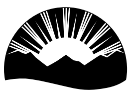

BRITISH COLUMBIA | Ministry of Health

RESIDENTIAL ASSESSMENT INSTRUMENT (RAI)
CONTINUING CARE REPORTING SYSTEM (CCRS) AND HOME CARE REPORTING SYSTEM (HCRS) DATA DICTIONARY

Continuing Care Reporting System (CCRS)

Episode - The service episode record is comprised a service start and a service end. A service end date is to be submitted when a client changes facility or service is ended due to an end reason. If there is no service end date then a client is still receiving service. This table includes client information such as name, ID, demographic information and regular routine. (CCRS_EPISODE)

RAI ID	DATA FIELD	DESCRIPTION
	EPISODE_ID	Identifier assigned to each episode, used to uniquely track each episode
AA1	UNIQUE_REGISTRATION_IDENTIFIER - replaced with a study specific identification number	The Unique Registration Identifier uniquely identifies the resident admission. It is composed of a facility number, a date and 7 characters.
AA2	SEX	Sex code
AA3a	BIRTH_DATE	Birth date (YYYYMM)
AA3b	ESTIMATED_BIRTH_DATE_FLAG	Indicates that the birth date is estimated
AA5a	UNENCRYPTED_HEALTH_CARD_NUMBER - replaced with a study specific identification number	Health card number assigned by the province or territory
AA5b	PROV_ISSUE_HEALTH_CARD	Province or territory that issued the health card number
AA6	FACILITY	Facility number assigned by the province or territory
AA9	DISCHARGE_REASON	Reason for discharge (discharge type). 06 - Discharge - Return not anticipated, 07 - Discharge - Return anticipated, 08 - Discharged prior to completing initial assessment.
AB1	ENTRY_DATE	Date that the resident entered the facility for care and that the stay began; date that the resident was most recently admitted to the facility
AB10a	DD_NO_OR_NOT_APPLICABLE	Conditions related to developmental disability status - not applicable, no developmental disability
AB10b	DD_DOWNS_SYNDROME	Conditions related to developmental disability status - Down’s syndrome
AB10c	DD_AUTISM	Conditions related to developmental disability status - autism
AB10d	DD_EPILEPSY	Conditions related to developmental disability status - epilepsy
AB10e	DD_ORGANIC_OTHER_CONDITION	Conditions related to developmental disability status - other developmental disability related to organic condition
AB10f	DD_NO_ORGANIC_CONDITION	Conditions related to developmental disability status - developmental disability with no organic condition
AB2a	ENTRY_SERVICE_TYPE	Admitted from facility / level of care
AB2b	ADMISSION_FROM_FACILITY	Admitted from Facility number
AB3	LIVED_ALONE	Resident's living arrangement prior to admission
AB4	RESIDENT_POSTAL_CODE	FSA of the prior primary resident postal code

RAI ID	DATA FIELD	DESCRIPTION
AB5a	STAY_HERE_BEFORE	Resident history 5 years prior to entry (AB1) - prior stay at this facility
AB5b	STAY_IN_OTHER_SIMILAR_FACILITY	Resident history 5 years prior to entry (AB1) - stay in other similar level of care facility
AB5c	STAY_IN_OTHER_RESIDE_FACILITY	Resident history 5 years prior to entry (AB1) - prior stay in other board and care facility, assisted living or group home
AB5d	STAY_IN_PSYCHIATRIC_SETTING	Resident history 5 years prior to entry (AB1) - prior stay in a psychiatric facility
AB5e	STAY_IN_DD_SETTING	Resident history 5 years prior to entry (AB1) - prior stay in developmental facility
AB7	EDUCATION_COMPLETED	Highest education completed
AB8	LANGUAGE	Primary language spoken by the resident at home on a regular basis
AB9	MENTAL_HEALTH_HISTORY_OR_DD	Resident's record indicates any history of mental illness or developmental disability problem
AC1a	STAYS_UP_LATE_AT_NIGHT	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - stays up late at night (after 9 pm)
AC1b	NAPS_DURING_DAY	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - naps regularly during day (at least one hour)
AC1c	GOES_OUT_OFTEN	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - goes out 1+ days a week
AC1d	STAYS_BUSY_WITH_HOBBIES	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - stays busy with hobbies, reading or fixed daily routines
AC1e	STAYS_ALONE_OR_TV	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - spends most of time alone or watching TV
AC1f	INDEPENDENT_INDOORS	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - moves independently indoors (with appliances, if used)
AC1g	USES_TOBACCO	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - uses tobacco products at least daily
AC1i	DISTINCT_FOOD_PREFER	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - distinct food preferences
AC1j	EATS_BETWEEN_MEALS	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - eats between meals all or most of the day
AC1k	USE_OF_ALCOHOL_WEEKLY	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - use of alcoholic beverage(s) at least weekly

RAI ID	DATA FIELD	DESCRIPTION
AC1m	BEDCLOTHES_MUCH_OF_DAY	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - in bedclothes much of the day
AC1n	WAKENS_TO_TOILET	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - wakens to toilet all or most nights
AC1o	IRREGULAR_BOWEL	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - has irregular bowel movement pattern
AC1p	SHOWERS_FOR_BATHING	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - showers for bathing
AC1q	BATHING_IN_PM	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - bathing in PM
AC1s	DAILY_CONTACT_RELATIVE	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - daily contact with relatives / close friends
AC1t	ATTENDS_CHURCH	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - usually attends church, temple, synagogue, etc.
AC1u	STRENGTH_IN_FAITH	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - finds strength in faith
AC1v	ANIMAL_COMPANION	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - daily animal companion / presence
AC1w	INVOLVED_GROUP_ACTIVITY	Resident's customary routine in the year prior to Admission Date to this facility or for the year last in the community if now being admitted from another facility - involved in group activities
R3a	DISCHARGE_LEVEL_OF_CARE	Level of care at time of discharge
R3b	DISCHARGE_TO_FACILITY	Discharged to Facility Number
R4	DISCHARGE_DATE	Date that resident is discharged from the facility
	BED_TYPE_AT_ADMISSION	To enable reporting on the different types of beds that residents may be placed within a facility. This may include specialized beds such as respite, convalescent or palliative beds in addition to general residential, long-term beds at entry date AD2
	BED_TYPE_AT_DISCHARGE	To enable reporting on the different types of beds that residents may be placed within a facility. This may include specialized beds such as respite, convalescent or palliative beds in addition to general residential, long-term beds at discharge date. AD2
	CIHI_ASSUMED_DISCHARGE_DATE	The first day of the second quarter after the resident’s latest event (admission or assessment).
	CIHI_FISCAL_QUARTER_DISCHARGE	Fiscal quarter of discharge. This is CIHI's fiscal quarters which are 1 - April to June, 2 - July to September, 3 - October to December and 4 - January to March

RAI ID	DATA FIELD	DESCRIPTION
	CIHI_FISCAL_QUARTER_ENTRY	Fiscal quarter of entry date. This is CIHI's fiscal quarters which are 1 - April - June, 2 - July to September, 3 - October to December and 4 - January to March
	CIHI_FISCAL_YEAR_DISCHARGE	Fiscal year of discharge
	CIHI_FISCAL_YEAR_ENTRY	Fiscal year of entry date
	CONSISTENT_BIRTH_DATE_FLAG	Flag for whether or not the resident has consistent information regarding birth date across all episodes within each facility they have resided in
	CONSISTENT_SEX_FLAG	Flag for whether or not the resident has consistent information regarding sex information across all episodes within each facility they have resided in within each sector
	DISCHARGE_FLAG	Indicates if the episode has a discharge record
	DISCHARGE_LOS_DAYS	Length of stay at discharge for the resident
	DQ_DATE_PROBLEMS_FLAG	A data quality flag assigned at the Episode level to flag episodes with date problems. 1-9 are removed from analytical reports and eReports. 1-10 are removed for linkage projects.
	DQ_DISCHARGE_ASSUMED_FLAG	Resident has not been discharged, expected date (assessment or discharge) has not been submitted to CIHI
	ENTRY_TYPE	Whether the entry is a new admission or re-entry 1 = Admission, 9 = Re-entry
	EPISODE_ASSESSMENT_STATUS	Whether or not the resident was assessed. If assessed, whether it was admission assessment or any other assessment 1 = Not assessed, 2 = Admission assessment, 3 = Other assessment, 9 = Not applicable
	LANGUAGE_GROUP	Indicates the grouping of the primary language spoken by the resident at home on a regular basis ENG - English, FRA - French, OTH- other language
	LAST_TRANSFER_DATE	Date of last transfer to facility
	LOS_DAYS_CATEGORY	Length of stay days category
	MARITAL_STATUS_ADMISSION	Resident's marital status at admission
	MIS_AT_ADMISSION	The Unit-MIS Functional Centre Account Code is the account number that is used to represent the statistical and financial reporting related to the unit in which the resident is placed in the facility at entry date
	MIS_AT_DISCHARGE	The Unit-MIS Functional Centre Account Code is the account number that is used to represent the statistical and financial reporting related to the unit in which the resident is placed in the facility at discharge date
	NUM_OF_ASSESSMENT_EPISODE	Number of assessments in the episode
	PREVIOUS_FACILITY	Previous facility
	RESIDENT_CENSUS_DIVISION	Statistics Canada's Standard Geographic census division code for the resident's prior primary residence postal code. See the Standard Geographical Classification (SGC) for lists of valid codes for census division. A missing census division is indicated
	RESIDENT_CENSUS_SUBDIVISION	Statistics Canada's Standard Geographic census subdivision code for the facility providing care to the resident. See the Standard Geographical Classification (SGC) for lists of valid codes for census subdivision. A missing census subdivision is indicated

RAI ID	DATA FIELD	DESCRIPTION
	RESIDENT_GEO_DIMENSION_LINK	Indicates whether the resident postal code linked to CIHI's Geography Dimension File, 1 - Link Successful -1 - Link Unsuccessful
	RESIDENT_HEALTH_REGION	The resident's prior primary residence health region. Health regions are subprovincial areas defined by provincial department of health. 10 - Interior Health Authority, 20 - Fraser Health Authority, 30 - Vancouver Coastal Health Authority, 40 - Vancouver Island Health Authority, 50 - Northern Health Authority
	RESIDENT_PROVINCE	Province based on Resident's Postal Code
	RESIDENT_QAIPPE	Resident's prior primary residence neighbourhood income quintile. 1 - LOWEST INCOME QUINTILE, 2 - 2nd QUINTILE, 3 - 3rd QUINTILE,4 - 4th QUINTILE,5 - HIGHEST INCOME QUINTILE, 9 - MISSING, -7 - N/A, -8 - invalid value
	RESIDENT_SAC_CODE	Statistics Canada's census metropolitan area/census agglomeration code for the resident's prior primary residence postal code, 000 - Territories, 001-995 - CMA/CA unique identifier, 996 - Strongly influenced zone, 997 - Moderately influenced zone, 998 - Weakly influenced zone, 999 - No influenced zone
	RESIDENT_SAC_TYPE	Resident's Prior Primary Residence Statistical Area Classification Type, 1 - Census Metropolitan Area 2 2 - Tracted Census Agglomeration, 3 - Non-Tracted Census Agglomeration, 4 - Non-Cmaca, Strong Cmaca Influence, 5 - Non-Cmaca, Moderate Cmaca Influence, 6 - Non-Cmaca, Weak Cmaca Influence, 7 - Non-Cmaca, No Cmaca Influence, 8 Territories
	RESIDENT_SUB_HEALTH_DISTRICT	The resident's prior primary residence health district code. Health districts are geographically defined areas which are smaller than health regions. They do not exist in all provinces/territories, 11 East Kootenay, 12 - Kootenay Boundary, 13 - Okanagan, 14 - Thompson Cariboo Shuswap, 21 - Fraser East, 22 - Fraser North, 23 - Fraser South, 31 – Richmond, 32 – Vancouver, 33 - North Shore/Coast Garibaldi, 41 - South Vancouver Island, 42 - Central Vancouver Island, 43 - North Vancouver Island, 51 – Northwest, 52 - Northern Interior, 53 - Northeast
	RESIDENT_URBAN_RURAL_CODE	Urban or rural status of Resident's prior residence or facility, 1 - Urban, 2 - Rural, 9 - Missing
	SECTOR	Main sector, hospital based or residential based, that facility is assigned to

Assessment - Contains the assessment information from RAI MDS 2.0, outcome scales, clinical assessment protocols (CAPs), and quality indicators. An assessment must have an episode record. (CCRS_ASSESSMENT)

RAI ID	DATA FIELD	DESCRIPTION
	ASSESSMENT_ID	Identifier assigned to each assessment in the database
A10a	LIVING_WILL	Legal existence of directives in the record regarding treatment options - living will
A10b	DO_NOT_RESUSCITATE	Legal existence of directives in the record regarding treatment options - do not resuscitate
A10c	DO_NOT_HOSPITALIZE	Legal existence of directives in the record regarding treatment options - do not hospitalize
A10d	ORGAN_DONATION	Legal existence of directives in the record regarding treatment options - organ donation

RAI ID	DATA FIELD	DESCRIPTION
A10e	AUTOPSY_REQUEST	Legal existence of directives in the record regarding treatment options - autopsy request
A10f	FEEDING_RESTRICTIONS	Legal existence of directives in the record regarding treatment options - feeding restrictions
A10g	MEDS_RESTRICTIONS	Legal existence of directives in the record regarding treatment options - medication restrictions
A10h	OTHER_TREAT_RESTRICTIONS	Legal existence of directives in the record regarding treatment options - other treatment restrictions
A3	ASSESSMENT_DATE	Assessment reference date - last day of the Resident's observation period
A5	MARITAL_STATUS	Resident's marital status
A9a	LEGAL_GUARDIAN	Responsibility for participating in decisions about Resident's health care, treatment, financial affairs and legal affairs - legal guardian
A9b	ENDURING_POA_FINANCES	Responsibility for participating in decisions about Resident's health care, treatment, financial affairs and legal affairs - durable power of attorney financial
A9c	OTHER_LEGAL_OVERSIGHT	Responsibility for participating in decisions about Resident's health care, treatment, financial affairs and legal affairs - other legal oversight
A9d	FAMILY_RESPONSIBLE	Responsibility for participating in decisions about Resident's health care, treatment, financial affairs and legal affairs - family member responsible
A9e	DURABLE_POA_HEALTH	Responsibility for participating in decisions about Resident's health care, treatment, financial affairs and legal affairs - durable power of attorney health care
A9f	PATIENT_RESPONSIBLE	Responsibility for participating in decisions about Resident's health care, treatment, financial affairs and legal affairs - resident responsible for self
AA1	UNIQUE_REGISTRATION_IDENTIFIER	The Unique Registration Identifier uniquely identifies the resident admission. It is composed of a facility number, a date and 7 characters.
AA6	FACILITY	Facility number assigned by the province or territory
AA8	ASSESSMENT_TYPE	Reason for assessment
B1	COMATOSE	Resident's record includes documented neurological diagnosis of coma or persistent vegetative state
B2a	SHORT_TERM_MEMORY	Resident's functional capacity to remember recent events
B2b	LONG_TERM_MEMORY_OK	Resident's functional capacity to remember long past events
B3a	CURRENT_SEASON	Memory recall performance during the last 7 days - current season
B3b	LOCATION_OF_OWN_ROOM	Memory recall performance during the last 7 days - location of own room
B3c	RECALL_NAMES_FACES	Memory recall performance during the last 7 days - staff names / faces
B3d	AWARE_IN_NURSING_HOME	Memory recall performance during the last 7 days - that he / she is in a facility
B4	COGNITIVE_SKILLS	Cognitive skills for making every day decisions about tasks or activities of daily living over the last 7 days

