF ABOVE		e
J5	STABILITY OF CONDITIONS	<i>(Check all that apply.)</i>		
		a. Conditions or diseases make resident's cognitive, ADL, mood, or behaviour patterns unstable (fluctuating, precarious, or deteriorating)		a
		b. Resident experiencing an acute episode or a flare-up of a recurrent or chronic		b
		c. End-stage disease; 6 months or less to live	* ◉	c
		d. NONE OF ABOVE		d

**SECTION J: HEALTH CONDITIONS**

J1	PROBLEM CONDITIONS	<i>(Check all problems present in last 7 days UNLESS OTHER TIME FRAME IS INDICATED.)</i>									
		<b>INDICATORS OF FLUID STATUS</b>									
		a. Weight gain or loss of 1.5 or more kilograms in last 7 days (3 lbs.)									a
		b. Inability to lie flat due to shortness of breath									b
		c. Dehydrated; e.g. output exceeds intake	*	◉							c
		d. Insufficient fluid; did NOT consume all or almost all liquids provided during last 3 days									d
		<b>OTHER</b>									
		e. Delusions									e
		f. Dizziness/vertigo									f
		g. Edema									g
		h. Fever									h
		i. Hallucinations	*	◉							i
		j. Internal bleeding									j
		k. Recurrent lung aspirations in last 90 days									k
		l. Shortness of breath									l
		m. Syncope (fainting)									m
		n. Unsteady gait									n
		o. Vomiting									o
		p. NONE OF ABOVE									p

**SECTION K: ORAL/NUTRITIONAL STATUS**

K1	ORAL PROBLEMS	<i>(Check all that apply in last 7 days.)</i>		
		a. Chewing problem		a
		b. Swallowing problem		b
		d. NONE OF ABOVE		d
K2	HEIGHT AND WEIGHT	<i>(a. Record height in centimetres) a. HEIGHT</i>		
		<i>(b. Record weight in kilograms) b. WEIGHT</i>		
		Base weight on most recent measure in LAST 30 DAYS; measure weight consistently in accord with standard facility practice (e.g. in AM after voiding, before meal, with shoes off, and in nightclothes).		
K3	WEIGHT CHANGE	a. Weight loss—5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS.		
		0. No	1. Yes	* ◉
		b. Weight gain—5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS		
		0. No	1. Yes	
K4	NUTRITIONAL PROBLEMS	<i>(Check all that apply in LAST 7 DAYS.)</i>		
		c. Leaves 25% or more of food uneaten at most meals	*	c
		d. NONE OF ABOVE		d
K5	NUTRITIONAL APPROACHES	<i>(Check all that apply in LAST 7 DAYS.)</i>		
		a. Parenteral/IV	◉	a
		b. Feeding tube	* ◉	b
		f. Dietary supplement between meals		f
		g. Plate guard, stabilized built-up utensil, etc.		g
		h. On a planned weight change program		h
		i. NONE OF ABOVE		i

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**SECTION K: ORAL/NUTRITIONAL STATUS (cont'd)**

K6	PARENTERAL OR ENTERAL INTAKE ○	(Skip to Section M if neither 5a nor 5b is checked.)	
		a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days	
		0. None                      2. 26% to 50%            4. 76% to 100%	
		1. 1% to 25%                3. 51% to 75%	
	b. Code the average fluid intake per day by IV or tube in the last 7 days		
		0. None                      3. 1001 to 1500 c	
		1. 1 to 500 cc/day            4. 1501 to 2000 cc/day	
		2. 501 to 1000                5. 2001 or more cc/day	
		cc/day	

