

National Rehabilitation Reporting System (NRS) Training Manual

February 26, 2015

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Chapter 1: Introduction

The National Rehabilitation Reporting System (NRS) was initiated by the Canadian Institute of Health Information (CIHI) to collect rehabilitation data from participating adult inpatient rehabilitation facilities and programs across Canada. The CIHI promotes health information standards for hospital-based inpatient rehabilitation, and initiated the NRS to develop and evaluate indicators, a minimum data set, and a related case-mix grouping methodology.

Meditech has developed an electronic version of this reporting system for recording and submitting the data collected by care providers to CIHI.

NRS Purpose

The purpose of the NRS is to:

- support the CIHI's mandate
- collect, process and analyze data on adult inpatient rehabilitation services
- support management decision making at the facility, regional and provincial/territorial levels
- facilitate provincial/territorial and national comparative reporting
- support related approved analysis and research
- ensure rehabilitation clients receive multi-dimensional (physical, cognitive, psychosocial) diagnostic, assessment treatment and service planning interventions

Data Elements

The NRS collects clinical information based on the following data elements. These elements are used to calculate a variety of indicators, such as waiting times and client outcomes.

- Client identifiers
- Socio-demographic information
- Administrative data (e.g. referral, admission and discharge)
- Health characteristics
- Activities and Participation (e.g. ADL, communication, social interaction)

Assessments include:

- The Functional Independence Measure (FIM instrument)
- CIHI cognitive assessment
- CIHI Instrumental Activities of Daily Living (IADL) (optional)

Chapter 2: Access and Navigation

Logging into Meditech

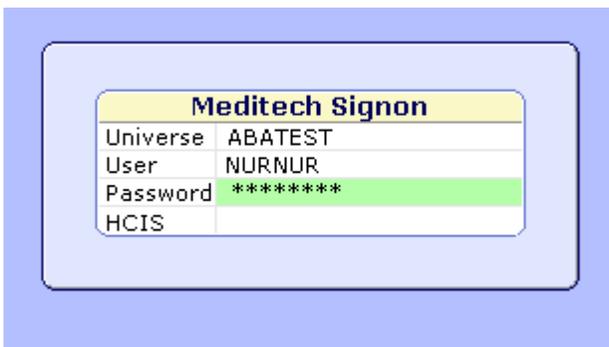
There are two methods for accessing Meditech:

1. Citrix Access via web link
2. Three tier/Desktop icon access

If you are unsure of which way to access Meditech in your area, speak to your support representative.



1. Selecting the Meditech UAT icon either via Citrix or on the desktop.
2. The Meditech login screen will display.

A screenshot of the Meditech Signon login screen. It has a light blue background and a white rounded rectangle containing a table with the following fields:

Meditech Signon	
Universe	ABATEST
User	NURNUR
Password	*****
HCIS	

3. Enter your Meditech **name/number** in 'User' prompt. Press **Enter**.
4. Enter your **password**. Press **Enter**.
5. Under HCIS:
 - a. Press the **F9** (Look-Up) button and you will see the HCIS List Screen.

Search

Mnemonic	Name	Ring
ARH.TEST5.67	Aspen Regional TEST HCIS	ABA.TEST5.67
CHR.TEST5.67	Chinook TEST HCIS	ABA.TEST5.67
DTH.TEST5.67	David Thompson TEST HCIS	ABA.TEST5.67
ECH.TEST5.67	East Central TEST HCIS	ABA.TEST5.67
NLH.TEST5.67	Northern Lights TEST HCIS	ABA.TEST5.67
PCH.TEST5.67	Peace Country TEST HCIS	ABA.TEST5.67
PHR.TEST5.67	Palliser Health TEST HCIS	ABA.TEST5.67

- b. Depending on your access, you may have several choices displayed. Choose the appropriate HCIS for your location or appropriate TEST instance.

NOTE:

Some TEST instances do not allow access using personalized username/number. To access TEST, you will have to log in with a generic access name. Contact support for assistance.

Accessing the NRS Menu

Use the following method to access the NRS Menu.

1. Log into Meditech.
2. Double-click **NRS** from the menu list.
3. Select the applicable site (for example, DRDH or DAHP).
4. Click the **NRS Menu** button on your computer desktop.



