



Data Submissions Guide Version 3

Procedures and Help Manual

MED e-Care Technical Team

1/8/2013

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Introduction

The process of submitting data to CIHI can be, at times, difficult and confusing. The purpose of this quick guide is to help you navigate the MED e-Care software through the processes of:

- submitting data to CIHI
- making data corrections for CIHI
- managing those submissions from the Detailed Submission Report

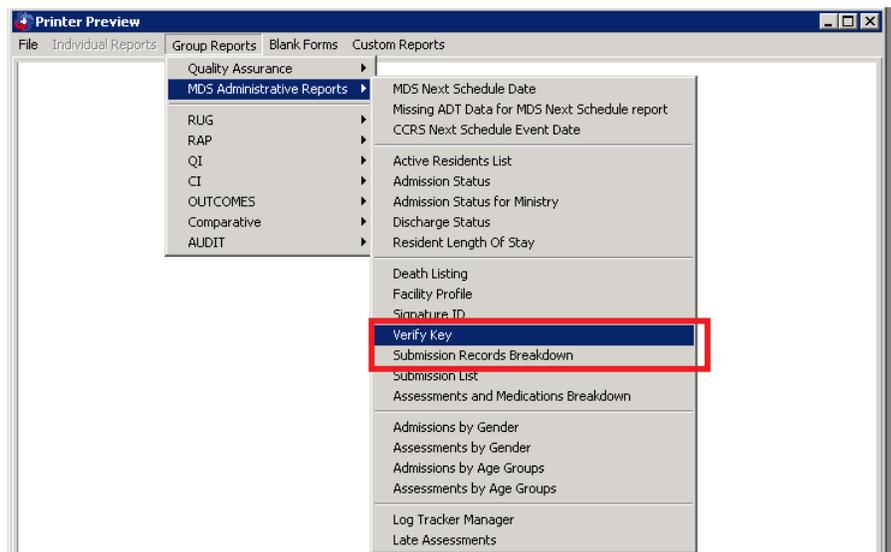
The MED e-Care software is designed in an easy to use fashion, which makes the quarterly process of submitting data to CIHI more streamlined for convenience, while also still allowing for total control of the clients health information. The MED e-Care system does this by using the CCRS/MDS Submissions to complete the quarterly assessment process. The software will help to manage the signed and submitted, rejected and accepted assessments. More importantly, the submissions have several layers of internal error checks and validations that will prevent erroneous data sent to CIHI.

Once the quarter is complete and all assessments have been signed you are ready to do submissions. There are two reports that we suggest running prior to this.

Verify Key Report – this report allows you to determine the type of assessment, the resident make sure there is a ARD date where necessary as well as if all assessments are signed. If the assessment shows no signature on this report, it will not be included in your submission to CIHI.

Submissions Records Breakdown Report –this report allows you to sort, with no parameters, to see how many assessments will be submitted as well as what type of assessments you will be submitting.

Both of these reports are available by navigating to the **Group Reports -> MDS Administrative Reports ->** then select the desired report.



Note: Submissions can be done at any time within the quarter. Some facilities prefer to do submissions monthly. For further CIHI rules on submission please refer to www.cihi.ca.

Submission Management

How to complete a Submission to CIHI

Step 1: Click "Communications", then select "Submission" from the drop-down menu.

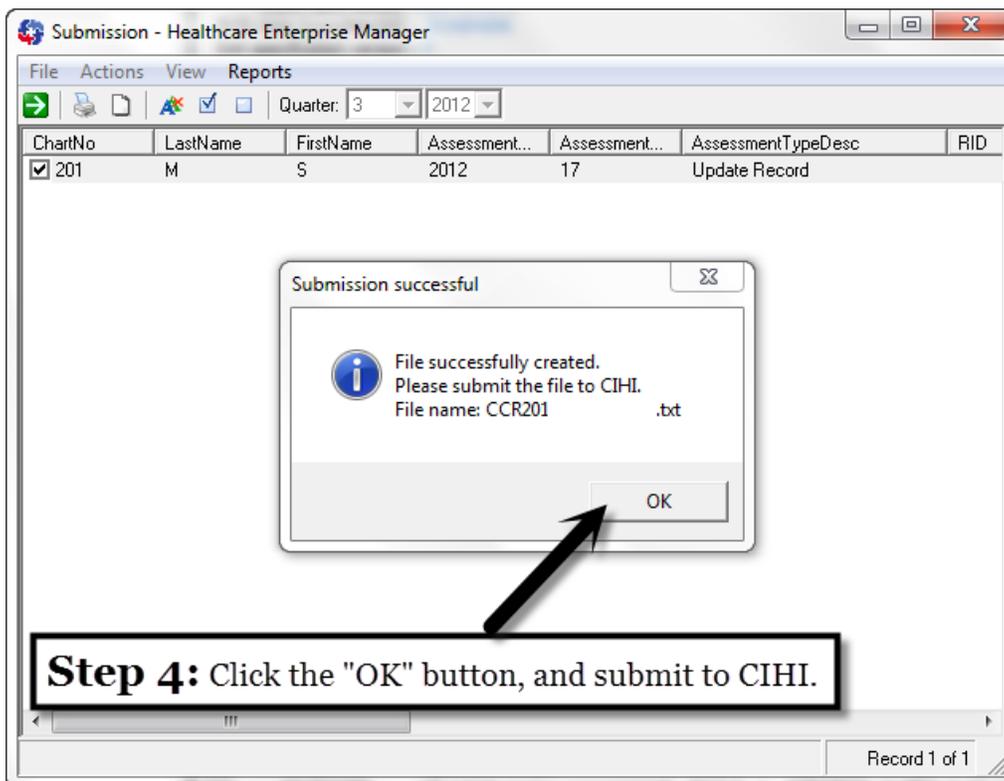
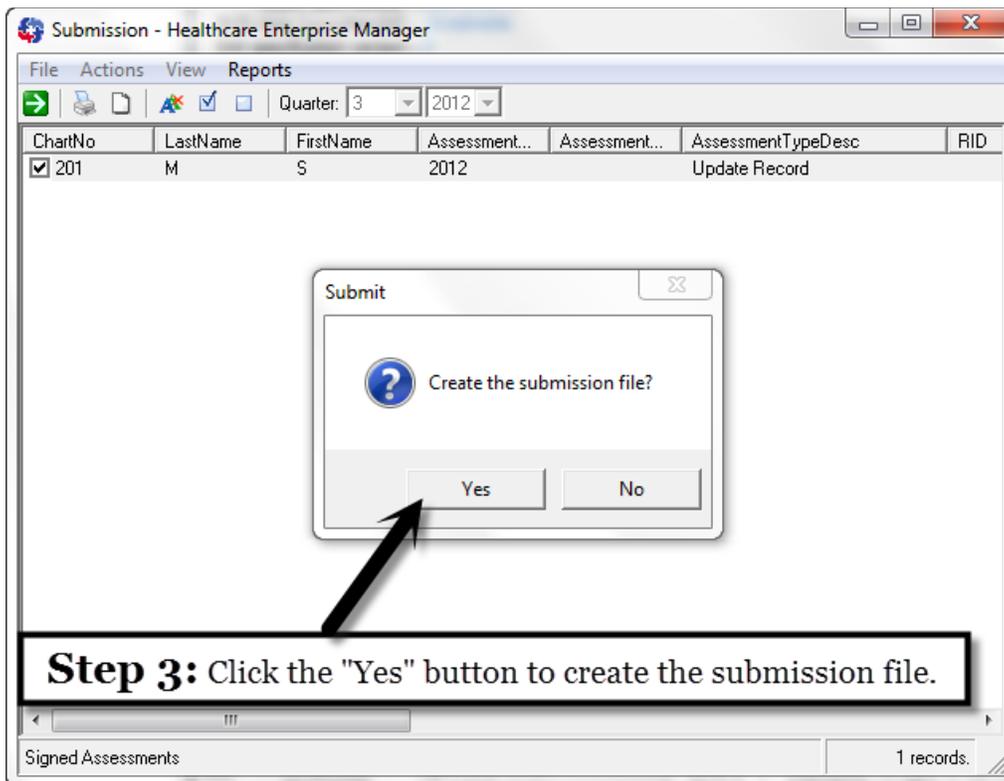
Step 2: Click "Actions", and scroll to the "Submit" button.