RAI ID	DATA FIELD	DESCRIPTION
B5a	EASILY_DISTRACTED	Delirium - periodic disordered thinking or awareness in last 7 days - easily distracted
B5b	PERIODS_OF_ALTERED_PERCEPTION	Delirium - periodic disordered thinking or awareness in last 7 days - periods of altered perception or awareness of surroundings
B5c	EPISODES_OF_DISORG_SPEECH	Delirium - periodic disordered thinking or awareness in last 7 days - episodes of disordered speech
B5d	PERIODS_OF_RESTLESSNESS	Delirium - periodic disordered thinking or awareness in last 7 days - periods of restlessness
B5e	PERIODS_OF_LETHARGY	Delirium - periodic disordered thinking or awareness in last 7 days - periods of lethargy
B5f	MENTAL_FUNCTION_VARIES	Delirium - periodic disordered thinking or awareness in last 7 days - mental function varies over course of day
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
C1	HEARING	Resident's ability to hear, with environmental adjustments if necessary, during the past 7 days
C2a	HEARING_AID_USED_REGULARLY	Communication devices and techniques over the last 7 days - hearing aid used regularly
C2b	HEARING_AID_NOT_USED_REGULARLY	Communication devices and techniques over the last 7 days - hearing aid not used regularly
C2c	OTHER_RECEPT_COMM_TECH	Communication devices and techniques over the last 7 days - other receptive communication techniques used
C3a	SPEECH	Resident makes needs known in last 7 days - speech
C3b	WRITING_MESSAGES	Resident makes needs known in last 7 days - writing messages
C3c	SIGN_LANGUAGE	Resident makes needs known in last 7 days - American sign or braille
C3d	SIGNS_GESTURES	Resident makes needs known in last 7 days - signs, gestures, sounds
C3e	COMMUNICATION_BOARD	Resident makes needs known in last 7 days - communication board
C3f	OTHER_EXPRESSION_MODE	Resident makes needs known in last 7 days - other modes
C4	MAKING_SELF_UNDERSTOOD	Resident's ability to express or communicate requests, needs, opinions, urgent problems and social conversation in last 7 days
C5	SPEECH_CLARITY	Quality of Resident's speech, not content or appropriateness in last 7 days
C6	UNDERSTAND_OTHERS	Resident's ability to comprehend verbal information content in last 7 days
C7	CHANGE_IN_COMMUNICATION	Change in Resident's ability to express, understand or hear information compared to 90 days ago or since last assessment if less than 90 days
D1	VISION	Resident's ability to see close objects in adequate lighting using customary visual appliances in last 7 days
D2a	SIDE_VISION_PROBLEMS	Resident's visual limitations or difficulties related to diseases common in aged persons - side vision problems

RAI ID	DATA FIELD	DESCRIPTION
D2b	SEES_HALOS	Resident's visual limitations or difficulties related to diseases common in aged persons - halos, rings around lights, flashes or curtains over eyes
D3	VISUAL_APPLIANCES	Resident uses visual appliances - glasses, contact lenses or magnifying glass
E1a	NEGATIVE_STATEMENTS	Frequency of indicators of depression, anxiety, sad mood in last 30 days - negative statements
E1b	REPETITIVE_QUESTIONS	Frequency of indicators of depression, anxiety, sad mood in last 30 days - repetitive questions
E1c	REPETITIVE_VERBALIZATIONS	Frequency of indicators of depression, anxiety, sad mood in last 30 days - repetitive verbalizations
E1d	PERSISTENT_ANGER	Frequency of indicators of depression, anxiety, sad mood in last 30 days - persistent anger with self or others
E1e	SELF_DEPRECATION	Frequency of indicators of depression, anxiety, sad mood in last 30 days - self deprecation
E1f	EXPRESS_UNREALISTIC_FEAR	Frequency of indicators of depression, anxiety, sad mood in last 30 days - expressions of what appear to be unrealistic fears
E1g	RECURRENT_TERRIBLE_STATEMENTS	Frequency of indicators of depression, anxiety, sad mood in last 30 days - recurrent statements that something terrible is about to happen
E1h	REPEAT_HEALTH_COMPLAINTS	Frequency of indicators of depression, anxiety, sad mood in last 30 days - repetitive health complaints
E1i	REPEAT_ANXIOUS_COMPLAINTS	Frequency of indicators of depression, anxiety, sad mood in last 30 days - repetitive anxious complaints or concerns
E1j	UNPLEASANT_MOOD_IN_MORNING	Frequency of indicators of depression, anxiety, sad mood in last 30 days - unpleasant mood in morning
E1k	INSOMNIA	Frequency of indicators of depression, anxiety, sad mood in last 30 days - insomnia or change in usual sleep pattern
E1l	SAD_FACIAL_EXPRESSION	Frequency of indicators of depression, anxiety, sad mood in last 30 days - sad, pained, worried facial expression
E1m	CRYING	Frequency of indicators of depression, anxiety, sad mood in last 30 days - crying, tearfulness
E1n	REPEAT_PHYSICAL_MOVEMENTS	Frequency of indicators of depression, anxiety, sad mood in last 30 days - repetitive physical movements
E1o	WITHDRAWAL_FROM_ACTIVITIES	Frequency of indicators of depression, anxiety, sad mood in last 30 days - withdrawal from activities of interest
E1p	REDUCED_SOCIAL_INTERACTION	Frequency of indicators of depression, anxiety, sad mood in last 30 days - reduced social interaction
E2	MOOD_PERSISTENCE	One or more indicators of depression, anxiety or sad mood not easily altered by attempts to cheer up, console or reassure resident in last 7 days
E3	CHANGE_IN_MOOD	Resident's mood status has changed compared to status 90 days ago or since last assessment if less than 90 days
E4aA	WANDERING_FREQ	Behavioural symptoms frequency in last 7 days - wandering
E4aB	WANDERING_ALTER	Behavioural symptoms alterability in last 7 days - wandering

RAI ID	DATA FIELD	DESCRIPTION
E4bA	VERBALLY_ABUSE_FREQ	Behavioural symptoms frequency in last 7 days - verbally abusive
E4bB	VERBAL_ABUSE_ALTER	Behavioural symptoms alterability in last 7 days - verbally abusive
E4cA	PHYSICAL_ABUSE_FREQ	Behavioural symptoms frequency in last 7 days - physically abusive
E4cB	PHYSICAL_ABUSE_ALTER	Behavioural symptoms alterability in last 7 days - physically abusive
E4dA	DISRUPTIVE_FREQ	Behavioural symptoms frequency in last 7 days - socially inappropriate or disruptive
E4dB	DISRUPTIVE_ALTER	Behavioural symptoms alterability in last 7 days - socially inappropriate or disruptive
E4eA	RESISTS_CARE_FREQ	Behavioural symptoms frequency in last 7 days - resists care
E4eB	RESISTS_CARE_ALTER	Behavioural symptoms alterability in last 7 days - resists care
E5	CHANGE_IN_BEHAVIOUR_SYMPTOM	Change in behavioural symptoms compared to status 90 days ago or since last assessment if less than 90 days
F1a	EASY_INTERACT_WITH_OTHERS	Sense of initiative or involvement in last 7 days - at ease interacting with others
F1b	EASY_PLANNED_ACTIVITY	Sense of initiative or involvement in last 7 days - at ease doing planned or structured activities
F1c	EASY_SELF_INITIATE_ACTIVITY	Sense of initiative or involvement in last 7 days - at ease doing self-initiated activities
F1d	ESTABLISH_OWN_GOALS	Sense of initiative or involvement in last 7 days - establishes own goals
F1e	PURSUES_INVOLVEMENT	Sense of initiative or involvement in last 7 days - pursues involvement in life of facility
F1f	ACCEPTS_INVITATIONS	Sense of initiative or involvement in last 7 days - accepts invitations into most group activities
F2a	CONFLICT_WITH_STAFF	Unsettled relationship in last 7 days - covert or open conflict with or repeated criticism of staff
F2b	UNHAPPY_WITH_ROOMMATE	Unsettled relationship in last 7 days - unhappy with roommate
F2c	UNHAPPY_WITH_OTHER_RESIDENTS	Unsettled relationship in last 7 days - unhappy with residents other than roommate
F2d	CONFLICT_WITH_FAMILY	Unsettled relationship in last 7 days - openly expresses conflict or anger with family or friends
F2e	NO_CONTACT_WITH_FAMILY	Unsettled relationship in last 7 days - absence of personal contact with family or friends
F2f	RECENT_LOSS_FAMILY	Unsettled relationship in last 7 days - recent loss of close family member or friend
F2g	ADJUST_TO_ROUTINE_CHANGE	Unsettled relationship in last 7 days - does not adjust easily to change in routines
F3a	IDENTIFY_PAST_ROLES	Recognition or acceptance of feelings regarding roles or status previous to living in facility in last 7 days - strong identification with past roles and life status

RAI ID	DATA FIELD	DESCRIPTION
F3b	SAD_OVER_LOST_ROLES	Recognition or acceptance of feelings regarding roles or status previous to living in facility in last 7 days - expresses sadness, anger or empty feeling over lost roles or status
F3c	PERCEIVES_DIFF_ROUTINE	Recognition or acceptance of feelings regarding roles or status previous to living in facility in last 7 days - perceives that daily life is very different from prior pattern in community
G1aA	ADL_BED_MOBILITY_SELF_PERF	Self care performance in activities of daily living in last 7 days - bed mobility
G1aB	BED_MOBILITY_SUPPORT	Highest level of support received for activities of daily living in last 7 days - bed mobility
G1bA	ADL_TRANSFER_SELF_PERF	Self care performance in activities of daily living in last 7 days - transfer
G1bB	TRANSFER_SUPPORT	Highest level of support received for activities of daily living in last 7 days - transfer
G1cA	ADL_WALK_IN_ROOM_SELF_PERF	Self care performance in activities of daily living in last 7 days - walk in room
G1cB	WALK_IN_ROOM_SUPPORT	Highest level of support received for activities of daily living in last 7 days - walk in room
G1dA	ADL_WALK_IN_CORRIDOR_SELF_PERF	Self care performance in activities of daily living in last 7 days - walk in corridor
G1dB	WALK_IN_CORRIDOR_SUPPORT	Highest level of support received for activities of daily living in last 7 days - walk in corridor
G1eA	ADL_LOCOMOT_ON_UNIT_SELF_PERF	Self care performance in activities of daily living in last 7 days - locomotion on unit
G1eB	LOCOMOT_ON_UNIT_SUPPORT	Highest level of support received for activities of daily living in last 7 days - locomotion on unit
G1fA	ADL_LOCOMOT_OFF_UNIT_SELF_PERF	Self care performance in activities of daily living in last 7 days - locomotion off unit
G1fB	LOCOMOT_OFF_UNIT_SUPPORT	Highest level of support received for activities of daily living in last 7 days - locomotion off unit
G1gA	ADL_DRESSING_SELF_PERF	Self care performance in activities of daily living in last 7 days - dressing
G1gB	DRESSING_SUPPORT	Highest level of support received for activities of daily living in last 7 days - dressing
G1hA	ADL_EATING_SELF_PERF	Self care performance in activities of daily living in last 7 days - eating
G1hB	EATING_SUPPORT	Highest level of support received for activities of daily living in last 7 days - eating
G1iA	ADL_TOILET_USE_SELF_PERF	Self care performance in activities of daily living in last 7 days - toilet
G1iB	TOILET_USE_SUPPORT	Highest level of support received for activities of daily living in last 7 days - toilet
G1jA	ADL_PERSONAL_HYGIENE_SELF	Self care performance in activities of daily living in last 7 days - personal hygiene
G1jB	PERSONAL_HYGIENE_SUPPORT	Highest level of support received for activities of daily living in last 7 days - personal hygiene

RAI ID	DATA FIELD	DESCRIPTION
G2A	BATHING_SELF_PERFORMANCE	Bathing self performance
G2B	BATHING_SUPPORT	Bathing support
G3a	BALANCE_WHILE_STANDING	Test for balance in last 7 days - balance while standing
G3b	BALANCE_WHILE_SITTING	Test for balance in last 7 days - balance while sitting
G4aA	NECK_RANGE_OF_MOTION	Functional limitation in range of motion in last 7 days - neck
G4aB	NECK_VOLUNTARY_MOVEMENT	Loss of voluntary movement in last 7 days - neck
G4bA	ARM_RANGE_OF_MOTION	Functional limitation in range of motion in last 7 days - arm including shoulder or elbow
G4bB	ARM_VOLUNTARY_MOVEMENT	Loss of voluntary movement in last 7 days - arm including shoulder or elbow
G4cA	HAND_RANGE_OF_MOTION	Functional limitation in range of motion in last 7 days - hand including wrist or fingers
G4cB	HAND_VOLUNTARY_MOVEMENT	Loss of voluntary movement in last 7 days - hand including wrist or fingers
G4dA	LEG_RANGE_OF_MOTION	Functional limitation in range of motion in last 7 days -leg including hip or knee
G4dB	LEG_VOLUNTARY_MOVEMENT	Loss of voluntary movement in last 7 days - leg including hip or knee
G4eA	FOOT_RANGE_OF_MOTION	Functional limitation in range of motion in last 7 days - foot including ankle or toes
G4eB	FOOT_VOLUNTARY_MOVEMENT	Loss of voluntary movement in last 7 days - foot including ankle or toes
G4fA	OTHER_LTD_RANGE_OF_MOTION	Functional limitation in range of motion in last 7 days - other limitation or loss
G4fB	OTHER_LTD_VOLUNTARY_MOVEMENT	Loss of voluntary movement in last 7 days -limitation or loss in other joints not listed
G5a	CANE_WALKER	Modes of locomotion in last 7 days - cane, walker, crutch
G5b	WHEELED_SELF	Modes of locomotion in last 7 days - wheeled self
G5c	OTHER_PERSON_WHEELED	Modes of locomotion in last 7 days - other person wheeled
G5d	WHEELCHAIR_PRIMARY_LOCOMOT	Modes of locomotion in last 7 days - wheelchair primary mode of locomotion
G6a	BEDFAST	Modes of transfer in last 7 days - bedfast all or most of time
G6b	BED_RAILS_FOR_BED_MOBILITY	Modes of transfer in last 7 days - bed rails used for bed mobility or transfer
G6c	LIFTED_MANUALLY	Modes of transfer in last 7 days - lifted manually
G6d	LIFTED_MECHANICALLY	Modes of transfer in last 7 days - lifted mechanically
G6e	TRANSFER_AID	Modes of transfer in last 7 days - transfer aid
G7	TASK_SEGMENTATION	Task segmentation in last 7 days - some or all of the activities of daily living broken into subtasks
G8a	RES_MORE_INDEPENDENCE	Activities of daily living functional rehabilitation potential in last 7 days - resident believes self to be capable of increased independence in at least some ADLs