**SECTION M: SKIN CONDITION**

M1	ULCERS (due to any cause) ○	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply in LAST 7 DAYS. Code 9 for 9 or more.) Requires a full body exam.	
		a. Stage 1—A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved	
		b. Stage 2—A partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater	
		c. Stage 3—A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue	
		d. Stage 4—A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone	
M2	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in LAST 7 DAYS using scale in item M1—i.e., 0 = none; stages 1, 2, 3, 4.)	
		a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue * ○	
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
M4	OTHER SKIN PROBLEMS OR LESIONS PRESENT	(Check all that apply during LAST 7 DAYS.)	
		a. Abrasions, bruises	a
		b. Burns (second or third degree) ○	b
		c. Open lesions other than ulcers, rashes or cuts (e.g. cancer lesions) ○	c
		d. Rashes (e.g. intertrigo, eczema, drug/heat rash, herpes)	d
		e. Skin desensitized to pain or pressure	e
		f. Skin tears or cuts (other than surgery)	f
		g. Surgical wounds ○	g
		h. NONE OF ABOVE	h
M5	SKIN TREATMENTS	(Check all that apply during LAST 7 DAYS.)	
		a. Pressure relieving device(s) for chair ○	a
		b. Pressure relieving device(s) for bed ○	b
		c. Turning or repositioning program ○	c
		d. Nutrition or hydration intervention to manage skin problems ○	d
		e. Ulcer care ○	e
		f. Surgical wound care ○	f
		g. Application of dressings (with or without topical medications) other than to feet ○	g
		h. Application of ointments or medications (except to feet) ○	h
		i. Other preventative or protective skin care (except to feet)	i

M6	FOOT PROBLEMS AND CARE	(Check all that apply during LAST 7 DAYS.)	
		a. Resident has one or more foot problems (e.g. corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems)	a
		b. Infection of the foot (e.g. cellulitis, purulent drainage) ○	b
		c. Open lesions on the foot ○	c
		d. Nails or callouses trimmed during LAST 90 DAYS	d
		e. Received preventative or protective foot care (e.g. used special shoes, inserts, pads, toe separators)	e
		f. Application of dressings (with or without topical meds) ○	f
		g. NONE OF ABOVE	g

**SECTION N: ACTIVITY PURSUIT PATTERNS**

N1	TIME AWAKE * ○	(Check appropriate time periods over LAST 7 DAYS.) Resident awake all or most of the time (i.e. naps no more than 1 hour per time period) in the:	
		a. Morning                      a                      c. Evening                      c	
		b. Afternoon                      b                      d. NONE OF ABOVE                      d	
(If resident is comatose, skip to Section O.)			
N2	AVERAGE TIME INVOLVED IN ACTIVITIES *	(When awake and not getting treatment or ADL care) 0. Most—more than 2/3 of time	
		1. Some—from 1/3 to 2/3 of time	
		2. Little—less than 1/3 of time	
		3. None	

**SECTION O: MEDICATIONS**

O1	NUMBER OF MEDICATIONS	(Record the NUMBER of different MEDICATIONS used in the LAST 7 DAYS. Enter "00" if none used.)	
O3	INJECTIONS ○	(Record the NUMBER OF DAYS injections of any type were received during the LAST 7 DAYS. Enter "0" if none used.)	
O4	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the NUMBER OF DAYS during LAST 7 DAYS; enter "0" if not used. N.B. Enter "1" for long-acting meds used less than weekly.)	
		a. Antipsychotic *	
		b. Antianxiety *	
		c. Antidepressant *	
		d. Hypnotic *	
		e. Diuretic	
		f. Analgesic	

☐ = when box blank, must enter number or letter      a = when letter in box, or when instructed to do so, check if condition applies

\* - indicates variable used in QI calculation  
○ - indicates variable used in RUG calculation

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**SECTION P: SPECIAL TREATMENTS AND PROCEDURES**

P1	SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS	<b>a. SPECIAL CARE</b> —(Check treatments or programs received in LAST 14 DAYS.)		
		<b>TREATMENTS</b>		
		a. Chemotherapy	<input type="radio"/>	a
		b. Dialysis	<input type="radio"/>	b
		c. IV medication	<input type="radio"/>	c
		d. Intake/output		d
		e. Monitoring acute medical condition		e
		f. Ostomy care		f
		g. Oxygen therapy	<input type="radio"/>	g
		h. Radiation	<input type="radio"/>	h
		i. Suctioning	<input type="radio"/>	i
		j. Trach. Care	<input type="radio"/>	j
		k. Transfusions	<input type="radio"/>	k
		l. Ventilator or respirator	<input type="radio"/>	l
		<b>PROGRAMS</b>		
		m. Alcohol or drug treatment program		m
		n. Alzheimer's or dementia special care unit		n
		o. Hospice care		o
		p. Pediatric care		p
		q. Respite care		q
		r. Training in skills to return to the community (e.g. taking medications, house-work,		r
		s. <b>NONE OF ABOVE</b>		s
		<b>b. THERAPIES</b> —(Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the LAST 7 DAYS. Enter "0" if none or less than 15 minutes daily.) Note: Count only post-admission therapies.		
		Box A = # of days administered for 15 minutes or more		
		Box B = total # of minutes provided in last 7 days		
				A B
		a. Speech—language pathology, audiology Service	<input type="radio"/>	
		b. Occupational therapy	<input type="radio"/>	
c. Physical therapy	<input type="radio"/>			
d. Respiratory therapy	<input type="radio"/>			
e. Psychological therapy (by any licensed mental health professional)				
f. Recreation therapy				