Assessment...	Assessment...	AssessmentTypeDesc
2009/07/06	01	Admission
2009/07/13	01	Admission assessment (require...
2009/07/25	05	Quarterly review assessment
2009/07/27	01	Admission
2009/07/11	07	Discharge, return anticipated
2009/07/14	09	Re-entry
2009/07/24	01	Admission
2009/07/02	01	Admission
2009/07/09	01	Admission assessment (require...
2009/07/10	01	Admission
2009/07/30	02	Full annual assessment
2009/08/20	07	Discharge, return anticipated
2009/08/01	01	Admission
2009/07/08	01	Admission
2009/07/15	01	Admission assessment (require...
2009/07/23	07	Discharge, return anticipated
2009/08/25	01	Admission
2009/08/26	01	Admission
2009/09/10	06	Discharge, no return
2009/07/22	07	Discharge, return anticipated

When submitting, make sure that the correct quarter and year are selected. Make sure you have selected all the necessary assessments you want to submit.

Signed Assessments: 22 records.

Feeding tubes : 0 - None
Dehydration / Fluid : 0 - None
Dental care : 0 - None
Pressure Ulcers : 0 - None
Psychotropic drug use : 0 - None



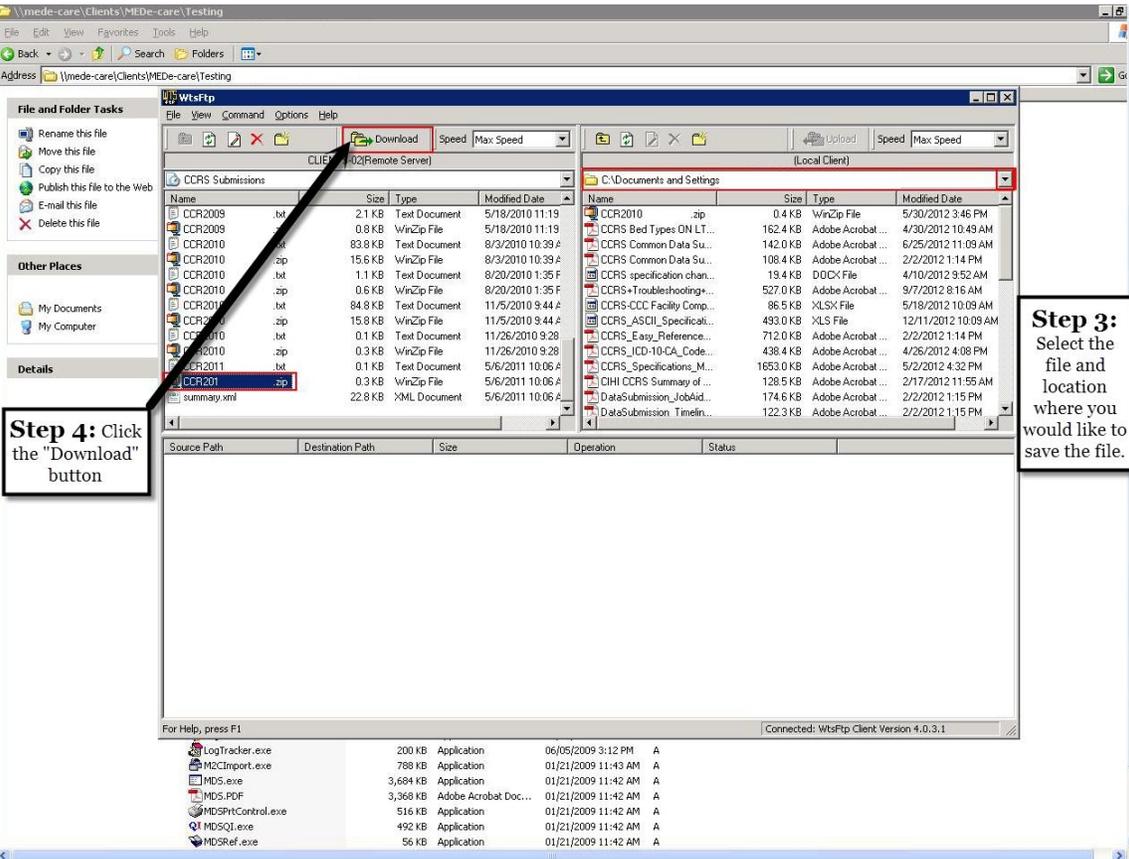
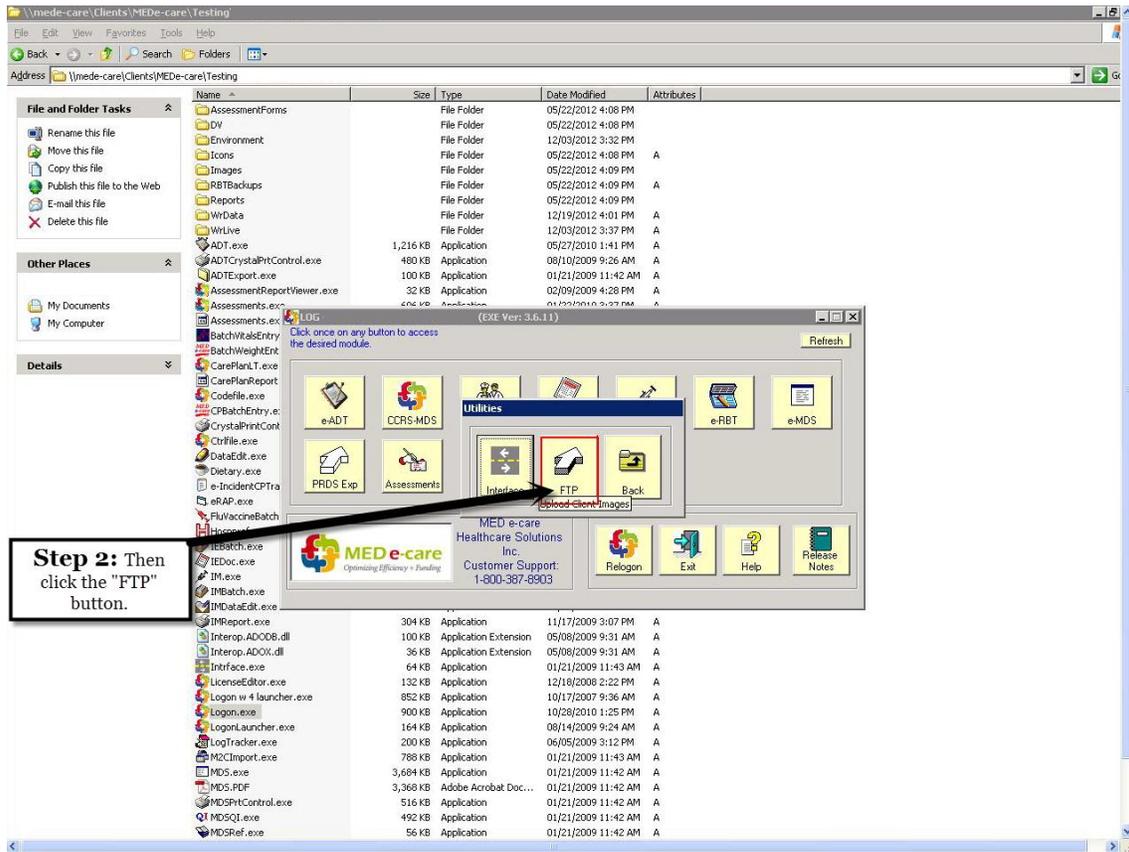
Downloading Submission File

The screenshot shows a Windows Explorer window displaying a directory structure for a client named 'MEDe-care'. The address bar shows the path: \\mede-care\Clients\MEDe-care\Testing. The file list includes folders like AssessmentForms, DV, Environment, Icons, Images, RBTBackups, Reports, WvData, WvLive, and various application files such as ADT.exe, ADTCrystalPrtControl.exe, ADTExport.exe, AssessmentReportViewer.exe, and Assessments.exe.