RAI ID	DATA FIELD	DESCRIPTION
G8b	STAFF_MORE_INDEPENDENCE	Activities of daily living functional rehabilitation potential in last 7 days - staff believe resident is capable of increased independence in at least some ADLs
G8c	SLOW_PERFORMING_TASKS	Activities of daily living functional rehabilitation potential in last 7 days - resident able to perform tasks or activity but is very slow
G8d	AM_PM_DIFFER_ADLS	Activities of daily living functional rehabilitation potential in last 7 days - difference in ADL self performance or ADL support comparing mornings to evenings
G9	CHANGE_IN_ADL_FUNCTION	Activities of daily living self performance status has changed compared to status 90 days ago or since last assessment if less than 90 days
H1a	BOWEL_CONTINENCE	Continence in last 14 days - bowel continence
H1b	BLADDER_CONTINENCE_SELF	Continence in last 14 days - bladder continence
H2a	BOWEL_ELIMINATION_REGULAR	Bowel elimination pattern in last 14 days - regular
H2b	CONSTIPATION	Bowel elimination pattern in last 14 days - constipation
H2c	DIARRHEA	Bowel elimination pattern in last 14 days - diarrhea
H2d	FECAL_IMPACTION	Bowel elimination pattern in last 14 days - fecal impaction
H3a	SCHEDULED_TOILETING_PLAN	Applicance and programs in last 14 days - scheduled toilet plan
H3b	BLADDER_RETRAINING_PROGRAM	Applicance and programs in last 14 days - bladder retraining program
H3c	EXTERNAL_CATHETER	Applicance and programs in last 14 days - external catheter
H3d	INDWELLING_CATHETER	Applicance and programs in last 14 days - indwelling catheter
H3e	INTERMITTENT_CATHETER	Applicance and programs in last 14 days - intermittent catheter
H3f	DID_NOT_USE_TOILET	Applicance and programs in last 14 days - did not use toilet
H3g	PADS_OR_BRIEFS	Applicance and programs in last 14 days - pads or briefs used
H3h	ENEMAS_IRRIGATION	Applicance and programs in last 14 days - enemas or irrigation
H3i	OSTOMY_PRESENT	Applicance and programs in last 14 days - ostomy present
H4	CHANGE_IN_URINARY_CONTINENCE	Change in urinary continence compared to 90 days ago or since last assessment if less than 90 days
I1a	DIABETES_MELLITUS	Disease - diabetes mellitus
I1aa	PARKINSONS	Disease - Parkinson's disease
I1b	HYPERTHYROIDISM	Disease - hyperthyroidism
I1bb	QUADRIPLEGIA	Disease - quadriplegia
I1c	HYPOTHYROIDISM	Disease - hypothyroidism
I1cc	SEIZURE_DISORDER	Disease - seizure disorder
I1d	ARTERIO_HEART_DISEASE	Disease - arteriosclerotic heart
I1dd	TRANSIENT_ISCHEMIC_ATTACK	Disease - transient ischemic attack
I1e	CARDIAC_DYSRHYTHMIAS	Disease - cardiac dysrhythmia

RAI ID	DATA FIELD	DESCRIPTION
I1ee	TRAUMATIC_BRAIN_INJURY	Disease - traumatic brain injury
I1f	CONGESTIVE_HEART_FAILURE	Disease - congestive heart failure
I1ff	ANXIETY_DISORDER	Disease - anxiety disorder
I1g	DEEP_VEIN_THROMBOSIS	Disease - deep vein thrombosis
I1gg	DEPRESSION	Disease - depression
I1h	HYPERTENSION	Disease - hypertension
I1hh	MANIC_DEPRESSIVE	Disease - bipolar disorder, manic depressive
I1i	HYPOTENSION	Disease - hypotension
I1ii	SCHIZOPHRENIA	Disease - schizophrenia
I1j	PERIPHERAL_VASC_DISEASE	Disease - peripheral vascular
I1jj	ASTHMA	Disease - asthma
I1k	OTHER_CARDIOVASC_DISEASE	Disease - other cardiovascular
I1kk	EMPHYSEMA_COPD	Disease - emphysema or COPD
I1l	ARTHRITIS	Disease - arthritis
I1ll	CATARACTS	Disease - cataracts
I1m	HIP_FRACTURE	Disease - hip fracture
I1mm	DIABETIC_RETINOPATHY	Disease - diabetic retinopathy
I1n	MISSING_LIMB	Disease - missing limb
I1nn	GLAUCOMA	Disease - glaucoma
I1o	OSTEOPOROSIS	Disease - osteoporosis
I1oo	MACULAR_DEGENERATION	Disease - macular degeneration
I1p	PATHOLOGICAL_BONE_FRACTURE	Disease - pathological bone fracture
I1pp	ALLERGIES	Disease - allergies
I1q	AMYOTROPHIC_LAT_SCLEROSIS	Disease - amyotrophic lateral sclerosis
I1qq	ANEMIA	Disease - anemia
I1r	ALZHEIMERS	Disease - Alzheimer's
I1rr	CANCER	Disease - cancer
I1s	APHASIA	Disease - aphasia
I1ss	GASTROINTESTINAL_DISEASE	Disease - gastrointestinal disease
I1t	CEREBRAL_PALSY	Disease - cerebral palsy
I1tt	LIVER_DISEASE	Disease - liver disease
I1u	CEREBROVASCULAR_ACCIDENT	Disease - cerebrovascular accident

RAI ID	DATA FIELD	DESCRIPTION
I1uu	RENAL_FAILURE	Disease - renal failure
I1v	DEMENTIA_NOT_ALZHEIMERS	Disease - dementia other than Alzheimer's
I1w	HEMIPLEGIA_HEMIPARESIS	Disease - hemiplegia or hemiparesis
I1x	HUNTINGTONS_CHOREA	Disease - Huntington's chorea
I1y	MULTIPLE_SCLEROSIS	Disease - multiple sclerosis
I1z	PARAPLEGIA	Disease - paraplegia
I2a	ANTIBIOTIC_RESIST_INFECT	Infection - antibiotic resistant infection
I2b	CELLULITIS	Infection - cellulitis
I2c	CLOSTRIDIUM_DIFFICILE	Infection - clostridium difficile
I2d	CONJUNCTIVITIS	Infection - conjunctivitis
I2e	HIV_INFECTION	Infection - HIV infection
I2f	PNEUMONIA	Infection - pneumonia
I2g	RESPIRATORY_INFECTION	Infection - respiratory infection
I2h	SEPTICEMIA	Infection - septicemia
I2i	SEXUALLY_TRANSMIT_DISEASES	Infection - sexually transmitted disease
I2j	TUBERCULOSIS	Infection - tuberculosis
I2k	URINARY_TRACT_INFECTION	Infection - urinary tract infection in last 30 days
I2l	VIRAL_HEPATITIS	Infection - viral hepatitis
I2m	WOUND_INFECTION	Infection - wound infection
I3a	OTHER_DIAG_A	Other current diagnosis ICD-10-CA code
I3b	OTHER_DIAG_B	Other current diagnosis ICD-10-CA code
I3c	OTHER_DIAG_C	Other current diagnosis ICD-10-CA code
I3d	OTHER_DIAG_D	Other current diagnosis ICD-10-CA code
I3e	OTHER_DIAG_E	Other current diagnosis ICD-10-CA code
I3f	OTHER_DIAG_F	Other current diagnosis ICD-10-CA code
J1a	WEIGHT_FLUCTUATION	Problem conditions in last 7 days - weight gain or loss of 1.5+ kilos
J1b	INABILITY_TO_LIE_FLAT	Problem conditions in last 7 days - inability to lie flat due to shortness of breath
J1c	DEHYDRATION	Problem conditions in last 7 days - dehydrated, output exceeds input
J1d	INSUFFICIENT_FLUIDS	Problem conditions - insufficient fluid consumed in last 3 days
J1e	DELUSIONS	Problem conditions in last 7 days - delusions
J1f	DIZZINESS	Problem conditions in last 7 days - dizziness or vertigo
J1g	EDEMA	Problem conditions in last 7 days - edema

RAI ID	DATA FIELD	DESCRIPTION
J1h	FEVER	Problem conditions in last 7 days - fever
J1i	HALLUCINATIONS	Problem conditions in last 7 days - hallucinations
J1j	INTERNAL_BLEEDING	Problem conditions in last 7 days - internal bleeding
J1k	RECURRENT_LUNG_ASPIRATIONS	Problem conditions - recurrent lung aspirations in last 90 days
J1l	SHORTNESS_OF_BREATH	Problem conditions in last 7 days - shortness of breath
J1m	SYNCOPE	Problem conditions in last 7 days - syncope
J1n	UNSTEADY_GAIT	Problem conditions in last 7 days - unsteady gait
J1o	VOMITING	Problem conditions in last 7 days - vomiting
J2a	PAIN_SYMPTOMS_FREQ	Frequency of complaints or evidence of pain in last 7 days
J2b	PAIN_SYMPTOMS_INTENSITY	Intensity of pain in last 7 days
J3a	BACK_PAIN	Site where pain was present in last 7 days - back
J3b	BONE_PAIN	Site where pain was present in last 7 days - bone
J3c	CHEST_PAIN	Site where pain was present in last 7 days - chest
J3d	HEADACHE	Site where pain was present in last 7 days - headache
J3e	HIP_PAIN	Site where pain was present in last 7 days - hip
J3f	INCISIONAL_PAIN	Site where pain was present in last 7 days - incisional
J3g	JOINT_PAIN_HIP	Site where pain was present in last 7 days - joint other than hip
J3h	SOFT_TISSUE_PAIN	Site where pain was present in last 7 days - soft tissue
J3i	STOMACH_PAIN	Site where pain was present in last 7 days - stomach
J3j	OTHER_PAIN	Site where pain was present in last 7 days - other
J4a	FELL_IN_PAST_30_DAYS	Accident - fell in past 30 days
J4b	FELL_IN_PAST_31_180_DAYS	Accident - fell in past 31 to 180 days
J4c	HIP_FRACTURE_IN_LAST_180_DAYS	Accident - hip fracture in last 180 days
J4d	OTHER_FRACTURE	Accident - other fracture in last 180 days
J5a	CONDITION_LEADS_TO_INSTABLITY	Stability of condition - cognitive, ADL, mood or behaviour patterns unstable
J5b	EXPERIENCING_ACUTE_EPISODE	Stability of condition - acute episode or flare-up of recurrent or chronic problem
J5c	END_STAGE_DISEASE	Stability of condition - end stage disease, 6 months or less to live
K1a	CHEWING_PROBLEM	Oral problem in last 7 days - chewing
K1b	SWALLOWING_PROBLEM	Oral problem in last 7 days - swallowing
K1c	MOUTH_PAIN	Oral problem in last 7 days - mouth pain
K2a	HEIGHT	Height in centimetres
K2b	WEIGHT	Weight in kilograms

RAI ID	DATA FIELD	DESCRIPTION
K3a	WEIGHT_LOSS	Weight loss 5% or more in last 30 days or 10% or more in last 180 days
K3b	WEIGHT_GAIN	Weight gain 5% or more in last 30 days or 10% or more in last 180 days
K4a	COMPLAINS_ABOUT_TASTE	Nutritional problems in last 7 days - complains about the taste of many foods
K4b	COMPLAINTS_OF_HUNGER	Nutritional problems in last 7 days - regular or repetitive complaints of hunger
K4c	LEAVES_FOOD_UNEATEN	Nutritional problems in last 7 days - leaves 25% or more of food uneaten at most meals
K5a	PARENTERAL_IV	Nutritional approaches in last 7 days - parenteral IV
K5b	FEEDING_TUBE	Nutritional approaches in last 7 days - feeding tube
K5c	MECHANIC_ALTERED_DIET	Nutritional approaches in last 7 days - mechanically altered diet
K5d	ORAL_FEEDING	Nutritional approaches in last 7 days - syringe oral feeding
K5e	THERAPEUTIC_DIET	Nutritional approaches in last 7 days - therapeutic diet
K5f	DIETARY_SUPPLEMENT	Nutritional approaches in last 7 days - dietary supplement between meals
K5g	PLATE_GUARD	Nutritional approaches in last 7 days - plate guard, stabilized built-up utensils etc.
K5h	PLANNED_WEIGHT_CHANGE_PROG	Nutritional approaches in last 7 days - planned weight change program
K6a	TOTAL_CALORIES	Parenteral or enteral intake in last 7 days - proportions of total calories
K6b	AVERAGE_FLUIDS	Parenteral or enteral intake in last 7 days - average fluid intake
L1a	DEBRIS_IN_MOUTH	Oral status and disease prevention in last 7 days - debris present in mouth prior to going to bed at night
L1b	DENTURES_REMOVE_BRIDGE	Oral status and disease prevention in last 7 days - dentures or removable bridge
L1c	NATURAL_TEETH_LOST	Oral status and disease prevention in last 7 days - some or all natural teeth lost, does not use dentures
L1d	BROKEN_LOOSE_TEETH	Oral status and disease prevention in last 7 days - broken, loose or carious teeth
L1e	INFLAMED_GUMS	Oral status and disease prevention in last 7 days - inflamed, swollen or bleeding gums, oral abscesses, ulcers or rashes
L1f	DAILY_CLEANING_TEETH	Oral status and disease prevention in last 7 days - daily cleaning of teeth or dentures
M1a	STAGE1_ULCERS	Ulcers in last 7 days - stage 1, persistent area of skin redness does not disappear when pressure is relieved
M1b	STAGE2_ULCERS	Ulcers in last 7 days - stage 2, partial thickness loss of skin layers that presents as abrasion, blister or shallow crater
M1c	STAGE3_ULCERS	Ulcers in last 7 days - stage 3, full thickness of skin loss, exposing subcutaneous tissues, deep crater
M1d	STAGE4_ULCERS	Ulcers in last 7 days - stage 4, full thickness of skin and subcutaneous tissue loss, exposing muscle or bone