5. Select **NRS Assessments > Enter/Edit**.



Special Function Keys and Keyboard Shortcuts

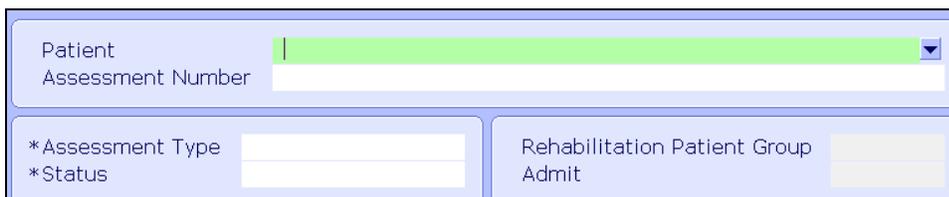
Key	Function
Tab	Move to the next field
Shift + Tab	Move to the previous field
Shift + F6	Move to the Status field
F5	Recall; display response from previous assessment
F9	Lookup or search function

Performing Patient Searches

The NRS offers multiple search options to locate a person from the database. You can search by a patient's name or by any of the identifying numbers. The most accurate way to search is by the patient's account number. Many routines begin with the Patient name field.

To search for a person

1. Type the patient surname, the visit account number or the unit number in the Patient field.



The screenshot shows a search form with the following fields:

- Patient Assessment Number**: A text input field with a dropdown arrow on the right, highlighted in green.
- *Assessment Type**: A text input field.
- *Status**: A text input field.
- Rehabilitation Patient Group Admit**: A text input field.

Note:

You can type in the full surname or just the first few letters of the surname.

2. Press **ENTER**.
A list of results displays. Results include the following:

- Inpatients: ADM IN

- Outpatients: REG RCR, SCH RCR
- Discharged patients: DIS IN

Name	Account Num	Status	Date	Location	Med Rec Num
UDITSTEST,NRS1	GE0010017/14	ADM IN	01/10/14	DAHBPB223-1	GE00010386
UDITSTEST,NRS2	GE0010018/14	ADM IN	05/10/14	DAHBPB225-1	GE00010387
UDITSTEST,NRS6	GE0000001/13	DIS IN	12/01/14	DAHBPB228-1	GE00010388
UDITSTEST,NRS8	GE0000002/13	DIS IN	01/11/13	DAHBPB225-2	GE00010389
UDITSTEST,NRS9	GE0000003/13	DIS IN	01/11/13	DAHBPB226-1	GE00010390
UDITSTEST,NRS10	GE0000004/13	DIS IN	01/11/14	DAHBPB226-2	GE00010391
UDITSTEST,NRS11	GE0000005/13	DIS IN	11/12/14	DAHBPB236-1	GE00010392

Note:

In the above example, the search was performed with the letters *UD*. The results include all persons in the database whose names begin with those letters.

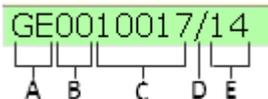
- Click to select the patient you are searching for. You can also use the arrow keys on the keyboard to scroll through the list. Below the main window, additional identifying information displays from the Admissions module.

Address	BOX 1000	Birthdate Age	01/01/1950	64
City	PONOKA	Sex	M	
Province	AB	Conf Comment		
Postal Code	T4J 1A4	Client		
Phone	(403)783-7727	Temp Location		
Final Bill	N	Other Location		

Searching by Account Number

The account number is the most accurate search method. The account number is related to the patient’s current visit in a specific facility (for example, the 118th person to be admitted this year). A new account number is assigned each time a person is re-admitted to the facility.

The following diagram and table describes the components of an account number.



Letter	Definition
A	Two letters specific to the facility

B	Zeroes that precede the visit number must be left out during a search
C	Visit number
D	Last two digits of the calendar year

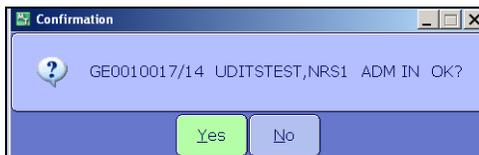
To search by account number

1. Search by the account number, excluding the proceeding (section B above) zeroes that precede the visit number.

Important:

Including the zeroes that precede the visit number can result in errors. See the diagram above to identify them.

2. Press **ENTER**.
A Confirmation message appears.



3. Click **Yes**, or press **ENTER**.
A single search result appears.
4. Ensure the result is highlighted, and then press **ENTER**.

Searching by Unit Number

You can search by the patient's Unit number or permanent Medical Record Number for a specific facility. The Unit Number is unique to the person and tracks all visits in one medical record.

For example, the number DJ0000090, will include the following:

- Two letters specific to the facility
- Zeroes
- Unit Number

The zeroes may be left out for the search (for example, DJ90).

To search by Unit number

1. Type the Unit Number search short-cut, "U#".
2. Enter the **Unit number**, excluding the zeros (for example, U#DJ90)
3. Press **Enter**
4. A Confirmation message appears.



5. Click **Yes**, or press **ENTER**.
Search results appear.

Name	Account Num	Status	Date	Location	Med Rec Num
UDITSTEST,NRS1	GE0010017/14	ADM IN	01/10/14	DAHBP223-1	GE00010386

6. Scroll to the correct record, and then press **ENTER** or **F12**.

Tip:

If the patient has multiple visits on file, ensure you select the correct visit. In the above example, the status for the current visit is *ADM IN* (admitted inpatient). Past visits will be labeled with *DIS* (discharged), for example, *ADM DIS*.