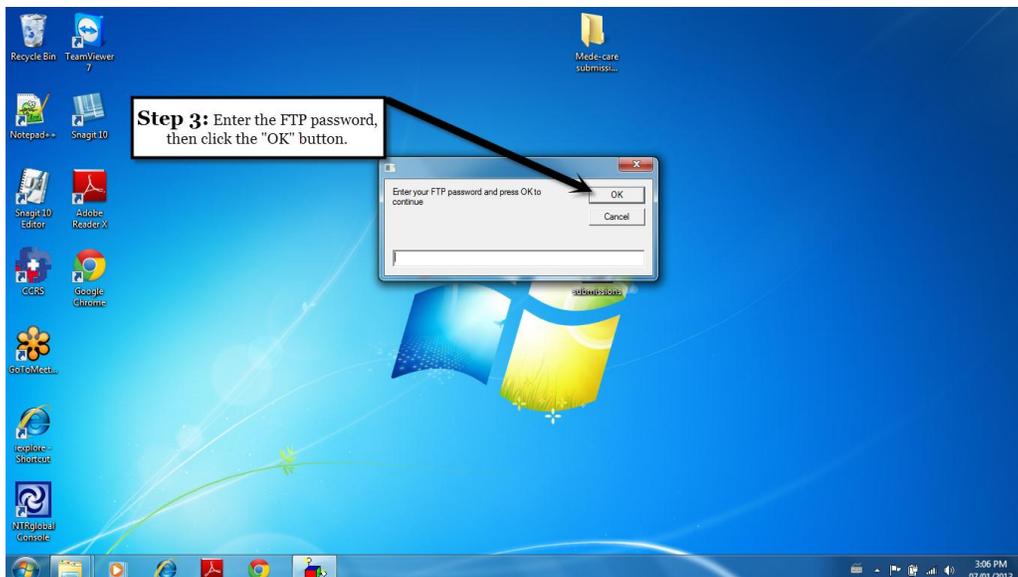
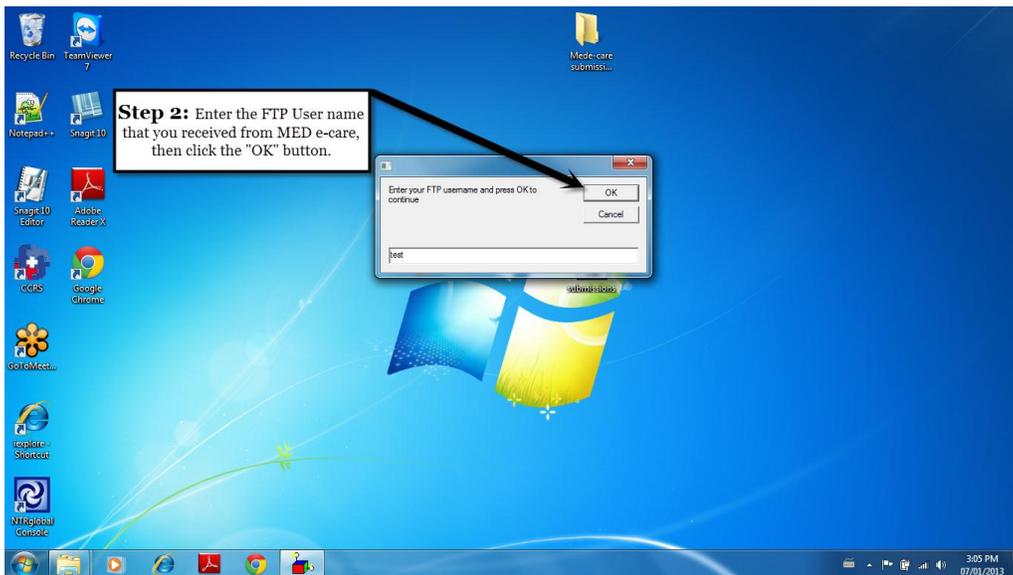
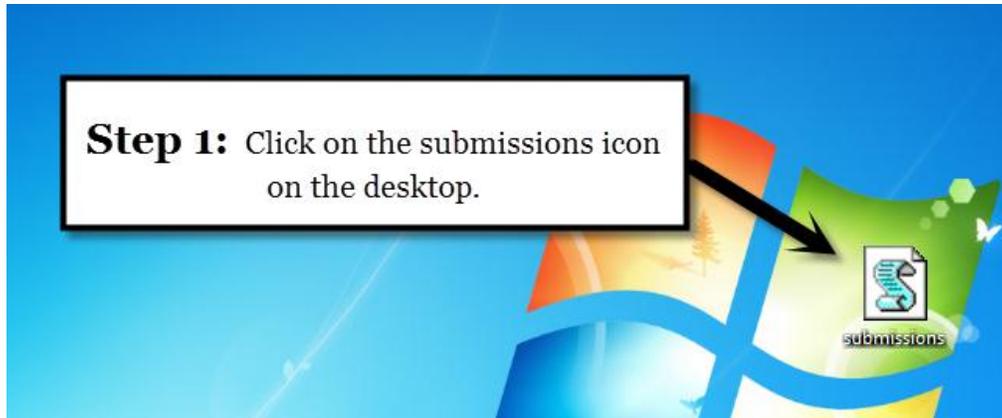
Overlaid on the Explorer window is a utility application window titled 'LOG (EXE Ver: 3.6.11)'. The window contains a grid of buttons for different modules: e-ADT, CCRS-MDS, e-Plan, e-Incident, e-Infection, e-RBT, e-MDS, PRDS Exp, Assessments, Utilities, Sys. Maint., and Gen. Maint. The 'Utilities' button is highlighted with a red box. Below the grid, there is a logo for 'MED e-care Healthcare Solutions Inc.' and contact information: 'Customer Support: 1-800-387-8903'. At the bottom right of the utility window are buttons for 'Relogon', 'Exit', 'Help', and 'Release Notes'.

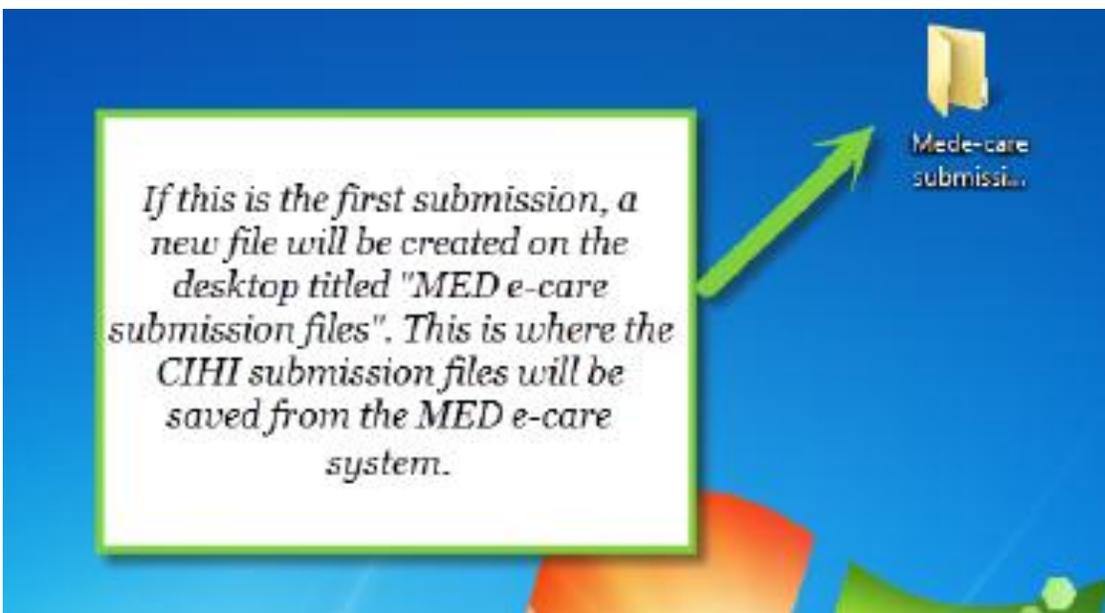
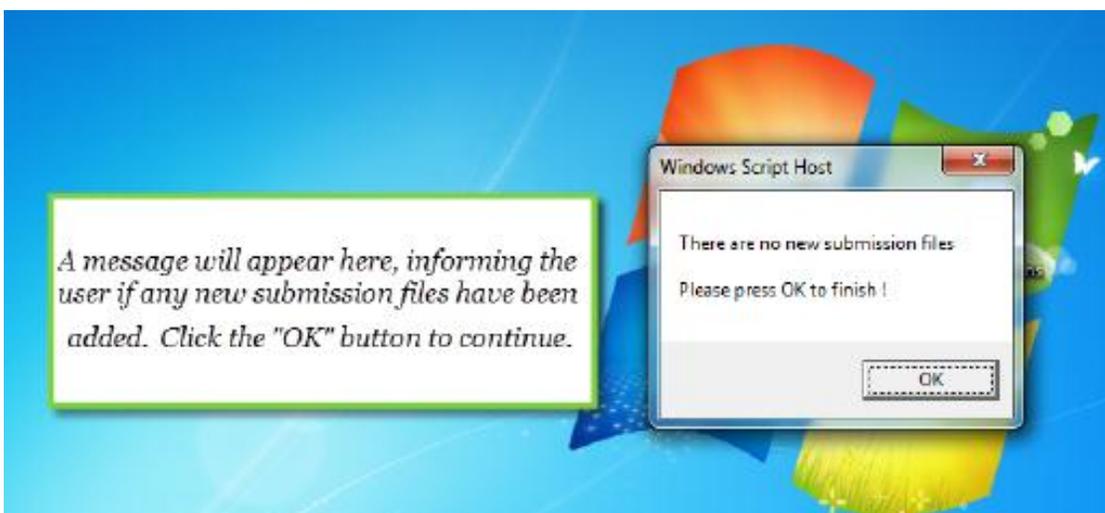
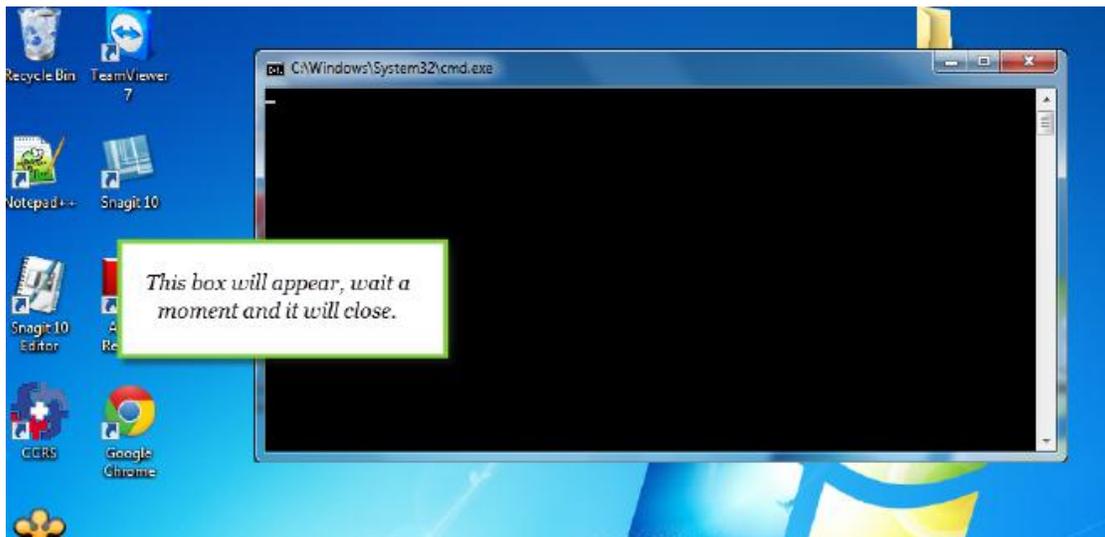
A callout box on the left side of the utility window contains the text: **Step 1: Click on the "Utilities" button.**