RAI ID	DATA FIELD	DESCRIPTION
M2a	STAGE_OF_PRESSURE_ULCER	Type of ulcer in last 7 days - pressure
M2b	STAGE_OF_STASIS_ULCER	Type of ulcer in last 7 days - stasis
M3	HISTORY_OF_RESOLVED_ULCERS	Ulcer resolved or cured in last 90 days
M4a	ABRASIONS_BRUISES	Other skin problem or lesion in last 7 days - abrasions, bruises
M4b	BURNS	Other skin problem or lesion in last 7 days - burns, second or third degree
M4c	OPEN_LESIONS_NOT_ULCERS	Other skin problem or lesion in last 7 days - open lesions other than ulcers, rashes, cuts
M4d	RASHES	Other skin problem or lesion in last 7 days - rash
M4e	SKIN_DESENSITIZED_TO_PAIN	Other skin problem or lesion in last 7 days - skin desensitized to pain or pressure
M4f	SKIN_TEARS_OR_CUTS	Other skin problem or lesion in last 7 days - skin tears or cuts other than surgery
M4g	SURGICAL_WOUND	Other skin problem or lesion in last 7 days - surgical wounds
M5a	RELIEVING_DEVICE_CHAIR	Skin treatments in last 7 days - pressure relieving device for chair
M5b	RELIEVING_DEVICE_BED	Skin treatments in last 7 days - pressure relieving device for bed
M5c	TURNING_PROGRAM	Skin treatments in last 7 days - turning or repositioning program
M5d	SKIN_NUTRITION_INTERVENTION	Skin treatments in last 7 days - nutrition or hydration intervention to manage skin problems
M5e	ULCER_CARE	Skin treatments in last 7 days - ulcer care
M5f	SURGICAL_WOUND_CARE	Skin treatments in last 7 days - surgical wound care
M5g	APPLY_DRESSING_NOT_FEET	Skin treatments in last 7 days - application of dressings other than to feet
M5h	APPLY_OINTMENT_NOT_FEET	Skin treatments in last 7 days - application of ointments or medications other than to feet
M5i	OTHER_PREVENT_NOT_FEET	Skin treatments in last 7 days - other preventative or protective skin care other than feet
M6a	FOOT_PROBLEM	Foot problem and care in last 7 days - one or more foot problems
M6b	INFECTION_OF_FOOT	Foot problem and care in last 7 days - infection of foot
M6c	OPEN_LESIONS_ON_FOOT	Foot problem and care in last 7 days - open lesions on the foot
M6d	NAILS_CALLUSES_TRIMMED	Foot problem and care - nails or calluses trimmed in last 90 days
M6e	RECEIVED_PREVENT_FOOT_CARE	Foot problem and care in last 7 days - received preventative or protective foot care
M6f	APPLY_DRESSING_FOOT	Foot problem and care in last 7 days - application of dressings
N1a	TIME_AWAKE_MORNING	Time awake in last 7 days - morning
N1b	TIME_AWAKE_AFTERNOON	Time awake in last 7 days - afternoon
N1c	TIME_AWAKE_EVENING	Time awake in last 7 days - evening
N2	AVERAGE_TIME_ACTIVITIES	Average time involved in activities in last 7 days

RAI ID	DATA FIELD	DESCRIPTION
N3a	PREF_ACT_OWN_ROOM	Preferred activity setting in last 7 days - own room
N3b	PREF_ACT_ACTIVITY_ROOM	Preferred activity setting in last 7 days - day or activity room
N3c	PREF_ACT_INSIDE	Preferred activity setting in last 7 days - inside facility or off unit
N3d	PREF_ACT_OUTSIDE	Preferred activity setting in last 7 days - outside facility
N4a	PREF_ACT_CARDS_GAMES	Preferred activity in last 7 days - cards, other games
N4b	PREF_ACT_CRAFTS	Preferred activity in last 7 days - crafts or arts
N4c	PREF_ACT_EXERCISE	Preferred activity in last 7 days - exercise or sports
N4d	PREF_ACT_MUSIC	Preferred activity in last 7 days - music
N4e	PREF_ACT_READING	Preferred activity in last 7 days - reading or writing
N4f	PREF_ACT_SPIRITUAL	Preferred activity in last 7 days - spiritual or religious activities
N4g	PREF_ACT_TRIPS	Preferred activity in last 7 days - trips or shopping
N4h	PREF_ACT_WALKING	Preferred activity in last 7 days - walking or wheeling outdoors
N4i	PREF_ACT_WATCH_TV	Preferred activity in last 7 days - watching TV
N4j	PREF_ACT_GARDENING	Preferred activity in last 7 days - gardening or plants
N4k	PREF_ACT_TALKING	Preferred activity in last 7 days - talking or conversing
N4l	PREF_ACT_HELP_OTHERS	Preferred activity in last 7 days - helping others
N5a	PREFER_CHANGE_IN_ACTIVITY	Prefers change in daily routine in last 7 days - in current activities
N5b	PREFER_CHANGE_IN_INVOLVEMENT	Prefers change in daily routine in last 7 days - in extent of involvement in activities
O1	NUM_OF_MEDS	Number of medications in last 7 days
O2	NEW_MEDS	New medications in last 90 days
O3	DAYS_INJECTIONS	Number of days injections were received in last 7 days
O4a	DAYS_ANTIPSYCHOTIC	Number of days received medication in last 7 days - antipsychotic
O4b	DAYS_ANTIANXIETY	Number of days received medication in last 7 days - antianxiety
O4c	DAYS_ANTIDEPRESSANT	Number of days received medication in last 7 days - antidepressant
O4d	DAYS_HYPNOTIC	Number of days received medication in last 7 days - hypnotic
O4e	DAYS_DIURETIC	Number of days received medication in last 7 days - diuretic
O4f	DAYS_ANALGESIC	Number of days received medication in last 7 days - analgesic
P1aa	CHEMOTHERAPY	Special care in last 14 days - chemotherapy
P1ab	DIALYSIS	Special care in last 14 days - renal dialysis
P1ac	IV_MEDS	Special care in last 14 days - IV medication
P1ad	INTAKE_OUTPUT	Special care in last 14 days - intake or output
P1ae	MONITOR_MEDICAL_CONDITION	Special care in last 14 days - monitoring acute medical condition

RAI ID	DATA FIELD	DESCRIPTION
P1af	OSTOMY_CARE	Special care in last 14 days - ostomy care
P1ag	OXYGEN_THERAPY	Special care in last 14 days - oxygen therapy
P1ah	RADIATION	Special care in last 14 days - radiation
P1ai	SUCTIONING	Special care in last 14 days - suctioning
P1aj	TRACHEOSTOMY	Special care in last 14 days - tracheostomy care
P1ak	TRANSFUSIONS	Special care in last 14 days - transfusions
P1al	VENTILATOR_OR_RESPIRATOR	Special care in last 14 days - ventilator or respirator
P1am	ALCOHOL_DRUG_PROGRAM	Special care in last 14 days - alcohol or drug treatment program
P1an	ALZHEIMERS_CARE_UNIT	Special care in last 14 days - Alzheimer's or dementia special care unit
P1ao	HOSPICE_CARE	Special care in last 14 days - hospice care
P1ap	PEDIATRIC_UNIT	Special care in last 14 days - pediatric unit
P1aq	RESPITE_CARE	Special care in last 14 days - respite care
P1ar	TRAINING_COMMUNITY_SKILLS	Special care in last 14 days - training in skills required to return to community
P1baA	DAYS_SPEECH_THERAPY	Number of days of therapy administered for at least 15 minutes a day in last 7 days - speech, language pathology and audiology services
P1baB	MINS_SPEECH_THERAPY	Total minutes of therapy provided in last 7 days - speech, language pathology and audiology services
P1bbA	DAYS_OCCUPATION_THERAPY	Number of days of therapy administered for at least 15 minutes a day in last 7 days - occupational
P1bbB	MINS_OCCUPATION_THERAPY	Total minutes of therapy provided in last 7 days - occupational
P1bcA	DAYS_PHYSICAL_THERAPY	Number of days of therapy administered for at least 15 minutes a day in last 7 days - physical
P1bcB	MINS_PHYSICAL_THERAPY	Total minutes of therapy provided in last 7 days - physical
P1bdA	DAYS_RESPIRATORY_THERAPY	Number of days of therapy administered for at least 15 minutes a day in last 7 days - respiratory
P1bdB	MINS_RESPIRATORY_THERAPY	Total minutes of therapy provided in last 7 days - respiratory
P1beA	DAYS_PSYCHO_THERAPY	Number of days of therapy administered for at least 15 minutes a day in last 7 days - psychological
P1beB	MINS_PSYCHO_THERAPY	Total minutes of therapy provided in last 7 days - psychological
P1bfA	DAYS_RECREATION_THERAPY	Number of days of therapy administered for at least 15 minutes a day in last 7 days - recreational
P1bfB	MINS_RECREATION_THERAPY	Total minutes of therapy provided in last 7 days - recreational
P2a	INTERV_PRG_SPEC_BEHAV_SYMPTOM	Intervention program for mood, behaviour, cognitive loss in last 7 days - special behaviour symptom evaluation
P2b	INTERV_PRG_EVAL_MH_SPECIALIST	Intervention program for mood, behaviour, cognitive loss - evaluation by licensed mental health specialist in last 90 days

RAI ID	DATA FIELD	DESCRIPTION
P2c	INTERV_PRG_GROUP_THERAPY	Intervention program for mood, behaviour, cognitive loss in last 7 days - group therapy
P2d	INTERV_PRG_RESIDENT_CHANGE_ENV	Intervention program for mood, behaviour, cognitive loss in last 7 days - resident specific deliberate changes in environment to address mood or behaviour patterns
P2e	INTERV_PRG_REORIENTATION	Intervention program for mood, behaviour, cognitive loss in last 7 days - reorientation
P3a	REHAB_DAYS_ROM_PASSIVE	Number of days of nursing rehabilitation or restorative care in last 7 days - range of motion passive
P3b	REHAB_DAYS_ROM_ACTIVE	Number of days of nursing rehabilitation or restorative care in last 7 days - range of motion active
P3c	REHAB_DAYS_SPLINT_ASSIST	Number of days of nursing rehabilitation or restorative care in last 7 days - splint or brace assistance
P3d	REHAB_DAYS_BED_MOBILITY	Number of days of nursing rehabilitation or restorative care in last 7 days - bed mobility
P3e	REHAB_DAYS_TRANSFER	Number of days of nursing rehabilitation or restorative care in last 7 days - transfer
P3f	REHAB_DAYS_WALKING	Number of days of nursing rehabilitation or restorative care in last 7 days - walking
P3g	REHAB_DAYS_DRESSING	Number of days of nursing rehabilitation or restorative care in last 7 days - dressing or grooming
P3h	REHAB_DAYS_EATING	Number of days of nursing rehabilitation or restorative care in last 7 days - eating or swallowing
P3i	REHAB_DAYS_AMPUTATION	Number of days of nursing rehabilitation or restorative care in last 7 days - amputation or prosthesis care
P3j	REHAB_DAYS_COMMUNICATION	Number of days of nursing rehabilitation or restorative care in last 7 days - communication
P3k	REHAB_DAYS_OTHER	Number of days of nursing rehabilitation or restorative care in last 7 days - other
P4a	FULL_BED_RAILS	Devices or restraints in last 7 days - full bed rails on all sides
P4b	OTHER_TYPES_OF_RAILS	Devices or restraints in last 7 days - other types of bed rails
P4c	TRUNK_RESTRAINT	Devices or restraints in last 7 days - trunk restraint
P4d	LIMB_RESTRAINT	Devices or restraints in last 7 days - limb restraint
P4e	CHAIR_PREVENTS_RISING	Devices or restraints in last 7 days - chair prevents rising
P5	HOSPITAL_STAYS	Hospital stay in last 90 days or since last assessment if less than 90 days
P6	EMERGENCY_ROOM_VISITS	Emergency room visits in last 90 days or since the last assessment if less than 90 days
P7	DAYS_PHYSICIAN_VISITS	Physician visits in last 14 days or since admission if less than 14 days
P8	DAYS_DOCTOR_ORDERS_CHANGED	Physician-s orders in last 14 days or since admission if less than 14 days

RAI ID	DATA FIELD	DESCRIPTION
P9	ABNORMAL_LAB_VALUES	Abnormal lab values in last 90 days or since admission if less than 90 days
Q1a	WANTS_RETURN_TO_COMMUNITY	Discharge potential in next 3 months - expresses or indicates preference to return to community
Q1b	SUPPORT_POSITIVE_DISCHARGE	Discharge potential in next 3 months - has a support person who is positive towards discharge
Q1c	STAY_SHORT_DURATION	Discharge potential in next 3 months - stay projected to be of short duration
Q2	CHANGE_IN_CARE_NEEDS	Overall change in care needs and level of self sufficiency in last 90 days or since assessment if less than 90 days
R1a	RES_PARTICIPATED_ASSESS	Participation in assessment - resident
R1b	FAMILY_PARTICIPATED_ASSESS	Participation in assessment - family
R1c	OTHER_PARTICIPATED_ASSESS	Participation in assessment - significant other
R2b	SIGNED_COMPLETE_DATE	Date that the registered nurse coordinator signed the assessment as being complete
	ABS	Score for Aggressive Behaviour Scale for the resident on current assessment
	ABS_CHANGE_CODE	Change in score for Aggressive Behaviour Scale for the resident on current assessment from previous assessment
	ACTIVE_NEW_STATUS	Identifies whether a resident is new or existing in the facility. A new resident is one whose date of assessment minus date of admission is less than 92 days
	ACTIVITIES_CAP	Activities CAP
	ADL_CAP	Activities of Daily Living CAP
	ADL_HIERARCHY	Score for ADL Hierarchy Scale for the resident on current assessment
	ADL_HIERARCHY_CHANGE_CODE	Change in score for ADL Hierarchy Scale for the resident on current assessment from previous assessment
	ADL_LONG_FORM	Score for ADL Long Form Scale for the resident on current assessment
	ADL_LONG_FORM_CHANGE_CODE	Change in score for ADL Long Form Scale for the resident on current assessment from previous assessment
	ADL_SHORT_FORM	Score for ADL Short Form Scale for the resident on current assessment
	ADL_SHORT_FORM_CHANGE_CODE	Change in score for ADL Short Form Scale for the resident on current assessment from previous assessment
	APPROP_MEDS_CAP	Appropriate Medication CAP
	ASSESSMENT_FY_FACILITY_FLAG	Flag for whether this particular ax is selected to represent the resident's condition in the CCRS facility in the fiscal year of ax. Selection based on the ax being the last ax for the resident in the CCRS facility in the fiscal year.
	ASSESSMENT_FY_SECTOR_FLAG	Flag for whether this particular ax is selected to represent the resident's condition in the sector in the fiscal year of ax. Selection based on the ax being the last ax for the resident in the sector in the fiscal year.