P3	NURSING REHABILITATION/ RESTORATIVE CARE	(Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the LAST 7 DAYS. Enter "0" if none or less than 15 minutes daily.)																						
		<table border="1"> <tr><td>a. Range of motion (passive)</td><td></td></tr> <tr><td>b. Range of motion (active)</td><td></td></tr> <tr><td>c. Splint or brace assistance</td><td></td></tr> <tr><td colspan="2"><b>Training and skill practice in:</b></td></tr> <tr><td>d. Bed mobility</td><td></td></tr> <tr><td>e. Transfer</td><td></td></tr> <tr><td>f. Walking</td><td></td></tr> <tr><td>g. Dressing or grooming</td><td></td></tr> <tr><td>h. Eating or swallowing</td><td></td></tr> <tr><td>i. Amputation or prosthesis care</td><td></td></tr> <tr><td>j. Communication</td><td></td></tr> <tr><td>k. Other</td><td></td></tr> </table>	a. Range of motion (passive)		b. Range of motion (active)		c. Splint or brace assistance		<b>Training and skill practice in:</b>		d. Bed mobility		e. Transfer		f. Walking		g. Dressing or grooming		h. Eating or swallowing		i. Amputation or prosthesis care		j. Communication	
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b. Range of motion (active)																								
c. Splint or brace assistance																								
<b>Training and skill practice in:</b>																								
d. Bed mobility																								
e. Transfer																								
f. Walking																								
g. Dressing or grooming																								
h. Eating or swallowing																								
i. Amputation or prosthesis care																								
j. Communication																								
k. Other																								
P4	DEVICES AND RESTRAINTS	(Use the following codes for the LAST 7 DAYS.)																						
		<table border="1"> <tr> <td>0. Not used</td> <td>1. Used less than daily</td> <td>2. Used daily</td> </tr> <tr> <td>a. Full bed rails on all open sides of bed</td> <td></td> <td></td> </tr> <tr> <td>b. Other types of side rails used (e.g. half rail, 1 side)</td> <td></td> <td></td> </tr> <tr> <td>c. Trunk restraint</td> <td>*</td> <td></td> </tr> <tr> <td>d. Limb restraint</td> <td>*</td> <td></td> </tr> <tr> <td>e. Chair prevents rising</td> <td>*</td> <td></td> </tr> </table>	0. Not used	1. Used less than daily	2. Used daily	a. Full bed rails on all open sides of bed			b. Other types of side rails used (e.g. half rail, 1 side)			c. Trunk restraint	*		d. Limb restraint	*		e. Chair prevents rising	*					
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b. Other types of side rails used (e.g. half rail, 1 side)																								
c. Trunk restraint	*																							
d. Limb restraint	*																							
e. Chair prevents rising	*																							
P7	PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission, if less than 14 days in facility), how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter "00" if none.)																						
P8	PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission, if less than 14 days in facility), on how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter "00" if none.)																						

**SECTION Q: DISCHARGE POTENTIAL AND OVERALL STATUS**

Q2	OVERALL CHANGE IN CARE NEEDS	Resident's overall level of self-sufficiency has changed significantly as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days ago). 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support
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= when box blank, must enter number or letter

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**SECTION U: MEDICATION LIST**

List all medications that the resident received during the LAST 7 DAYS. Include scheduled medications that are used regularly, but less than weekly