Name	Size	Type	Date Modified	Attributes
AssessmentForms		File Folder	05/22/2012 4:08 PM	
DV		File Folder	05/22/2012 4:08 PM	
Environment		File Folder	12/03/2012 3:32 PM	
Icons		File Folder	05/22/2012 4:08 PM	A
Images		File Folder	05/22/2012 4:09 PM	
RBTBackups		File Folder	05/22/2012 4:09 PM	A
Reports		File Folder	05/22/2012 4:09 PM	
WvData		File Folder	12/19/2012 4:01 PM	A
WvLive		File Folder	12/03/2012 3:37 PM	A
ADT.exe	1,216 KB	Application	05/27/2010 1:41 PM	A
ADTCrystalPrtControl.exe	480 KB	Application	08/10/2009 9:26 AM	A
ADTExport.exe	100 KB	Application	01/21/2009 11:42 AM	A
AssessmentReportViewer.exe	32 KB	Application	02/09/2009 4:28 PM	A
Assessments.exe	606 KB	Application	01/22/2010 3:37 PM	A
Assessments.ex				
Assessments.ex				
BatchWvlsEntry				
BatchWeightEnt				
CarePlanLT.exe				
CarePlanReport				
Codefile.exe				
CPBatchEntry.e				
CrystalPrtCont				
Ctrlfile.exe				
DataEdit.exe				
Dietary.exe				
e-IncidentCPTra				
eRAP.exe				
FluVaccineBatch				
Hospprof.exe				
IEBatch.exe				
IEDoc.exe				
IM.exe				
IMBatch.exe				
IMDataEdit.exe				
IMReport.exe	304 KB	Application	11/17/2009 3:07 PM	A
Interop.ADODB.dll	100 KB	Application Extension	05/08/2009 9:31 AM	A
Interop.ADOX.dll	36 KB	Application Extension	05/08/2009 9:31 AM	A
Intrface.exe	64 KB	Application	01/21/2009 11:43 AM	A
LicenseEditor.exe	132 KB	Application	12/18/2008 2:22 PM	A
Logon w 4 launcher.exe	852 KB	Application	10/17/2007 9:36 AM	A
Logon.exe	900 KB	Application	10/28/2010 1:25 PM	A
LogonLauncher.exe	164 KB	Application	08/14/2009 9:24 AM	A
LogTracker.exe	200 KB	Application	06/05/2009 3:12 PM	A
M2CImport.exe	788 KB	Application	01/21/2009 11:43 AM	A
MDS.exe	3,684 KB	Application	01/21/2009 11:42 AM	A
MDS.PDF	3,368 KB	Adobe Acrobat Doc...	01/21/2009 11:42 AM	A
MDSPrntControl.exe	516 KB	Application	01/21/2009 11:42 AM	A
MDSQL.exe	492 KB	Application	01/21/2009 11:42 AM	A
MDSRef.exe	56 KB	Application	01/21/2009 11:42 AM	A



Downloading Submission File (For those with CCRS only)





Understanding the detailed submission report

Continuing Care Reporting System **Detailed Submission Report**

Submission Organization: **CIHI**
 Facility: **CIHI**
 Master Number: **CIHI**
 File Name: **CIHI**

How to understand the Detailed Submission Report

This report from CIHI will, in detail, show where errors had occurred in the coding or submission.

e-Spec Version: MDS_2_0-1.0
 Processing Date: Nov 2012

REJECTED RECORDS

Record ID	Record Type	Sub Type	Health Record Number	Unique Registration Identifier (URI)	Event Date	Element ID	Element Name	Submitted Value	Rule #	Rule	Rule Action (Reject/Flag)
	QA	N			2012	AA8	Reason For Assessment	02	A0021	Submitted element data must match one of the valid codes/values.	Reject Record
						M5a	Pressure relieving device(s) for chair	0	C1119	If the resident does not have control of bowel (H1a = 3 or 4), pressure relieving devices for chair should be in place (M5a = 1).	Accept with Flag
						M5b	Pressure relieving device(s) for bed	0	C1120	If the resident does not have control of bowel (H1a = 3 or 4), pressure relieving devices for bed should be in place (M5b = 1).	Accept with Flag
						M5c	Turning or repositioning program	0	C1121	If the resident does not have control of bowel (H1a = 3 or 4), turning/repositioning program should be in place (M5c = 1).	Accept with Flag
						A3	Assessment Reference Date	20120710	C1272	Resident's length of stay within a facility should be between 0 and 17.5 years. Length of stay is the difference between assessment reference date (A3) and admission/re-entry date (AB1).	Accept with Flag
	AD	N			2012	A6a	Health Record Number	800	C1276	Resident from the same facility (AA6) with the same health card number (A6a) should only have one health record number (A6a). Please check all personal identifiers. Health card number of 0 or 1 is excluded from the	Reject Record

If you have a client, like this one, who has a "Reject Record" and also "Accept with Flag" in the report; the whole assessment must be marked as **Rejected**.

Both of these clients must have their submissions marked as **Rejected**.