RAI ID	DATA FIELD	DESCRIPTION
	BED_TYPE_AT_ASSESSMENT	To enable reporting on the different types of beds that residents may be placed within a facility. This may include specialized beds such as respite, convalescent or palliative beds in addition to general residential, long-term beds at assessment date
	BEHAVIOUR_CAP	Behaviour CAP
	BOWEL_CONDITIONS_CAP	Bowel Conditions CAP
	CARDIO_RESPIRATORY_CAP	Cardio Respiratory Condition CAP
	CHESS	Score for CHESS for the resident on current assessment
	CHESS_CHANGE_CODE	Change in score for CHESS for the resident on current assessment from previous assessment
	CIHI_ASSESSMENT_PREV_QTR_FLAG	Flag for whether the assessed resident has had an assessment in the previous quarter
	CIHI_FISCAL_QUARTER_ASSESSMENT	Fiscal quarter of assessment. This is CIHI's fiscal quarters which are 1 - April to June, 2 - July to September, 3 - October to December and 4 - January to March
	CIHI_FISCAL_YEAR_ASSESSMENT	Fiscal year of assessment
	CIHI_QUARTER_FLAG	Flag for whether this particular assessment is selected to represent the resident's condition in the fiscal quarter of assessment
	CMI_HIERARCHY	CMI Code for Hierarchical Methodology
	CMI_INDEX_MAX	CMI for Index Maximizing Methodology
	COGNITIVE_LOSS_CAP	Cognitive Loss CAP
	COMATOSE_CHANGE_FLAG	Whether or not comatose status has changed since previous
	COMMUNICATION_CAP	Communication CAP
	CPS	Score for Cognitive Performance Scale for the resident on current assessment
	CPS_CHANGE_CODE	Change in score for Cognitive Performance Scale for the resident on current assessment from previous assessment
	DAY_FLAG	Flag for whether this particular assessment is selected to represent the resident's condition on the day of assessment
	DEHYDRATION_CAP	Dehydration CAP
	DELIRIUM_CAP	Delirium CAP
	DQ_ASSESSMENT_FLAG	A data quality flag assigned at the Assessment level to flag Assessment with date problems. 1-9 and 99 are removed from analytical reports and eReports. 1-10 and 99 are removed for linkage projects.
	DRS	Score for Depression Rating Scale for the resident on current assessment
	DRS_CHANGE_CODE	Change in score for Depression Rating Scale for the resident on current assessment from previous assessment
	EPISODE_ID	Identifier assigned to each episode, used to uniquely track each episode
	FALLS_CAP	Falls CAP

RAI ID	DATA FIELD	DESCRIPTION
	FEEDING_TUBE_CAP	Feeding Tube CAP
	ISE	Score for Index for Social Engagement for the resident on current assessment
	ISE_CHANGE_CODE	Change in score for Index for Social Engagement for the resident on current assessment from previous assessment
	MIS_AT_ASSESSMENT	The Unit MIS Functional Centre Account Code is the account number that is used to represent the statistical and financial reporting related to the unit in which the resident is placed in the facility at assessment date
	MOOD_CAP	Mood CAP
	NO_TRIGGERED_CAPS	No triggered CAPs
	NUM_OF_MEDS_RECORDS_SUBMIT	Number of medication records submitted
	PAIN	Score for Pain Scale for the resident on current assessment
	PAIN_CAP	Pain CAP
	PAIN_CHANGE_CODE	Change in score for Pain Scale for the resident on current assessment from previous assessment
	PHYSICAL_RESTRAINTS_CAP	Physical Restraints CAP
	PRESSURE_ULCER_CAP	Pressure Ulcer CAP
	PREVIOUS_ASSESSMENT_ID	Assessment ID for the previous assessment of resident, if applicable, which was used in the calculation of Nr & Dr flag of incidence indicators and for change in outcome scale scores
	PURS	Score for Pressure Ulcer Risk Scale
	PURS_SCORE_CHANGE	Change in score for PURS for the resident on current assessment from previous assessment
	RUG_HIERARCHY_CATEGORY	RUG category for Hierarchical Methodology
	RUG_HIERARCHY_CODE	RUG category for Hierarchical Methodology
	RUG_INDEX_MAX_CATEGORY	RUG Category for Index Maximizing Methodology
	RUG_INDEX_MAX_CODE	RUG Code for Index Maximizing Methodology
	SECTOR	Main sector, hospital based or residential based, that facility is assigned to
	SOCIAL_RELATIONSHIP_CAP	Social Relationship CAP
	UNDERNUTRITION_CAP	Undernutrition CAP
	URINARY_INCONTINENCE_CAP	Urinary Incontinence CAP

Organization - Contains information on the organization/site where a residential care service took place. (CCRS_ORGANIZATION)

RAI ID	DATA FIELD	DESCRIPTION
AA6	FACILITY	Facility number assigned by the province or territory. The CIHI base 20 provider number.
	CITY	Facility city
	DELIVERY_SITE_END_DATE	The date this facility closes or closed for business

RAI ID	DATA FIELD	DESCRIPTION
	FACILITY_CENSUS_DIVISION	Statistics Canada's Standard Geographic census division code for the facility providing care to the resident. Field has the format nn where each n can take on the value of 0 to 9. See the 2001 Standard Geographical Classification (SGC) for lists of valid codes for census division. A missing census division is indicated by "00"
	FACILITY_CENSUS_SUBDIVISION	Statistics Canada's Standard Geographic census subdivision code for the facility providing care to the resident. Field has the format nnn where each n can take on the value of 0 to 9. See the 2001 Standard Geographical Classification (SGC) for lists of valid codes for census subdivision. A missing census subdivision is indicated by "999"
	HA_NM	The name of the Health Authority
	HEALTH_AUTHORITY_CODE	The code of the Health Authority (01, 02, 03, 04 or 05)
	FACILITY_NAME	Facility name
	HSDA_CD	The code of the Health Service Delivery Area
	HSDA_NM	The name of the Health Service Delivery Area
	FACILITY_QAIPPE	Neighbourhood income quintile for the facility providing care to the resident
	FACILITY_SAC_CODE	Statistics Canada's census metropolitan area/census agglomeration code for the facility providing care to the resident. Field has the format nnn where each n can take on the value of 0 to 9
	FACILITY_SAC_TYPE	Statistical area classification type for the facility providing care to the resident
	FACILITY_SIZE	Facility size
	CIHI_URBAN_RURAL_CODE	Urban/rural status of facility
	POSTAL_CODE	Facility postal code
	PROVINCE	Province or territory in which the facility is located
	SECTOR	Main sector, hospital based or residential based, that facility is assigned to

Medication - Contains information on the medications listed during the RAI MDS 2.0 assessment. An assessment can list multiple medications. (CCRS_MEDICATION)

RAI ID	DATA FIELD	DESCRIPTION
	ASSESSMENT_ID	Identifier assigned to each assessment in the database
U2	ADMIN_ROUTE	Route of administration of medication received in last 7 days
U3	ADMIN_FREQUENCY	Frequency that medication is administered
U4	ADMIN_AMOUNT	Amount of medication administered
U5	PRN_DOSES_NUMBER	Number of doses in last 7 days if U3 frequency is as necessary
U6	DIN	Drug Identification Number of medication received in last 7 day
	MEDS_SEQ_NUMBER	Sequence number assigned to the various medications given to a resident for each assessment (1-N where N is the number of medication records per assessment)

Functional Centre - Contains information on the MIS functional centre where MIS functional centre fields are referenced at admission, discharge and assessment. (CCRS_FUNCTIONAL_CENTRE)

RAI ID	DATA FIELD	DESCRIPTION
AA1	UNIQUE_REGISTRATION_IDENTIFIER - replaced with a study specific identification number	The Unique Registration Identifier uniquely identifies the resident admission. It is composed of a facility number, a date and 7 characters.
AD3	MIS_ACCOUNT_CODE	MIS Functional Centre Account Code is the account number used to represent the statistical and financial reporting related to the unit in which the resident is placed at the facility. MIS is the Standards for Management Information Systems in Canadian Health
	MIS_DQ_FLAG	Determines if the response is valid AD3
	MIS_EFFECTIVE_DATE	Date when Update record was received

Home Care Reporting System (HCRS)

Episode - The service episode record is comprised a service start and a service end. A service end date is to be submitted when a client changes facility or service is ended due to an end reason. If there is no service end date then a client is still receiving service. (HCRS_EPISODE)

RAI ID	DATA FIELD	DESCRIPTION
	EPISODE_ID	Uniquely track each episode
AA3a	UNENCRYPTED_HEALTH_CARD_NUMBER - replaced with a study specific identification number	Unencrypted Health Card Number
AA4	CLIENT_POSTAL_CODE	Forward Sortation Area of the postal code of residence
BB1	SEX	Sex
BB2a	BIRTH_DATE	Birth Date (YYYYMM)
BB2b	ESTIMATED_BIRTH_DATE_FLAG	A flag to indicate that client birth date is estimated
BB4	MARITAL_STATUS	Marital Status
BB5a	LANGUAGE	Primary Language
CC1	DATE_CASE_OPENED_REOPENED	Date Case Opened or Reopened
X30	DISCHARGE_DATE	Date a source organization completes administrative processes that record termination of all home care services provided
X31	SERVICE_GOALS_MET_AT_DISCHARGE	Indicates whether home care client-s documented service goals have been met at discharge
X32	DISCHARGE_REASON	Reason for the client-s discharge from the source organization-s home care program
X33	REFERRAL_TO_OTH_HEALTH_SERVICE	The health service setting that a client was referred to at time of discharge from the home care program
X4	PROGRAM_TYPE	Program under which the source organization provides home care services
X5	REFERRAL_SOURCE	Person or organization that referred the client for home care services
X6	ACCEPTANCE_DATE	The date on which an individual is accepted into the home care program
Z1a	ORGANIZATION_IDENTIFIER	Uniquely identifies an organization. This is the health authority code precededby a 9. 90001 - Interior Health Authority, 90002 - Fraser Health Authority, 90003 - Vancouver Coastal Health Authority, 90004 - Vancouver Island Health Authority, 90005 - Northern Health Authority
	CLIENT_GROUP_ADMISSION	Client Group assigned at admission to Home Care
	CLIENT_GROUP_DISCHARGE	Client Group assigned at Discharge

Assessment - Contains the RAI-HC assessment information, outcome scales, Method for Assigning Priority Levels (MAPLe), clinical assessment protocols (CAPs), and quality indicators. An assessment must have an episode record. (HCRS_ASSESSMENT)

RAI ID	DATA FIELD	DESCRIPTION
	ASSESSMENT_ID	Unique identifier for each assessment
A1	ASSESSMENT_DATE	Assessment Reference Date
A2	ASSESSMENT_REASON	Reason for Assessment
B1a	SHORT_TERM_MEMORY	Memory Recall Ability - Short term memory

RAI ID	DATA FIELD	DESCRIPTION
B1b	PROCEDURAL_MEMORY	Memory Recall Ability - Procedural memory
B2a	DECISION_MAKING	Cognitive Skills - Decision Making
B2b	WORSENING_DECISION_MAKING	Cognitive Skills - Worsening Decision Making
B3a	DELIRIUM_7_DAYS	Indicator of Delirium - Sudden or new onset or changes in mental function over last 7 days
B3b	DELIRIUM_90_DAYS	Indicator of delirium - Client-s behaviour over the past 90 days or since last assessment if less than 90 days
BB1	SEX	Sex
BB2a	BIRTH_DATE	Birth Date (YYYYMM)
BB2b	ESTIMATED_BIRTH_DATE_FLAG	A flag to indicate that client birth date is estimated
BB4	MARITAL_STATUS	Marital Status
BB5a	LANGUAGE	Primary Language
BB5b	INTERPRETER_NEEDED	Interpreter Needed
BB6	EDUCATION_COMPLETED	Highest level of education completed
BB7a	LEGAL_GUARDIAN	Legal Guardian or Substitute Decision Maker
BB7b	ADV_MEDICAL_DIRECTIVES	Written documentation that states type of intervention client does or does not desire
C1	HEARING	Evaluate client-s ability to hear during the past 3 day period
C2	MAKING_SELF_UNDERSTOOD	Level of making self understood
C3	ABILITY_TO_UNDERSTAND_OTHERS	Level of ability to understand others
C4	COMMUNICATION_DECLINE	To compare client-s current abilities to make him or herself understood or to understand others to status of 90 days ago
CC1	DATE_CASE_OPENED_REOPENED	Date Case Opened or Reopened
CC2	REASON_FOR_REFERRAL	To document the primary reason for referral to the home care agency
CC3a	UNDERSTAND_NURSING_TREATMENT	Understanding of goals of care - Skilled nursing treatment
CC3b	UNDERSTAND_MONITORING	Understanding of goals of care - Monitoring
CC3c	UNDERSTAND_REHABILITATION	Understanding of goals of care - Rehabilitation
CC3d	UNDERSTAND_FAMILY_EDUCATION	Understanding of goals of care - Client and family education
CC3e	UNDERSTAND_FAMILY_RESPITE	Understanding of goals of care - Family Respite
CC3f	UNDERSTAND_PALLIATIVE_CARE	Understanding of goals of care - Palliative Care
CC4	LAST_HOSPITAL_STAY	Time since discharge from last inpatient setting
CC5	LIVED_TIME_OF_REFERRAL	Client-s permanent living arrangement at time of referral
CC6	LIVING_ARRANGEMENT	Whom the client lives with presently at time of referral
CC7	PRIOR_RESIDENT_CARE_FACILITY	Resided in one or more residential care facilities at anytime during 5 years prior to case opening