1. **Medication name and dose ordered.**
2. **Route of administration (RA).** Code the route of administration using the following codes:  
 01 = by mouth (PO)    02 = sublingual (SL)    03 = intramuscular (IM)    04 = intravenous (IV)    05 = subcutaneous (SC)  
 06 = rectally (PR)    07 = topical    08 = inhalation    09 = enteral tube    10 = other
3. **Frequency.** Code the number of times per day, week or month that the medication is administered using the following list:  
 prn = as necessary    q1h = every 1 hour    q2h = every 2 hours    q3h = every 3 hours    q4h = every 4 hours  
 q6h = every 6 hours    q8h = every 8 hours    od = once a day    hs = at bedtime    bid = two times daily  
 tid = three times daily    qid = four times daily    eod = every other day    1wk = once a week    2wk = twice a week  
 3wk = three times a week    4wk = four times a week    5wk = five times a week    1mo = once a month    2mo = twice a month  
 cont = continuous    othr = other
4. **Amount Administered.** Record the number of tablets, capsules, suppositories, or liquid (any route) per dose administered to the resident. Code 999 for topicals, eyedrops, inhalants and oral medications that need to be dissolved in water.
5. **PRN—number of doses.** If the frequency code for the medication is "PRN" record the number of times during the last 7 days that each PRN medication was given. Code "99" for STAT medications given once.
6. **DIN Number—Drug Information Number** for each medication given. Be sure to enter the correct DIN for the drug name, strength and form. The DIN must match the drug dispensed by the pharmacy.

	1. Medication Name and Dose Ordered	2. RA	3. Frequency	4. Amount Administered	5. PRN Number of Doses	6. DIN Number
A						
B						
C						
D						
E						
F						
G						
H						
I						
J						
K						
L						
M						
N						
O						
P						
Q						
R						
S						
T						

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 June 2002

# Minimum Data Set (MDS) 2.0<sup>®</sup> Canadian Version

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## RE-ENTRY FORM

(To be completed if discharged with anticipated return)

*Addressograph*

### SECTION AA & A: IDENTIFICATION INFORMATION

AA1	UNIQUE RESIDENT IDENTIFIER			
	RESIDENT NAME			
AA2	SEX	M. Male	F. Female	O. Other
AA3a	BIRTH DATE	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Year	Month	Day
AA3b	ESTIMATED BIRTH DATE?	Birth date is estimated.	0. No	1. Yes
AA4a	TREATY/BAND	<input type="text"/>		
		Band	Treaty	Placement
AA6	FACILITY NUMBER	<input type="text"/>	<input type="text"/>	
		Prov/Terr	Facility Number	
		(See CCRS manual for province/territory codes)		
AA5a	HEALTH CARD NUMBER	a. Health card number. Enter the resident's health care number, or enter "0" if unknown or "1" if not applicable.		
		<input type="text"/>		
AA5b	PROVINCE/TERRITORY ISSUING HEALTH CARD NUMBER	b. Enter the Province/Territory code issuing health card number (See CCRS manual for province/territory codes)		
		<input type="text"/>		
A6a	HEALTH RECORD NUMBER	a. Enter the resident's assigned record number, or enter "0" if unknown or "1" if not applicable.		
		<input type="text"/>		
A6b	HEALTH REGISTER NUMBER	b. Enter the resident's facility assigned register number, or enter "0" if unknown or "1" if not applicable.		
		<input type="text"/>		
AA8	REASON FOR ASSESSMENT	Primary reason for assessment 09. Re-entry		

### SECTION AB: DEMOGRAPHIC INFORMATION

AB1b	RE-ENTRY DATE	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Year	Month	Day
AB2c	ADMITTED FROM FACILITY/LEVEL OF CARE (at re-entry)	c. Facility/Level of Care		
		00 Ambulatory Health Service		
		01 Inpatient Acute Care Service		
		02 Inpatient Rehabilitation Service (General)		
		03 Inpatient Continuing Care Service		
		04 Residential Care Service (24-hour nursing care)		
		05 Inpatient Psychiatry Service		
		06 Other/Unclassified Service		
		07 Inpatient Rehabilitation Service (Specialized)		
		08 Home Care Service		
		09 Residential Care Service (board and care)		
		10 Private Home (no home care)		
AB2d	FACILITY ADMITTED FROM NUMBER (at re-entry)	<input type="text"/>	<input type="text"/>	
		Prov/Terr	Facility Number	
		(See CCRS manual for province/territory characters)		

SIGNATURES OF PERSONS COMPLETING THESE ITEMS		
Signatures	Title	Date