Submission Organization:
 Facility:
 Master Number:
 File Name: CCR2012 .txt

e-Spec Version: MDS_2_0-1.0
 Processing Date: Nov 12, 2012

ACCEPTED WITH FLAG RECORDS

Record ID	Record Type	Sub Type*	Health Record Number	Unique Registration Identifier	Event Date	Element ID	Element Name	Submitted Value	Rule #	Rule	Rule Action (Reject /Flag)
	QA	N			2012	M5c	Turning or program	0	C1268	If the resident has any presence of	Accept with Flag
						P1ae	Monitoring acute medical conditions	0	C1169	If the resident has any presence of stage 2, 3 or 4 ulcers (M1b, M1c or M1d not equal to 0), the resident should be monitored for acute medical conditions (P1ae = 1).	Accept with Flag
	QA	N			2012	M5b	Pressure relieving device(s) for bed	0	C1120	If the resident does not have constipation of bowel (H1a = 3 or 4), pressure relieving devices for bed should be in place (M5b = 1).	Accept with Flag
	QA	N			2012	M5b	Pressure relieving device(s) for bed	0	C1120	If the resident does not have constipation of bowel (H1a = 3 or 4), pressure relieving devices for bed should be in place (M5b = 1).	Accept with Flag

These records have been **Accepted** in order to make corrections to these records leave them as submitted and then make the necessary corrections.

*N = New; C = Correction; D = Deletion

This is the section where the assessments will be unsubmitted. Check off the required assessments and click on the unsubmit option.

Chart	Assessment...	Assessment...	AssessmentTypeDesc	RI
<input checked="" type="checkbox"/>	12	05	Quarterly review assessment	
<input checked="" type="checkbox"/>	12	05	Quarterly review assessment	
<input checked="" type="checkbox"/>	12	05	Quarterly review assessment	
<input checked="" type="checkbox"/>	12	05	Quarterly review assessment	
<input checked="" type="checkbox"/>	12	02	Full annual assessment	
<input checked="" type="checkbox"/>	12	06	Discharge, no return	
<input checked="" type="checkbox"/>	P	E	Quarterly review assessment	
<input checked="" type="checkbox"/>	F	D	Discharge, no return	
<input checked="" type="checkbox"/>	A	E	Quarterly review assessment	
<input checked="" type="checkbox"/>	T	C	Quarterly review assessment	
<input checked="" type="checkbox"/>	T	H	Full annual assessment	
<input checked="" type="checkbox"/>	v	M	Quarterly review assessment	
<input checked="" type="checkbox"/>	F	E	Quarterly review assessment	
<input checked="" type="checkbox"/>	L	C	Quarterly review assessment	
<input checked="" type="checkbox"/>	C	G	Quarterly review assessment	
<input checked="" type="checkbox"/>	P	E	Quarterly review assessment	
<input checked="" type="checkbox"/>	F	C	Quarterly review assessment	
<input checked="" type="checkbox"/>	T	R	Quarterly review assessment	
<input checked="" type="checkbox"/>	B	K	Quarterly review assessment	
<input checked="" type="checkbox"/>	B	K	Discharge, no return	
<input checked="" type="checkbox"/>	C	D	Full annual assessment	

Submitted Assessments 143 records.

Record Corrections

How to create a Correction Record in V3

Step 1: Open the clients Assessment record you want to create a correction record for.

Step 2: Open section "R" and delete the name in the field R2a to unsign the assessment.

PARTICIPATION IN ASSESSMENT		
a. Resident :	1	yes
b. Family :	0	No
c. Significant other :	2	None

Signatures of persons completing these items		
Signature	Title	Date
r h	activation	2012/10/30
A S	Food Service Coordinator	2012/10/31
Y D	PhysioTherapist	2012/11/01
M B	RN	2012/11/05

R2 Date RN Assessment Coordinator signed as complete (yyyy/mm/dd) b 2012/12/01
Signature of RN Assessment Coordinator a: Name

Warning

Saving changes to this assessment will cause a change to the assessment type and a new record to be sent to CIHI. Are you sure you want to save these changes?

Yes No

Step 3: Upon unsigning the assessment you will see this pop-out window, click the "Yes" button.

Healthcare Enterprise Manager 3.6.

File Edit View Communications Templates Tools Reports Window Help

Minimum Data Set

- 05 - 2008/11/12
- 02 - 2009/02/12
- 05 - 2009/05/11
- 05 - 2009/08/11
- 05 - 2009/11/11
- 02 - 2010/02/11
- 05 - 2010/05/11
- 05 - 2010/08/11
- 05 - 2010/11/11
- 03 - 2011/01/31
- 05 - 2011/04/30
- 05 - 2011/07/31
- 05 - 2011/10/30
- 02 - 2012/01/30
- 05 - 2012/04/30
- 05 - 2012/07/30
- 10 - 2012/10/30 (c)

Notice the "(c)" to denote the correction record has been created.

Section L: Oral / dental status

L1

ORAL STATUS AND DISEASE PREVENTION (Check all that apply in last 7 days.)

Debris (soft, easily removable substances) present in mouth prior to going to bed at night a : 0 no

Has dentures and/or removable bridge b : 1 yes

Some or all natural teeth lost - does not have or does not use dentures (or partial plates) c : 0 no

Broken, loose, or carious teeth d : 0 no

Inflamed gums (gingiva): swollen or bleeding gums, oral abscesses, ulcers, or rashes e : 0 no

Daily cleaning of teeth or dentures, or daily mouth care - by resident or staff f : 1 yes

Signatures of persons completing these items

M.	B.	Signature	Title	Date
*			RN	2012/11/05

Step 4: Update the relevant client information, and sign the assessment.

L: Oral / dental status

Submission - Healthcare Enterprise Manager

File Actions View Reports

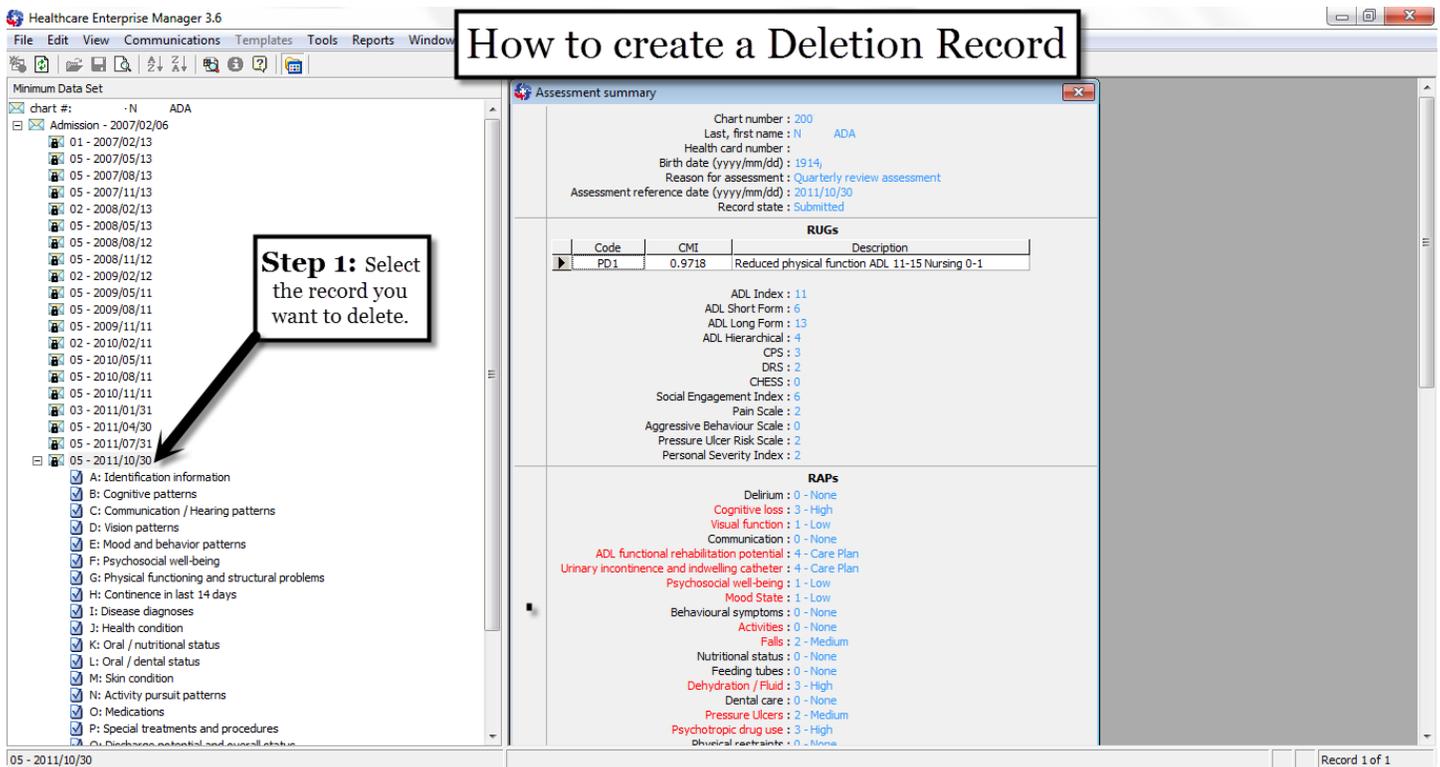
Quarter: 3 2012

ChartNo	LastName	FirstName	Assessment...	Assessment...	AssessmentTypeDesc	RID
2007	N	ADA	2012/10/30	10	Significant correction of prior q...	