RAI ID	DATA FIELD	DESCRIPTION
CC8	RESIDENCE_HISTORY	Moved to current residence within last two years
D1	VISION	To evaluate client-s ability to see close objects using client-s customary visual appliances for close vision
D2	VISUAL_LIMITATIONS	To document whether client experiences visual limitations or difficulties related to diseases common in aged persons
D3	VISUAL_DECLINE	Has vision declined
E1a	SAD_MOOD	Indicators of Depression, Anxiety, Sad Mood in last 3 days - A feeling of sadness or being depressed
E1b	PERSISTENT_ANGER	Indicators of Depression, Anxiety, Sad Mood in last 3 days - Persistent anger with self or others
E1c	UNREALISTIC_FEARS	I Indicators of Depression, Anxiety, Sad Mood in last 3 days - Expressions of what appear to be unrealistic fears
E1d	REPETITIVE_HEALTH_COMPLAINTS	Indicators of Depression, Anxiety, Sad Mood in last 3 days - Repetitive health complaints
E1e	REPETITIVE_ANXIOUS_COMPLAINTS	Indicators of Depression, Anxiety, Sad Mood in last 3 days - Repetitive anxious complaints or concerns non health related
E1f	SAD_FACIAL_EXPRESSION	Indicators of Depression, Anxiety, Sad Mood in last 3 days - Sad, pained, worried facial expressions
E1g	RECURRENT_CRYING_TEARFULNESS	Indicators of Depression, Anxiety, Sad Mood in last 3 days - Recurrent Crying, Tearfulness
E1h	WITHDRAWAL_FROM_ACTIVITIES	Indicators of Depression, Anxiety, Sad Mood in last 3 days - Withdrawal from Activities of Interest
E1i	REDUCED_SOCIAL_INTERACTION	Indicators of Depression, Anxiety, Sad Mood in last 3 days - Reduced Social Interaction
E2	MOOD_DECLINE	To compare current status of mood indicators to status 90 days ago
E3a	WANDERING_FREQ	Behavioural symptoms frequency in last 3 days - Wandering
E3b	VERBALLY_ABUSE_FREQ	Behavioural symptoms frequency in last 3 days - Verbally Abusive
E3c	PHYSICAL_ABUSE_FREQ	Behavioural symptoms frequency in last 3 days - Physically Abusive
E3d	DISRUPTIVE_FREQ	Behavioural symptoms frequency in last 3 days - Socially Inappropriate or Disruptive
E3e	RESISTS_CARE_FREQ	Behavioural symptoms frequency in last 3 days - Resists Care
E4	DECLINE_IN_BEHAVIOUR_SYMPTOM	Behavioural symptoms or resistance to care exhibited by client have as compared to status of 90 days ago or since last assessment if less than 90 days
F1a	EASY_INTERACT_WITH_OTHERS	Involvement - At ease interacting with others
F1b	CONFLICT_WITH_FAMILY	Involvement - Openly expresses conflict or anger with family or friends
F2	DECLINE_IN_SOCIAL_ACTIVITIES	Recent change compared to 90 days ago in the level of participation in activities or relationships
F3a	LENGTH_OF_TIME_ALONE_IN_DAY	Isolation - Length of actual time client is alone during morning and afternoon

RAI ID	DATA FIELD	DESCRIPTION
F3b	CLIENT_FEELS_LONELY	Isolation - Client-s perception of feeling lonely
G1eA	LIVES_WITH_CLIENT_PRIMARY	Informal Helper Lives with Client - Primary informal caregiver support system
G1eB	LIVES_WITH_CLIENT_SECONDARY	Informal Helper Lives with Client - Secondary informal caregiver support system
G1fA	RELATIONSHIP_CLIENT_PRIMARY	Informal helper-s relationship to client - Primary
G1fB	RELATIONSHIP_CLIENT_SECONDARY	Informal helper-s relationship to client - Secondary
G1gA	EMOTIONAL_SUPPORT_PRIMARY	Informal helper-s Areas of Help - Advice or Emotional Support - Primary
G1gB	EMOTIONAL_SUPPORT_SECONDARY	Informal helper-s Areas of Help - Advice or Emotional Support - Secondary
G1hA	IADL_CARE_PRIMARY	Informal helper-s Areas of Help - Instrumental Activities of Daily Living Care - Primary
G1hB	IADL_CARE_SECONDARY	Informal helper-s Areas of Help - Instrumental Activities of Daily Living Care - Secondary
G1iA	ADL_CARE_PRIMARY	Informal helper-s Areas of Help - Activities of Daily Living Care - Primary
G1iB	ADL_CARE_SECONDARY	Informal helper-s Areas of Help - Activities of Daily Living Care - Secondary
G1jA	WILLING_MORE_SUPPORT__PRIMARY	Informal helper-s willingness to increase Emotional Support - Primary
G1jB	WILLING_MORE_SUPPORT_SECONDARY	Informal helper-s willingness to increase Emotional Support - Secondary
G1kA	WILLING_MORE_IADL_CARE_PRIMARY	Informal helper-s willingness to increase Instrumental Activities of Daily Living Care - Primary
G1kB	WILLING_MORE_IADL_CARE_SECOND	Informal helper-s willingness to increase Instrumental Activities of Daily Living Care - Secondary
G1lA	WILLING_MORE_ADL_CARE_PRIMARY	Informal helper-s willingness to increase Activities of Daily Living Care - Primary
G1lB	WILLING_MORE_ADL_CARE_SECOND	Informal helper-s willingness to increase Activities of Daily Living Care - Secondary
G2a	CAREGIVER_UNABLE_TO_CONTINUE	Caregiver Status - The caregiver, client, or assessor believes a caregiver(s) is not able to continue in caring activities
G2b	CAREGIVER_NO_SATISFIED_SUPPORT	Caregiver Status - The primary caregiver is not satisfied with support others are currently providing in care of client
G2c	CAREGIVER_EXPRESS_DISTRESS	Caregiver Status - Primary caregiver expresses feeling of distress, anger depression or in conflict because of caring for client
G2d	CAREGIVER_STATUS_NONE_OF_ABOVE	Caregiver Status - None of the Above
G3a	INFORMAL_HELP_5_WEEKDAYS	Extent of informal help over the last 7 days - Capture number of hours
G3b	INFORMAL_HELP_2_WEEKEND_DAYS	Extent of informal help over the last 7 days - Capture number of hours
H1aA	IADL_MEAL_PREP_SELF_PERF	IADL in last 7 days - Meal Preparation - Self Performance
H1aB	IADL_MEAL_PREP_DIFFICULTY	IADL in last 7 days - Meal Preparation - Difficulty
H1bA	IADL_HOUSEWORK_SELF_PERF	IADL in last 7 days - Ordinary Housework - Self Performance
H1bB	IADL_HOUSEWORK_DIFFICULTY	IADL in last 7 days - Ordinary Housework - Difficulty

RAI ID	DATA FIELD	DESCRIPTION
H1cA	IADL_MANAGE_FINANCES_SELF_PERF	IADL in last 7 days - Managing Finances - Self Performance
H1cB	IADL_MANAGE_FINANCE_DIFFICULTY	IADL in last 7 days - Managing Finances - Difficulty
H1dA	IADL_MANAGE_MEDS_SELF_PERF	IADL in last 7 days - Managing Medications - Self Performance
H1dB	IADL_MANAGE_MEDS_DIFFICULTY	IADL in last 7 days - Managing Medications - Difficulty
H1eA	IADL_PHONE_USE_SELF_PERF	IADL in last 7 days - Phone Use - Self Performance
H1eB	IADL_PHONE_USE_DIFFICULTY	IADL in last 7 days - Phone Use - Difficulty
H1fA	IADL_SHOPPING_SELF_PERF	IADL in last 7 days - Shopping - Self Performance
H1fB	IADL_SHOPPING_DIFFICULTY	IADL in last 7 days - Shopping - Difficulty
H1gA	IADL_TRANSPORTATION_SELF_PERF	IADL in last 7 days - Transportation - Self Performance
H1gB	IADL_TRANSPORTATION_DIFFICULTY	IADL in last 7 days - Transportation - Difficulty
H2a	ADL_MOBILITY_IN_BED_SELF_PERF	Activities of Daily Living - Mobility in Bed
H2b	ADL_TRANSFER_SELF_PERF	Activities of Daily Living - Transfer - moving to and between surfaces
H2c	ADL_LOCOMOT_IN_HOME_SELF_PERF	Activities of Daily Living - Locomotion in Home
H2d	ADL_LOCOMOT_OUT_HOME_SELF_PERF	Activities of Daily Living - Locomotion Outside of Home
H2e	ADL_DRESS_UPPER_BODY_SELF_PERF	Activities of Daily Living - Dressing Upper Body
H2f	ADL_DRESS_LOWER_BODY_SELF_PERF	Activities of Daily Living - Dressing Lower Body
H2g	ADL_EATING_SELF_PERF	Activities of Daily Living - Eating
H2h	ADL_TOILET_USE_SELF_PERF	Activities of Daily Living - Toilet Use
H2i	ADL_PERSONAL_HYGIENE_SELF_PERF	Activities of Daily Living - Personal Hygiene
H2j	ADL_BATHING_SELF_PERF	Activities of Daily Living - Bathing
H3	ADL_DECLINE	Current Activities of Daily Living status to status of 90 days ago
H4a	MODE_OF_LOCOMOTION_INDOORS	Mode of Locomotion - Indoors
H4b	MODE_OF_LOCOMOTION_OUTDOORS	Mode of Locomotion - Outdoors
H5	STAIR_CLIMBING	Stair Climbing ability in last 3 days
H6a	DAYS_WENT_OUT_OF_HOUSE	Stamina - Went out of the house - How many days client went outdoors
H6b	HOURS_OF_PHYSICAL_ACTIVITY	Stamina - Hours of physical activity in the last 3 days
H7a	CLIENT_MORE_INDEPENDENCE	Functional Potential - Client believes she/he can increase function independence
H7b	CAREGIVER_MORE_INDEPENDENCE	Functional Potential - Caregivers believe client can increase function independence
H7c	GOOD_PROSPECT_OF_RECOVERY	Functional Potential - Good Prospect of Recovery from current disease or conditions
H7d	FUNCTIONAL_NONE_OF_THE_ABOVE	Functional Potential - None of the Above
I1a	BLADDER_CONTINENCE_SELF	Client-s pattern of bladder continence over the last 7 days

RAI ID	DATA FIELD	DESCRIPTION
I1b	WORSENING_OF_INCONTINENCE	Compare current bladder continence status to 90 days ago
I2a	PADS_OR_BRIEFS	Use of Pad or Briefs over the last 7 days
I2b	INDWELLING_URINARY_CATHETER	Use of indwelling urinary catheter over the last 7 days
I2c	BLADDER_DEVICE_NONE_OF_ABOVE	None of the above or no bladder devices being used over the last 7 days
I3	BOWEL_CONTINENCE	Client-s pattern of bowel continence over the last 7 days or since last assessment if less than 7 days
J1a	CEREBROVASCULAR_ACCIDENT	Heart/circulation disease diagnosis - Cerebrovascular Accident
J1aa	RENAL_FAILURE	Disease diagnosis - Renal Failure
J1ab	THYROID_DISEASE	Disease diagnosis - Thyroid Disease (hyper or hypo)
J1ac	DISEASE_NONE_OF_THE_ABOVE	Disease - None of the Above
J1b	CONGESTIVE_HEART_FAILURE	Heart/circulation disease diagnosis - Congestive Heart Failure
J1c	CORONARY_HEART_DISEASE	Heart/circulation disease diagnosis - one or more of the coronary arteries is narrowed by plaque or vascular spasms
J1d	HYPERTENSION	Heart/circulation disease diagnosis - Persistently high arterial blood pressure
J1e	IRREGULARLY_IRREGULAR_PULSE	Heart/circulation disease diagnosis - Any abnormal cardiac rhythm
J1f	PERIPH_VASC_DISEASE_MONITORED	Heart/circulation disease diagnosis - Vascular disease of the lower extremities
J1g	ALZHEIMERS	Neurological disease diagnosis - Alzheimer-s
J1h	DEMENTIA_OTHER_THAN_ALZHEIMERS	Neurological disease diagnosis - Dementia other than Alzheimer-s
J1i	HEAD_TRAUMA	Neurological disease diagnosis - wound or injury to head
J1j	HEMIPLEGIA_HEMIPARESIS	Neurological disease diagnosis - paralysis on ones side of body
J1k	MULTIPLE_SCLEROSIS	Neurological disease diagnosis - Multiple Sclerosis
J1l	PARKINSONS_MONITORED	Neurological disease diagnosis - Parkinsonism
J1m	ARTHRITIS	Musculo-skeletal disease diagnosis - Arthritis
J1n	HIP_FRACTURE	Musculo-skeletal disease diagnosis - Hip Fracture
J1o	OTHER_FRACTURE_WRIST_VERTEBRA	Musculo-skeletal disease diagnosis - Other Fractures (wrist, vertebral)
J1p	OSTEOPOROSIS	Musculo-skeletal disease diagnosis - Osteoporosis
J1q	CATARACTS	Senses disease diagnosis - Cataract
J1r	GLAUCOMA	Senses disease diagnosis - Glaucoma
J1s	ANY_PSYCHIATRIC_DIAGNOSIS	Any psychiatric diagnosis
J1t	HIV_INFECTION	Infection disease diagnosis - HIV infection
J1u	PNEUMONIA	Infection disease diagnosis - Pneumonia
J1v	TUBERCULOSIS	Infection disease diagnosis - Tuberculosis
J1w	URINARY_TRACT_INFECTION	Infection disease diagnosis - Urinary Tract Infection