Step 5: Submit the corrected assessment to CIHI.

Signed Assessments 1 records.

Record Deletions



How to create a Deletion Record

Step 1: Select the record you want to delete.

Healthcare Enterprise Manager 3.6

File Edit View Communications Templates Tools Reports Window

Minimum Data Set

- chart #: -N ADA
- Admission - 2007/02/06
 - 01 - 2007/02/13
 - 05 - 2007/05/13
 - 05 - 2007/08/13
 - 05 - 2007/11/13
 - 02 - 2008/02/13
 - 05 - 2008/05/13
 - 05 - 2008/08/12
 - 05 - 2008/11/12
 - 02 - 2009/02/12
 - 05 - 2009/05/11
 - 05 - 2009/08/11
 - 05 - 2009/11/11
 - 02 - 2010/02/11
 - 05 - 2010/05/11
 - 05 - 2010/08/11
 - 05 - 2010/11/11
 - 03 - 2011/01/31
 - 05 - 2011/04/30
 - 05 - 2011/07/31
 - 05 - 2011/10/30
- A: Identification information
- B: Cognitive patterns
- C: Communication / Hearing patterns
- D: Vision patterns
- E: Mood and behavior patterns
- F: Psychosocial well-being
- G: Physical functioning and structural problems
- H: Continence in last 14 days
- I: Disease diagnoses
- J: Health condition
- K: Oral / nutritional status
- L: Oral / dental status
- M: Skin condition
- N: Activity pursuit patterns
- O: Medications
- P: Special treatments and procedures
- Q: Disease potential and overall status

05 - 2011/10/30

Assessment summary

Chart number : 200
Last, first name : N ADA
Health card number :
Birth date (yyyy/mm/dd) : 1914
Reason for assessment : Quarterly review assessment
Assessment reference date (yyyy/mm/dd) : 2011/10/30
Record state : Submitted

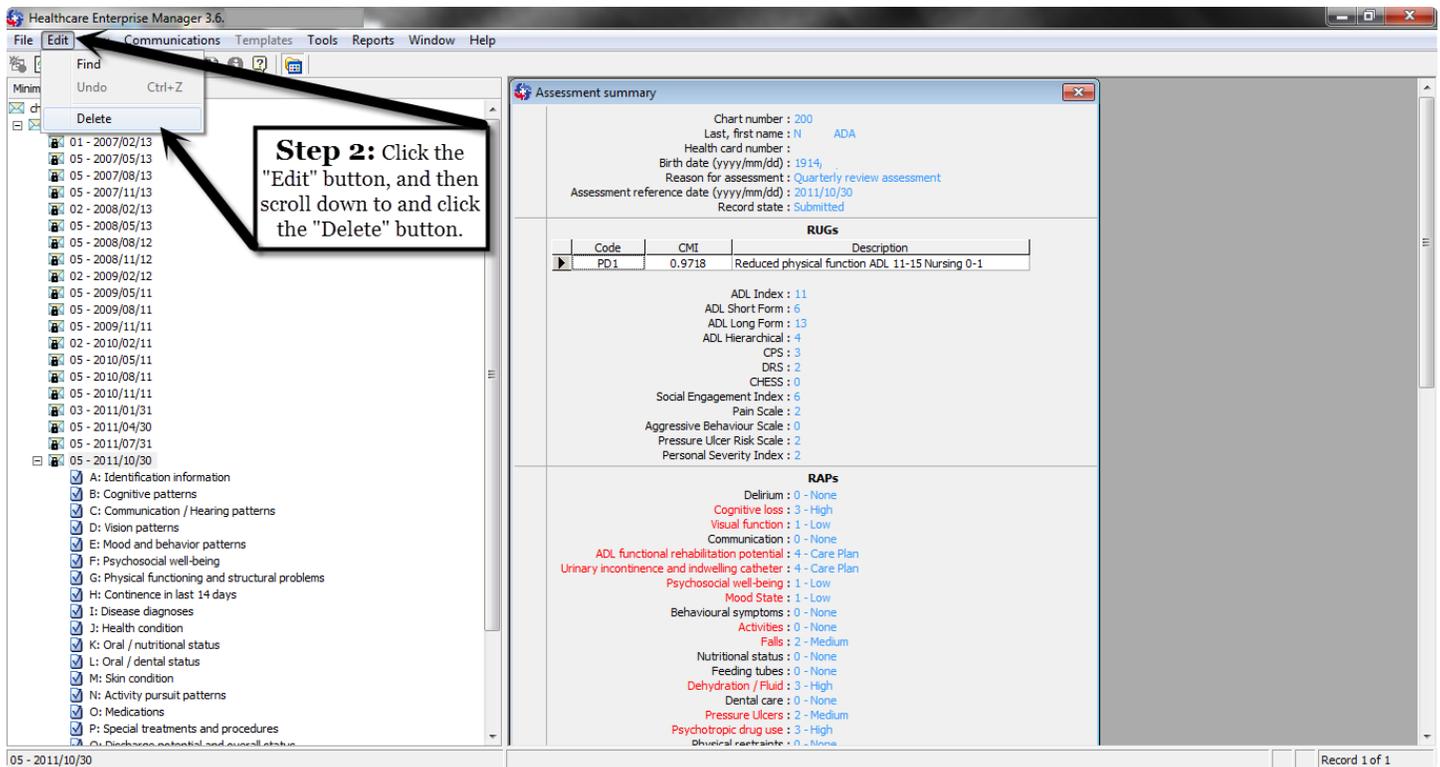
Code	CMI	Description
PD1	0.9718	Reduced physical function ADL 11-15 Nursing 0-1

ADL Index : 11
ADL Short Form : 6
ADL Long Form : 13
ADL Hierarchical : 4
CPS : 3
DRS : 2
CHESS : 0
Social Engagement Index : 6
Pain Scale : 2
Aggressive Behaviour Scale : 0
Pressure Ulcer Risk Scale : 2
Personal Severity Index : 2

RAPs

- Delirium : 0 - None
- Cognitive loss : 3 - High
- Visual function : 1 - Low
- Communication : 0 - None
- ADL functional rehabilitation potential : 4 - Care Plan
- Urinary incontinence and indwelling catheter : 4 - Care Plan
- Psychosocial well-being : 1 - Low
- Mood State : 1 - Low
- Behavioural symptoms : 0 - None
- Activities : 0 - None
- Falls : 2 - Medium
- Nutritional status : 0 - None
- Feeding tubes : 0 - None
- Dehydration / Fluid : 3 - High
- Dental care : 0 - None
- Pressure Ulcers : 2 - Medium
- Psychotropic drug use : 3 - High
- Physical restraints : 0 - None

Record 1 of 1



Step 2: Click the "Edit" button, and then scroll down to and click the "Delete" button.