RAI ID	DATA FIELD	DESCRIPTION
J1x	CANCER_NOT_INCLUDING_SKIN	Disease diagnosis - Cancer in past 5 years, not including skin cancer
J1y	DIABETES	Disease diagnosis - Diabetes
J1z	EMPHYSEMA_COPD_ASTHMA	Disease diagnosis - Emphysema/COPD/asthma
J2a	OTHER_A_ICD_10_CA	Other diseases that affect client-s status, require treatments or symptom management
J2b	OTHER_B_ICD_10_CA	Other diseases that affect client-s status, require treatments or symptom management
J2c	OTHER_C_ICD_10_CA	Other diseases that affect client-s status, require treatments or symptom management
J2d	OTHER_D_ICD_10_CA	Other diseases that affect client-s status, require treatments or symptom management
K1a	BLOOD_PRESSURE_MEASURED	Preventative Health - Blood pressure was measured by a clinician during the past two years
K1b	RECEIVED_INFLUENZA_VACCINATION	Preventative Health - Received vaccination for influenza prevention during the past two years
K1c	TEST_STOOL_BLOOD_ENDOSCOPY	Preventative Health - Entire colon (from anus to cecum) was viewed by means of a fiber-optic colonoscopy during the past 2 years
K1d	BREAST_EXAM_MAMMOGRAPHY	Preventative Health - Had either a mammogram or a breast examination by a clinician during the past 2 years
K1e	PREVENTIVE_NONE_OF_THE_ABOVE	Preventative Health - None of the Above
K2a	DIARRHEA	Problem Conditions present on 2+ days of the last 3 days - Diarrhea
K2b	CHANGE_IN_URINATING	Problem Conditions present on 2+ days of the last 3 days - difficulty urinating or urinating three or more times per night
K2c	FEVER	Problem Conditions present on 2+ days of the last 3 days - fever
K2d	LOSS_OF_APPETITE	Problem Conditions present on 2+ days of the last 3 days - loss of appetite
K2e	VOMITING	Problem Conditions present on 2+ days of the last 3 days - vomiting
K2f	CONDITIONS_NONE_OF_THE_ABOVE	None of the above Problem Conditions present 2+ days of the last 3 days
K3a	CHEST_PAIN	Physical Health Problem Conditions in the last 3 days -Chest pain at rest or on exertion
K3b	NO_BOWEL_MOVEMENT_IN_3_DAYS	Physical Health Problem Conditions in the last 3 days - No bowel movement
K3c	DIZZINESS	Physical Health Problem Conditions in the last 3 days -Dizziness or Lightheadedness
K3d	EDEMA	Physical Health Problem Conditions in the last 3 days -Accumulation of fluid in tissue
K3e	SHORTNESS_OF_BREATH	Physical Health Problem Conditions in the last 3 days -Difficulty breathing occurring at rest, with activity, or in response to illness or anxiety
K3f	DELUSIONS	Mental Health Problem Conditions in the last 3 days -Delusions
K3g	HALLUCINATIONS	Mental Health Problem Conditions in the last 3 days -Hallucinations

RAI ID	DATA FIELD	DESCRIPTION
K3h	MENTAL_HLTH_NONE_OF_THE_ABOVE	Mental Health Problem Conditions in the last 3 days -None of the above
K4a	PAIN_FREQUENCY	Pain - Frequency with which client complains or shows evidence of pain
K4b	PAIN_INTENSITY	Pain - Client-s perception of intensity or severity of pain
K4c	PAIN_DISRUPTS_USUAL_ACTIVITIES	Pain - From client-s point of view, pain intensely disrupts usual activities
K4d	CHARACTER_OF_PAIN	Pain - Client reported he/she was experiencing pain in single site/area or multiple sites/areas, over the last 3 days
K4e	ADEQUATE_MEDS_FOR_PAIN	Pain - Client reports adequacy of pain control with current medications taken
K5	FALLS_FREQUENCY	Number of times client fell in last 90 days or since last assessment if less than 90 days
K6a	UNSTEADY_GAIT	Danger of Fall - A gait that places the client at risk of falling
K6b	LIMIT_GOING_OUT_AFRAID_FALLING	Danger of Fall - Any restriction by self or others of going outdoors with goal of preventing fall
K7a	ADVISE_REDUCE_DRINKING	Lifestyle in the last 90 days - client or people in client life expressed concern regarding amount of alcohol consumption
K7b	ALCOHOL_IN_MORNING_OR_TROUBLE	Lifestyle in the last 90 days - client or caregiver report client had to have alcoholic drink first thing in the morning. The client or caregiver reports there has been trouble because of drinking
K7c	SMOKE_OR_CHEW_TOBACCO_DAILY	Lifestyle - Client Smoked or Chewed Tobacco Daily
K8a	CLIENT_FEELS_HAS_POOR_HEALTH	Health Status Indicators - client feels he/she has poor health
K8b	CONDITION_UNSTABLE_BEHAVIOUR	Health Status Indicators - Has conditions or disease that make cognition, ADL, mood, or behaviour patterns unstable, fluctuating, precarious, deteriorating
K8c	FLAREUP_RECURRENT_PROBLEM	Health Status Indicators - Experiencing a flare-up of a recurrent or chronic problem
K8d	TREATMENT_CHANGED_LAST_30_DAYS	Health Status Indicators - Treatments changed in last 30 days because of new acute episode or condition
K8e	LESS_THAN_6_MONTHS_TO_LIVE	Health Status Indicators - The client or family has been told by physician, the client has end-stage disease with six or fewer months to live
K8f	STATUS_NONE_OF_THE_ABOVE	Health Status Indicators - none of the above
K9a	FEARS_FAMILY_CAREGIVER	Other Status Indicators - Client expresses, either verbally or through behaviour, fear towards a family member or caregiver
K9b	UNUSUALLY_POOR_HYGIENE	Other Status Indicators - Client is observed to have unusually poor hygiene beyond what considered appropriate
K9c	UNEXPLAINED_INJURY_BROKEN_BONE	Other Status Indicators - Injuries or accidents that do not fit the clinical picture or realm of reasonable possibility given circumstance
K9d	NEGLECTED_ABUSED	Other Status Indicators - Client had serious or life threatening situation or conditions that go untreated or acknowledged
K9e	PHYSICALLY_RESTRAINED	Other Status Indicators - physically restrained regardless of stated intent
K9f	OTHER_STATUS_NONE_OF_THE_ABOVE	Other Status Indicators - none of the above

RAI ID	DATA FIELD	DESCRIPTION
L1a	WEIGHT_LOSS	Unintended weight loss of 5% or more in last 30 days or 10% or more in last 180 days
L1b	SEVERE_MALNUTRITION	Disorder of nutrition; may be due to a deficient diet, breakdown, assimilation, or utilization of food
L1c	MORBID_OBESITY	Obesity to a degree as to interfere with normal activities, including respiration
L2a	ONE_OR_FEWER_MEALS_A_DAY	In at least 2 out of the last three days, ate one or fewer meals a day
L2b	DECREASE_FOOD_FLUIDS_CONSUMED	In last 3 days, noticeable decrease in amount of food or fluids client usually consumes
L2c	INSUFFICIENT_FLUIDS	Did not consume all/almost all fluids during the last 3 days
L2d	ENTERAL_TUBE_FEEDING	Enteral tube feeding
L3	SWALLOWING_DIFFICULTY	Level of swallowing difficulty
M1a	PROBLEM_CHEWING	Inability to chew food easily and without pain or difficulties, regardless of cause
M1b	DRY_MOUTH	Client reports having a dry mouth, or observed difficulty in moving food bolus in mouth
M1c	PROBLEM_BRUSHING_TEETH_DENTURE	Difficulty in cleaning teeth and/or dentures due to endurance, motivation or fine motor skill problems
M1d	ORAL_STATUS_NONE_OF_THE_ABOVE	None of the above Oral Status issues
N1	SKIN_PROBLEMS	Any troubling skin condition or changes in skin condition such as bruises, rashes, itchiness, body lice or scabies
N2a	PRESSURE_ULCER	Ulcers present in the last 3 days - Lesion caused by pressure resulting in damage of underlying tissues
N2b	STASIS_ULCER	Ulcers present in the last 3 days - open lesion, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency
N3a	BURNS	Other Skin Problems Requiring Treatment - Burns
N3b	OPEN_LESIONS_OTHER_THAN_ULCERS	Other Skin Problems Requiring Treatment - Open lesions other than ulcers
N3c	SKIN_TEARS_OR_CUTS	Other Skin Problems Requiring Treatment - Skin tears or cuts
N3d	SURGICAL_WOUND	Other Skin Problems Requiring Treatment - Surgical wounds
N3e	CORNS_CALLUS_INFECTIONS_FUNGI	Other Skin Problems Requiring Treatment - Corns, Calluses, structural problems, infections, fungi
N3f	SKIN_NONE_OF_THE_ABOVE	Other Skin Problems Requiring Treatment - None of the Above
N4	PRIOR_PRESSURE_ULCER	History or prior pressure ulcer
N5a	ANTIBIOTICS	Wound or Ulcer Care - Antibiotics, systemic or topical
N5b	DRESSINGS	Wound or Ulcer Care - Dressing
N5c	SURGICAL_WOUND_CARE	Wound or Ulcer Care - Surgical wound care

RAI ID	DATA FIELD	DESCRIPTION
N5d	OTHER_WOUND_ULCER_CARE	Wound or Ulcer Care - Other wound or ulcer care such as pressure relieving device, nutrition, turning, debridement
N5e	WOUND_CARE_NONE_OF_THE_ABOVE	Wound or Ulcer Care - None of the Above
O1a	LIGHTING	Home Environment - Lighting assessment
O1b	FLOORS_CARPETS	Home Environment - Floors and carpets assessment
O1c	BATHROOM_TOILET	Home Environment - Bathroom and toilet assessment
O1d	KITCHEN	Home Environment - Kitchen assessment
O1e	HEATING_AND_COOLING	Home Environment - Heating and cooling assessment
O1f	PERSONAL_SAFETY	Home Environment - Personal safety assessment
O1g	ACCESS_TO_HOME	Home Environment - Access to home assessment
O1h	ACCESS_TO_ROOMS_IN_HOUSE	Home Environment - Access to rooms in house assessment
O1i	HOME_ENVIRON_NONE_OF_THE_ABOVE	Home Environment - None of the above
O2a	CLIENT_LIVES_WITH_OTHERS	Living Arrangement - compared to 90 days ago client now lives with other persons
O2b	OTHER_LIVING_ENVIRON_BETTER	Living Arrangement - Client or primary caregiver feels the client would be better off in another living environment
P1aA	HOME_HEALTH_AIDES_VISIT_DAYS	Formal Care - Home health aides - Traditionally provide -hands-on- ADL support to client and simple monitoring
P1aB	HOME_HEALTH_AIDES_HOURS	Formal Care - Home health aides - Traditionally provide -hands-on- ADL support to client and simple monitoring
P1aC	HOME_HEALTH_AIDES_MINS	Formal Care - Home health aides - Traditionally provide -hands-on- ADL support to client and simple monitoring
P1bA	VISITING_NURSES_VISIT_DAYS	Formal Care - Visiting nurses - Licensed/registered nurses provide assessment and complex or invasive interventions education and referral
P1bB	VISITING_NURSES_HOURS	Formal Care - Visiting nurses - Licensed/registered nurses provide assessment and complex or invasive interventions education and referral
P1bC	VISITING_NURSES_MINS	Formal Care - Visiting nurses - Licensed/registered nurses provide assessment and complex or invasive interventions education and referral
P1cA	HOMEMAKING_SERVICES_VISIT_DAYS	Formal Care - Homemaking services - include IADL support in the form of housekeeping services, shopping, meal preparation
P1cB	HOMEMAKING_SERVICES_HOURS	Formal Care - Homemaking services - include IADL support in the form of housekeeping services, shopping, meal preparation
P1cC	HOMEMAKING_SERVICES_MINS	Formal Care - Homemaking services - include IADL support in the form of housekeeping services, shopping, meal preparation
P1dA	MEALS_DELIVERED_DAYS	Formal Care - Meals - Prepared meals are delivered to the client for immediate or later consumption
P1dB	MEALS_DELIVERED_HOURS	Formal Care - Meals - Prepared meals are delivered to the client for immediate or later consumption

RAI ID	DATA FIELD	DESCRIPTION
P1dC	MEALS_DELIVERED_MINS	Formal Care - Meals - Prepared meals are delivered to the client for immediate or later consumption
P1eA	VOLUNTEER_SERVICES_DAYS	Formal Care - Volunteer services - Cover a great range of services from visiting to light housework and simple ADL/IADL support
P1eB	VOLUNTEER_SERVICES_HOURS	Formal Care - Volunteer services - Cover a great range of services from visiting to light housework and simple ADL/IADL support
P1eC	VOLUNTEER_SERVICES_MINS	Formal Care - Volunteer services - Cover a great range of services from visiting to light housework and simple ADL/IADL support
P1fA	PHYSICAL_THERAPY_DAYS	Formal Care - Physical therapy - Therapy services that are provided or directly supervised by a qualified physical therapist
P1fB	PHYSICAL_THERAPY_HOURS	Formal Care - Physical therapy - Therapy services that are provided or directly supervised by a qualified physical therapist
P1fC	PHYSICAL_THERAPY_MINS	Formal Care - Physical therapy - Therapy services that are provided or directly supervised by a qualified physical therapist
P1gA	OCCUPATIONAL_THERAPY_DAYS	Formal Care - Occupational therapy - Therapy services that are provided or directly supervised by a qualified occupational therapist
P1gB	OCCUPATIONAL_THERAPY_HOURS	Formal Care - Occupational therapy - Therapy services that are provided or directly supervised by a qualified occupational therapist
P1gC	OCCUPATIONAL_THERAPY_MINS	Formal Care - Occupational therapy - Therapy services that are provided or directly supervised by a qualified occupational therapist
P1hA	SPEECH_THERAPY_DAYS	Formal Care - Speech therapy - Services that are provided by a qualified speech language pathologist
P1hB	SPEECH_THERAPY_HOURS	Formal Care - Speech therapy - Services that are provided by a qualified speech language pathologist
P1hC	SPEECH_THERAPY_MINS	Formal Care - Speech therapy - Services that are provided by a qualified speech language pathologist
P1iA	DAY_CARE_OR_DAY_HOSPITAL_DAYS	Formal Care - Day care or day hospital - Program out of the home where client receives social, recreational, medical or functional support
P1iB	DAY_CARE_OR_DAY_HOSPITAL_HOURS	Formal Care - Day care or day hospital - Program out of the home where client receives social, recreational, medical or functional support
P1iC	DAY_CARE_OR_DAY_HOSPITAL_MINS	Formal Care - Day care or day hospital - Program out of the home where client receives social, recreational, medical or functional support
P1jA	SOCIAL_WORKER_IN_HOME_DAYS	Formal Care - Social worker in home - Social worker provided psychosocial support assessment to clients
P1jB	SOCIAL_WORKER_IN_HOME_HOURS	Formal Care - Social worker in home - Social worker provided psychosocial support assessment to clients
P1jC	SOCIAL_WORKERS_IN_HOME_MINS	Formal Care - Social worker in home - Social worker provided psychosocial support assessment to clients
P2a	OXYGEN_TREATMENT_ADHERE	Treatments - Either intermittent or continuous use of oxygen to support, promote or maintain vital functions and comfort
P2aa	TREATMENT_NONE_OF_THE_ABOVE	Treatments - Special treatment - None of the above