Healthcare Enterprise Manager 3.6

File Edit Communications Templates Tools Reports Window Help

Find

Undo Ctrl+Z

Delete

Minimum Data Set

- 01 - 2007/02/13
- 05 - 2007/05/13
- 05 - 2007/08/13
- 05 - 2007/11/13
- 02 - 2008/02/13
- 05 - 2008/05/13
- 05 - 2008/08/12
- 05 - 2008/11/12
- 02 - 2009/02/12
- 05 - 2009/05/11
- 05 - 2009/08/11
- 05 - 2009/11/11
- 02 - 2010/02/11
- 05 - 2010/05/11
- 05 - 2010/08/11
- 05 - 2010/11/11
- 03 - 2011/01/31
- 05 - 2011/04/30
- 05 - 2011/07/31
- 05 - 2011/10/30

05 - 2011/10/30

Assessment summary

Chart number : 200
Last, first name : N ADA
Health card number :
Birth date (yyyy/mm/dd) : 1914
Reason for assessment : Quarterly review assessment
Assessment reference date (yyyy/mm/dd) : 2011/10/30
Record state : Submitted

Code	CMI	Description
PD1	0.9718	Reduced physical function ADL 11-15 Nursing 0-1

ADL Index : 11
ADL Short Form : 6
ADL Long Form : 13
ADL Hierarchical : 4
CPS : 3
DRS : 2
CHESS : 0
Social Engagement Index : 6
Pain Scale : 2
Aggressive Behaviour Scale : 0
Pressure Ulcer Risk Scale : 2
Personal Severity Index : 2

RAPs

- Delirium : 0 - None
- Cognitive loss : 3 - High
- Visual function : 1 - Low
- Communication : 0 - None
- ADL functional rehabilitation potential : 4 - Care Plan
- Urinary incontinence and indwelling catheter : 4 - Care Plan
- Psychosocial well-being : 1 - Low
- Mood State : 1 - Low
- Behavioural symptoms : 0 - None
- Activities : 0 - None
- Falls : 2 - Medium
- Nutritional status : 0 - None
- Feeding tubes : 0 - None
- Dehydration / Fluid : 3 - High
- Dental care : 0 - None
- Pressure Ulcers : 2 - Medium
- Psychotropic drug use : 3 - High
- Physical restraints : 0 - None

Record 1 of 1

Healthcare Enterprise Manager 3.6

File Edit View Communications Templates Tools Reports Window Help

Minimum Data Set

- chart #: -N ADA
- Admission - 2007/02/06
 - 01 - 2007/02/13
 - 05 - 2007/05/13
 - 05 - 2007/08/13
 - 05 - 2007/11/13
 - 02 - 2008/02/13
 - 05 - 2008/05/13
 - 05 - 2008/08/12
 - 05 - 2008/11/12
 - 02 - 2009/02/12
 - 05 - 2009/05/11
 - 05 - 2009/08/11
 - 05 - 2009/11/11
 - 02 - 2010/02/11
 - 05 - 2010/05/11
 - 05 - 2010/08/11
 - 05 - 2010/11/11
 - 03 - 2011/01/31
 - 05 - 2011/04/30
 - 05 - 2011/07/31
 - 05 - 2011/10/30
- A: Identification information
- B: Cognitive patterns
- C: Communication / Hearing patterns
- D: Vision patterns
- E: Mood and behavior patterns
- F: Psychosocial well-being
- G: Physical functioning and structural problems
- H: Continence in last 14 days
- I: Disease diagnoses
- J: Health condition
- K: Oral / nutritional status
- L: Oral / dental status
- M: Skin condition
- N: Activity pursuit patterns
- O: Medications
- P: Special treatments and procedures
- Q: Diseases, potential, and overall status

Assessment summary

Chart number : 200
 Last, first name : N ADA
 Health card number :
 Birth date (yyyy/mm/dd) : 1914,
 Reason for assessment : Quarterly review assessment
 Assessment reference date (yyyy/mm/dd) : 2011/10/30
 Record state : Submitted

Code	CMI	Description
PD1	0.9718	Reduced physical function ADL 11-15 Nursing 0-1

Resubmit?

This record has been submitted to CIHI. Are you planning to submit this record again?
 If you click 'Yes', a delete record will be created, but this record will remain active and available for re-submission. If you click 'No', a delete record will still be created, but this record will be deleted permanently.

Yes No Cancel

ADL functional rehabilitation potential : 4 - Care Plan
 Urinary incontinence and indwelling catheter : 4 - Care Plan
 Psychosocial well-being : 1 - Low
 Mood State : 1 - Low
 Behavioural symptoms : 0 - None
 Activities : 0 - None
 Falls : 2 - Medium
 Nutritional status : 0 - None
 Feeding tubes : 0 - None
 Dehydration / Fluid : 3 - High
 Dental care : 0 - None
 Pressure Ulcers : 2 - Medium
 Psychotropic drug use : 3 - High
 Physical restraints : 0 - None

Please notice that both the "Yes" and "No" buttons will create a delete record.

Step 3: This pop-out window will appear after clicking "Delete", click "No" button to confirm the creation of a delete record, and remove the assessment record.

Record 1 of 1

Submission - Healthcare Enterprise Manager

File Actions View Reports

Quarter: 3 2011

ChartNo	LastName	FirstName	Assessment...	Assessment...	AssessmentTypeDesc
<input checked="" type="checkbox"/> 200	N	ADA	2011/10/30	05	Quarterly review assessment (delete)

Signed Assessments 1 records.

Step 4: Submit the file to CIHI.

Notice the change in the assessment type. Use the normal submission process to submit.

Change a Corrected Record Back to New

How to Change a Correction Record to a New Record

Step 1: Click the "Communications", then "Submission..."

Note the "(c)" to show that this is a correction record.

Section I: Disease diagnoses

DISEASES (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.)

ENDOCRINE/METABOLIC/NUTRITIONAL

- a. Diabetes mellitus : 0 no
- b. Hyperthyroidism : 0 no
- c. Hypothyroidism : 0 no

HEART/CIRCULATION

- d. Arteriosclerotic heart disease (ASHD) : 0 no
- e. Cardiac dysrhythmia : 0 no
- f. Congestive heart failure : 0 no
- g. Deep vein thrombosis : 0 no
- h. Hypertension : 1 yes
- i. Hypotension : 0 no
- j. Peripheral vascular disease : 0 no
- k. Other cardiovascular disease : 0 no

MUSCULOSKELETAL

- l. Arthritis : 1 yes
- m. Hip fracture : 0 no
- n. Missing limb (e.g. amputation) : 0 no
- o. Osteoporosis : 0 no
- p. Pathological bone fracture : 0 no

NEUROLOGICAL

- q. Amyotrophic lateral sclerosis (ALS) : 0 no
- r. Alzheimer's disease : 0 no
- s. Aphasia : 0 no
- t. Cerebral palsy : 0 no
- u. Cerebrovascular accident (stroke) : 1 yes
- v. Dementia other than Alzheimer's disease : 0 no
- w. Hemiplegia/hemiparesis : 0 no
- x. Huntington's chorea : 0 no
- y. Multiple sclerosis : 0 no
- z. Paraplegia : 0 no
- aa. Parkinson's disease : 0 no
- bb. Quadriplegia : 0 no
- cc. Seizure disorder : 0 no
- dd. Transient ischemic attack (TIA) : 0 no
- ee. Traumatic brain injury : 0 no

PSYCHIATRIC/MOOD

Submission - Healthcare Enterprise Manager

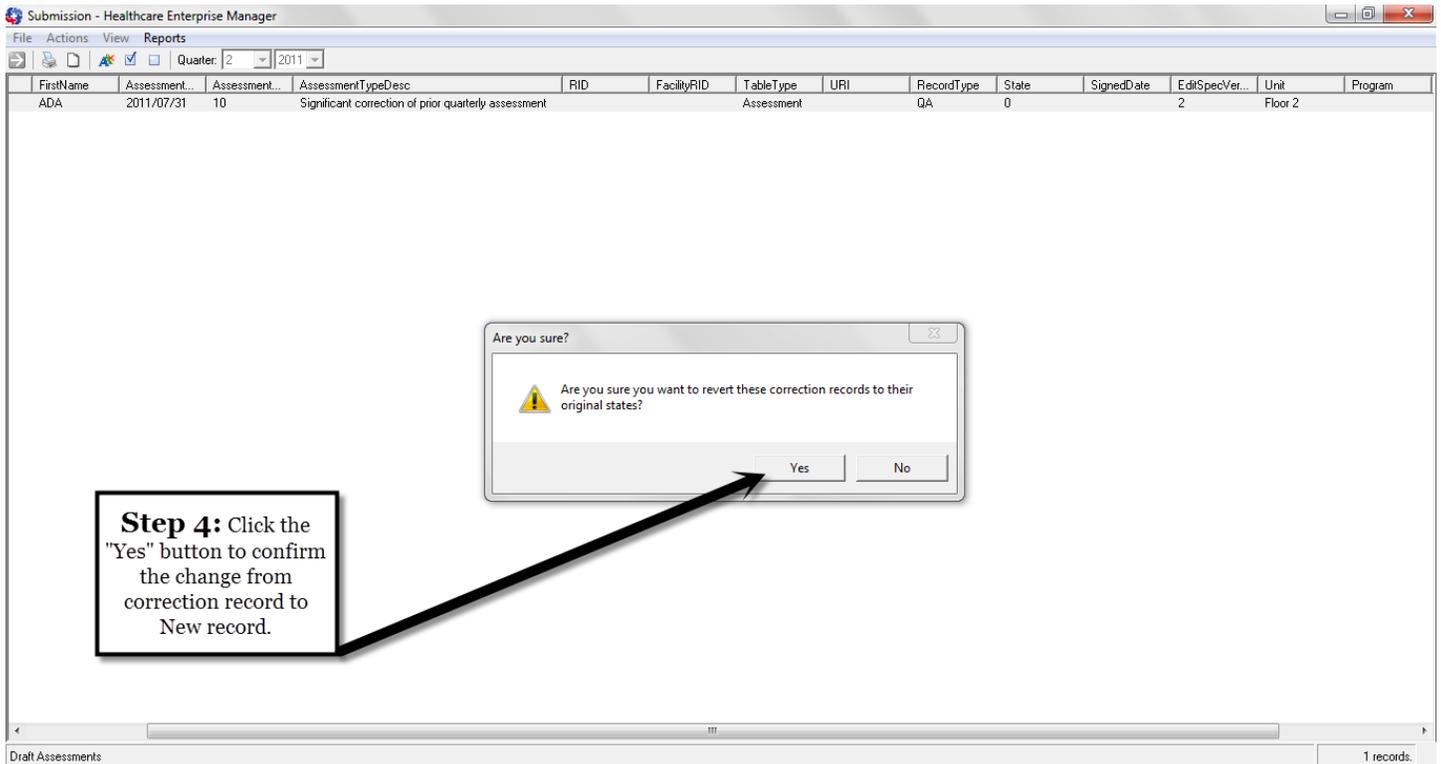
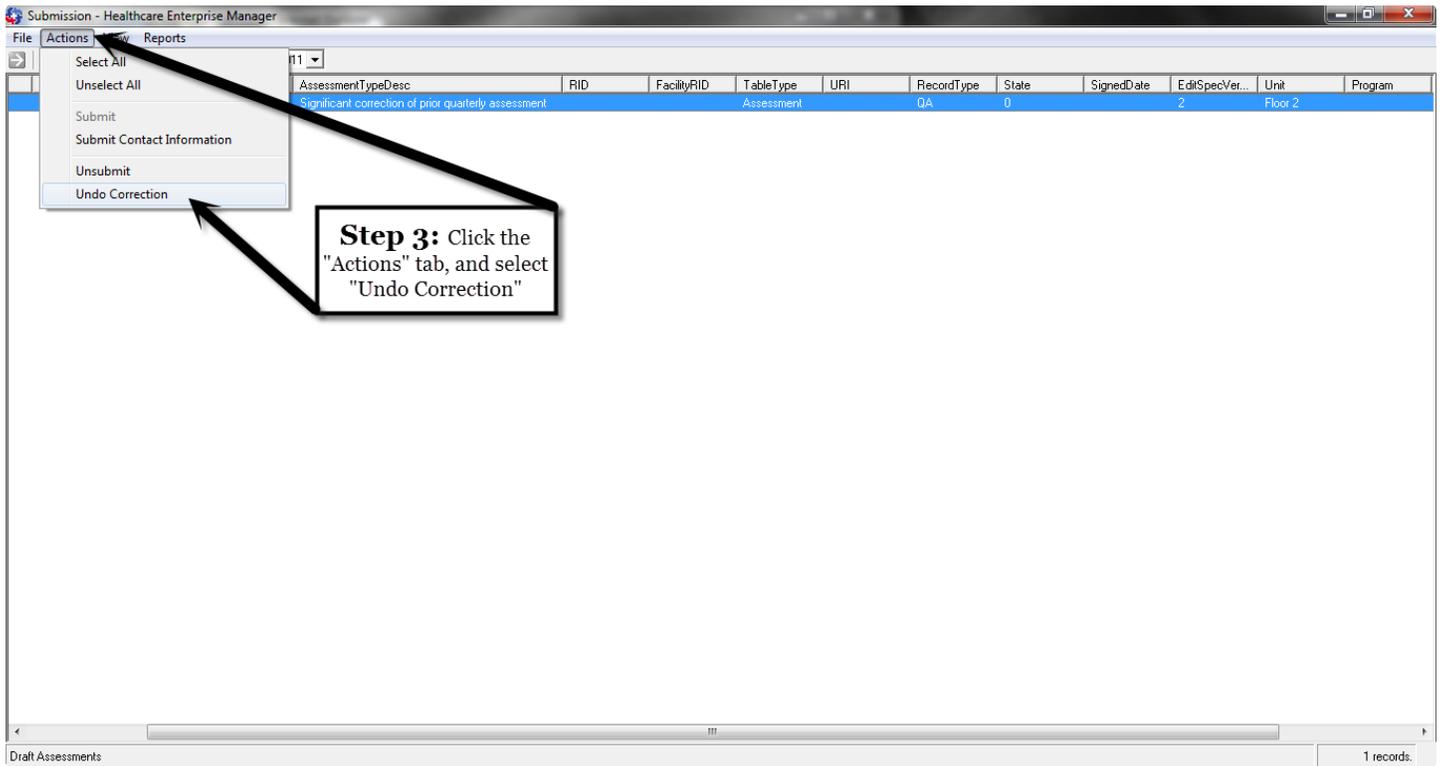
File Actions View Reports

Quarter: 2 2011

FirstName	Assessment...	Assessment...	RID
ADA	2011/07/31	10	Significant correction of prior quarterly assessment

Draft Assessments 1 records

Step 2: Select the Submission record you would like to change.



Healthcare Enterprise Manager 3.6

File Edit View Communications Templates Tools Reports Window Help

Minimum Data Set

- chart #: -N ADA
- Admission - 2007/02/06
 - 01 - 2007/02/13
 - 05 - 2007/05/13
 - 05 - 2007/08/13
 - 05 - 2007/11/13
 - 02 - 2008/02/13
 - 05 - 2008/05/13
 - 05 - 2008/08/12
 - 05 - 2008/11/12
 - 02 - 2009/02/12
 - 05 - 2009/05/11
 - 05 - 2009/08/11
 - 05 - 2009/11/11
 - 02 - 2010/02/11
 - 05 - 2010/05/11
 - 05 - 2010/08/11
 - 05 - 2010/11/11
 - 03 - 2011/01/31
 - 05 - 2011/04/30
 - 05 - 2011/07/31
- A: Identification information
- B: Cognitive patterns
- C: Communication / Hearing patterns
- D: Vision patterns
- E: Mood and behavior patterns
- F: Psychosocial well-being
- G: Physical functioning and structural problems
- H: Continence in last 14 days
- I: Disease diagnoses
- J: Health condition
- K: Oral / nutritional status
- L: Oral / dental status
- M: Skin condition
- N: Activity pursuit patterns
- O: Medications
- P: Special treatments and procedures
- Q: Discharge potential and overall status
- R: Assessment information

Assessment summary

Chart number :
Last, first name : N ADA
Health card number :
Birth date (yyyy/mm/dd) : 19
Reason for assessment : Quarterly review assessment
Assessment reference date (yyyy/mm/dd) : 2011/07/31
Record state : Draft

Code	CMI	Description
PD1	0.9718	Reduced physical function ADL 11-15 Nursing 0-1

ADL Index : 12
ADL Short Form : 5
ADL Long Form : 13
ADL Hierarchical : 2
CPS : 3
DRS : 3
CHESS : 0
Social Engagement Index : 6
Pain Scale : 2
Aggressive Behaviour Scale : 0
Pressure Ulcer Risk Scale : 3
Personal Severity Index : 2

RAPs
Delirium : 0 - None
Cognitive loss : 3 - High
Visual function : 1 - Low
Communication : 0 - None
ADL functional rehabilitation potential : 2 - Medium
Urinary incontinence and indwelling catheter : 4 - Care Plan
Psychosocial well-being : 1 - Low
Mood State : 2 - Medium
Behavioural symptoms : 0 - None
Activities : 0 - None
Falls : 4 - Care Plan
Nutritional status : 0 - None
Feeding tubes : 0 - None
Dehydration / Fluid : 3 - High
Dental care : 0 - None
Pressure Ulcers : 2 - Medium
Psychotropic drug use : 3 - High
Physical restraints : 0 - None

Step 5: Submit the record to CIHI, through the normal Version 3 process.

Notice the record has been set back to new record.