RAI ID	DATA FIELD	DESCRIPTION
P2b	RESPIRATOR_ASSISTIVE__ADHERE	Treatments - Respirator for assistive breathing
P2c	OTHER_RESPIRATORY_TREATMENT	Treatments - All other respiratory treatments
P2d	ALCOHOL_DRUG_PROGRAM_ADHERE	Treatments - Chemical dependency program Where psychological emotional support and/or medication is provided
P2e	BLOOD_TRANSFUSION_ADHERE	Treatments - Blood transfusion - To replace blood loss through injury surgery or disease
P2f	CHEMOTHERAPY_ADHERE	Treatments - Chemotherapy
P2g	DIALYSIS_ADHERE	Treatments - Dialysis
P2h	INFUSION_CENTRAL_IV_ADHERE	Treatments - IV Infusion Central - Drug given by intravenous push or drip
P2i	INFUSION_PERIPHERAL_IV_ADHERE	Treatments - IV Infusion Peripheral-Drug given by intravenous push or drip. Does not include saline or heparin flush to keep heparin lock patent
P2j	MEDS_BY_INJECTION_ADHERE	Treatments - Medication by injection - Medication delivered through a needle, IM,SQ, ID
P2k	OSTOMY_CARE_ADHERE	Treatments - Ostomy care - Refers to care of site with open wound and only care that requires nursing assistance
P2l	RADIATION_ADHERE	Treatments - Radiation therapy - The treatment of disease by ionizing radiation
P2m	TRACHEOSTOMY_CARE_ADHERE	Treatments - Tracheostomy care - Includes cleansing of tracheostomy and cannula
P2n	EXERCISE_THERAPY_ADHERE	Treatments - Exercise therapy - Planned program of prescribed exercises to support or enhance endurance, balance, stamina
P2o	OCCUPATIONAL_THERAPY_ADHERE	Treatments - Occupational therapy - Therapy services provided or directly supervised by qualified occupational therapist
P2p	PHYSICAL_THERAPY_ADHERE	Treatments - Physical therapy - Therapy services provided or directly supervised by qualified physical therapist
P2q	DAY_CENTRE_ADHERE	Treatments - Day centre - Program out of home where client receives social, recreational, medical or functional support
P2r	DAY_HOSPITAL_ADHERE	Treatments - Day hospital - Program out of home where client receives medical, functional and social support
P2s	HOSPICE_CARE_ADHERE	Treatments - Hospice care - Client is identified being in program for terminally ill persons
P2t	PHYSICIAN_CLINIC_VISIT_ADHERE	Treatments - Physician or clinic visit - Includes client visit to a physician office or clinic or physician visit to client home
P2u	RESPITE_CARE_ADHERE	Treatments - Respite care - Care program involves short term stay in facility to provide relief primary home based caregiver
P2v	DAILY_NURSE_MONITORING_ADHERE	Treatments - Daily nurse monitoring
P2w	NON_DAILY_NURSE_MONITOR_ADHERE	Treatments - Nurse monitoring less than daily
P2x	MED_BRACELET_ELEC_ALERT_ADHERE	Treatments - Medical alert bracelet or electronic security alert - Any identification or device that alerts people of client medical condition or location

RAI ID	DATA FIELD	DESCRIPTION
P2y	SKIN_ULCERATION_TREAT_ADHERE	Treatments - Skin treatment - Any skin intervention performed for prevention or treatment of skin ulceration
P2z	SPECIAL_DIET	Treatments - Special diet - Nutritionally supplemented or mechanically altered diet
P3a	MANAGE_OXYGEN_EQUIPMENT	Management of Equipment in last 3 days - Oxygen
P3b	MANAGE_IV	Management of Equipment in last 3 days - IV
P3c	MANAGE_CATHETER	Management of Equipment in last 3 days - Catheter
P3d	MANAGE_OSTOMY	Management of Equipment in last 3 days - Ostomy
P4a	OVERNIGHT_HOSPITAL_ADMISSION	Visits in last 90 days - Admitted to Hospital - Number of times client admitted to hospital with overnight stay
P4b	EMERGENCY_ROOM_VISITS	Visits in last 90 days - Visited Emergency Room - Number of visits to emergency room but not admitted for overnight stay
P4c	EMERGENT_CARE_VISITS	Visits in last 90 days - Emergent Care - Number of visits to or from a health provider that was unscheduled considered to be emergency
P5	TREATMENT_GOALS_ACHIEVED	Treatment Goals -Identify if treatment goals established by nurses social workers therapists or medical doctors have been achieved in last 90 days
P6	OVERALL_CHANGE_IN_CARE_NEEDS	Overall change in care needs - Monitor overall functional status over the past 90 to determine if significant change has occurred
P7	SPENDING_TRADE_OFFS	Trade offs - During the last month determine if limited funds prevented client from receiving required medical and environmental support
Q1	NUM_OF_MEDS	Number of Medications - Number of different medications over the counter and prescription client used in past 7 days
Q2a	ANTIPSYCHOTIC_NEUROLEPTIC	Receipt of Psychotropic Medications in last 7 days - Antipsychotic or Neuroleptic
Q2b	ANXIOLYTIC	Receipt of Psychotropic Medications in last 7 days - Anxiolytic
Q2c	ANTIDEPRESSANT	Receipt of Psychotropic Medications in last 7 days - Antidepressant
Q2d	HYPNOTICS_OR_ANALGESICS	Receipt of Psychotropic Medications in last 7 days - Hypnotics or Analgesics
Q3	MEDICAL_OVERSIGHT	Medical oversight - Client has discussed all their medications and therefore medical problems with a physician in the last 180 days
Q4	COMPLIANCE_ADHERENCE_WITH_MEDS	Compliance or Adherence with Medications - client is actually taking the medication as prescribed
R1c	DATE_ASSESSMENT_COMPLETE	Signatures of Persons Completing the Assessment - Date Assessment Coordinator signed as complete
X2	CLIENT_GROUP	High level description of home care clients based on health status and assessed needs
X70	ASSESSMENT_LOCATION	Assessment Location
X71	FACILITY_ADMISSION_DATE	Facility Admission Date
	ABUSE_CAP_HC	Elder Abuse Cap
	ABUSE_CAP2008_HC	Abusive Relationship Cap - 2008 Release

RAI ID	DATA FIELD	DESCRIPTION
	ADHERENCE_CAP_HC	Adherence Cap
	ADL_CAP2008_HC	Activities of Daily Living (ADLs) Cap - 2008 Release
	ADL_LONG_FORM_HC	Activities of Daily Living (ADL) Scale - Long Form
	ADL_REHAB_CAP_HC	ADL/Rehabilitation Cap
	ADL_SELF_PERFORM_HC	Activities of Daily Living (ADL) Scale - Self-Performance Hierarchy
	ADL_SHORT_FORM_HC	Activities of Daily Living (ADL) Scale - Short Form
	ALCOHOL_CAP_HC	Alcohol Dependence and Hazardous Drinking Cap
	APPROP_MEDS_CAP2008_HC	Appropriate Medications Cap - 2008 Release
	BEHAVIOUR_CAP_HC	Behaviour Cap
	BEHAVIOUR_CAP2008_HC	Behaviour Cap - 2008 Release
	BOWEL_CONDITIONS_CAP2008_HC	Bowel Conditions Cap - 2008 Release
	BOWEL_MGMT_CAP_HC	Bowel Management Cap
	BRITTLE_CAP_HC	Brittle Support Cap
	CARDIO_RESPIRATORY_CAP_HC	Cardio-respiratory Cap
	CARDIO_RESPIRATORY_CAP2008_HC	Cardio-Respiratory Conditions Cap - 2008 Release
	CHESS_HC	Changes in Health, End-Stage disease and Symptoms and Signs (CHESS) Score
	COGNITION_CAP_HC	Cognition Cap
	COGNITIVE_CAP2008_HC	Cognitive Loss Cap - 2008 Release
	COMMUNICATION_CAP_HC	Communication Disorder Cap
	COMMUNICATION_CAP2008_HC	Communication Cap - 2008 Release
	CPS_HC	Cognitive Performance Scale
	DEHYDRATION_CAP_HC	Dehydration Cap
	DEHYDRATION_CAP2008_HC	Dehydration Cap - 2008 Release
	DELIRIUM_CAP2008_HC	Delirium Cap - 2008 Release
	DEPRESSION_CAP_HC	Depression and Anxiety Cap
	DRS_HC	Depression Rating Scale
	ENVIRONMENT_CAP_HC	Environmental Assessment Cap
	ENVIRONMENT_CAP2008_HC	Home Environment Optimization Cap - 2008 Release
	EPISODE_ID	Uniquely track each episode
	FALLS_CAP_HC	Falls Cap
	FALLS_CAP2008_HC	Falls Cap - 2008 Release
	FEEDING_CAP2008_HC	Feeding Tube Cap - 2008 Release

RAI ID	DATA FIELD	DESCRIPTION
	HEALTH_CAP_HC	Health Promotion Cap
	IADL_CAP_HC	Instrumental Activities of Daily Living (IADLs) Cap
	IADL_CAP2008_HC	Instrumental Activities of Daily Living (IADLs) Cap - 2008 Release
	IADL_DIFFICULTY_HC	Instrumental Activities of Daily Living (IADL) Difficulty Scale
	IADL_INVOLVEMENT_HC	Instrumental Activities of Daily Living (IADL) Involvement Scale
	INSTITUTIONAL_RISK_CAP_HC	Institutional Risk Cap
	INSTITUTIONAL_RISK_CAP2008_HC	Institutional Risk Cap - 2008 Release
	MAPLE_HC	Method for Assigning Priority Levels (MAPLe)
	MEDS_CAP_HC	Medication Management Cap
	MOOD_CAP2008_HC	Mood Cap - 2008 Release
	NUM_OF_MEDS_RECORDS_SUBMIT	Number of medication records submitted
	NUTRITION_CAP_HC	Nutrition Cap
	ORAL_CAP_HC	Oral Health Cap
	PAIN_CAP_HC	Pain Cap
	PAIN_CAP2008_HC	Pain Cap - 2008 Release
	PAIN_HC	Pain Scale
	PALLIATIVE_CAP_HC	Palliative Care Cap
	PHYSICAL_ACTIVITY_CAP2008_HC	Physical Activities Promotion Cap - 2008 Release
	PRESSURE_ULCER_CAP2008_HC	Pressure Ulcer Cap - 2008 Release
	PRESSURE_ULCERS_CAP_HC	Pressure Ulcers Cap
	PREVENTIVE_CAP_HC	Preventive Health Measures: Immunization and Screening Cap
	PSYCH_DRUG_CAP_HC	Psychotropic Drugs Cap
	PURS_HC	Pressure Ulcer Risk Scale (PURS)
	REDUCED_FORMAL_SERVICES_CAP_HC	Reduction in Formal Services Cap
	RUG_III_HC	Resource Utilization Groups
	RUG_III_HC_CATEGORY	Seven major groups of RUG_III_HC
	SKIN_CAP_HC	Skin and Foot Conditions Cap
	SOCIAL_CAP_HC	Social Function Cap
	SOCIAL_CAP2008_HC	Social Relationship Cap - 2008 Release
	SUPPORT_CAP2008_HC	Informal Support Cap - 2008 Release
	URINARY_CAP_HC	Urinary Incontinence and Indwelling Catheter Cap
	URINARY_CAP2008_HC	Urinary Incontinence Cap - 2008 Release

RAI ID	DATA FIELD	DESCRIPTION
	VISUAL_CAP_HC	Visual Function Cap

Medication - Contains information on the medications listed during the RAI-HC assessment. An assessment can list multiple medications. (HCRS_MEDICATION)

RAI ID	DATA FIELD	DESCRIPTION
	ASSESSMENT_ID	Unique identifier for each assessment
Q5a	MEDS_NAME	List of All Medication Used in the last 7 days - Medication name
Q5b	MEDS_DOSE	List of All Medication Used in the last 7 days - Medication dose - Amount of medication ordered
Q5c	MEDS_FORM	List of All Medication Used in the last 7 days - Medication form - Route of administration
Q5d	MEDS_FREQUENCY	List of All Medication Used in the last 7 days - Medication frequency - number of times per day, week or month that the medication is administered
Q5e	MEDS_ON_PRN_BASIS	List of All Medication Used in the last 7 days - If PRN - If the client took the medication on a Pro Re Nata basis number of times the medication was taken
X40	MEDS_SEQUENCE_NUMBER	Number representing sequence of medication within section Q5 of RAI-HC assessment that is being submitted in an individual Medication Record
X41	DIN	Drug Identification Number of a medication listed in Q5 of RAI-HC assessment

Service - Contains information on the home care services provided to the client. A service must have an episode record. (HCRS_SERVICE)

RAI ID	DATA FIELD	DESCRIPTION
	EPISODE_ID	Uniquely track each episode
X10	SERVICE_START_DATE	Date which home care service provider began to provide home care service to client
X11	SERVICE_TYPE	The type of home care service provided to the client
X12	HOME_CARE_DISCIPLINE	Discipline, profession or occupational group of individuals providing home care services to client
X13	SERVICE_DELIVERY_SETTING	Location or setting where home care service was provided to client
X14	ACUTE_SERVICES_FLAG	Flag designed to capture delivery of acute care services to clients with rehabilitation or longer term needs
X15	NUM_OF_SERVICE_VISITS	Occasions more than 5 minutes during which home care service provider provides given home care service either face-to-face or remotely to client during reporting period
X16	MINS_OF_SERVICE	Minutes spent in delivery of home care service to or on behalf of home care client during reporting period
X17	SERVICE_END_DATE	Date which home care service provider stopped providing home care service to client
X30	DISCHARGE_DATE	Date a source organization completes administrative processes that record termination of all home care services provided

RAI ID	DATA FIELD	DESCRIPTION
Y12	REPORTING_FISCAL_YEAR	Fiscal Year to which the data being submitted relate
Y13	REPORTING_PERIOD	Fiscal period in which client event took place
*Note – not all health authorities are submitting service data		