Searching by Patient Name

You can locate a patient by performing a name search. Name search allows you to search by the following options.

- The first few letters of the patient's surname. The list will include all surnames that begin with those letters. Searching by "UD" will display names that start with UD, as well as any derivatives of that name. This list might be long.
- All the letters in the patient's surname. The list will include all patients with the same surname. For common names this might be long.
- The full surname and first name. The list will be limited to patients with the exact name entered.

In all cases, the list will show all visits, the current visit as well as past discharged visits.

To search by patient name

1. Type the first few letters of the patient's surname or their full name.

Note:

For common names, search by Surname,Firstname separated by a comma with no spaces.

2. Press **Enter** or **F9**.
Search results appear.

Note:

Multiple visits for each patient might be listed. Only ADM IN statuses should ever be selected from this list.

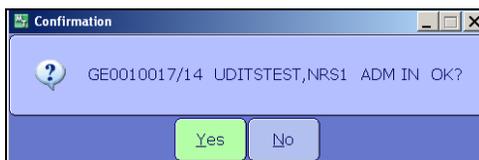
3. Scroll to and select the correct record.
 - **REG ER** for patients in the Emergency Department
 - **REG RCR or CL** for Registered Recurring or Clinic visits
 - **Discharged** visits will display with a Status of "DIS IN" or "DEP ER"
4. Press **ENTER** or **F12**.

Recalling a Patient Name

You can easily retrieve the last viewed patient record.

To recall a patient name

1. Navigate to the Patient Name field.
2. Press **SPACE BAR**, and then **ENTER** on your keyboard.
A confirmation message appears.



3. Click **Yes** or press **ENTER**.

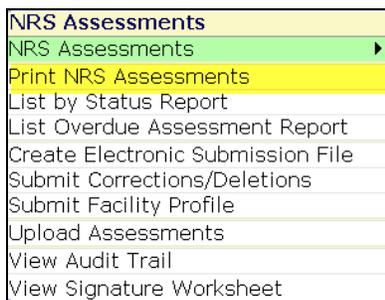
The last viewed patient name displays in the Name field.

Printing Assessments

You can print assessments for several patients or for a single patient.

To print assessments for several patients

Complete the top field of location (for example, DRDHU35 or DAHPFERI), and then press **ENTER**.



To print a single assessment

1. Press **Tab** to navigate to the Patient section and complete each column. F9 will provide options.
2. Tab through the below fields and indicate your response. The default response is 'Y'.
 - Include NRS Data
 - Include Audit Trail
 - Include Signature Worksheet



A screenshot of a software window for printing NRS assessments. At the top, there is a "Location" field and a "Load List for Care Provider" button. Below this is a table with columns: "Patient", "NRS Urm", "Status", and "Type". The table contains three rows of data:

	Patient	NRS Urm	Status	Type
1	GE0000001/13 UDITSTEST,NRS6	03	FINAL	FOLLOW ...
2	GE0000001/13 UDITSTEST,NRS6	02	FINAL	DISCHAR...
3	GE0000001/13 UDITSTEST,NRS6	01	FINAL	ADMISSI...
4				
5				
6				
7				
8				
9				
10				
11				
12				

At the bottom of the window, there are three checkboxes with labels: "*Include NRS Data", "*Include Audit Trail", and "*Include Signature Worksheet?". Each checkbox is checked, and the corresponding input field contains the letter "Y".

3. Press **OK**. Optionally, you can select **Preview**.
4. Click **Print**, select your printer and then click **OK**.

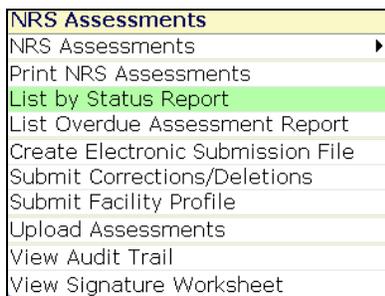


Printing Reports

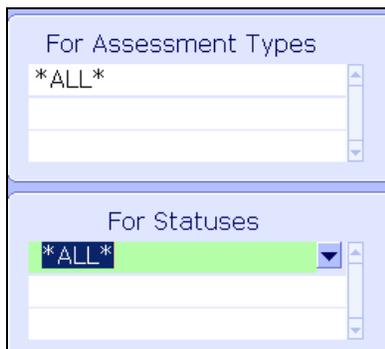
You can print status reports and overdue reports.

To print an NRS status report

1. Select **List by Status Report** from the NRS Menu (see [Accessing the NRS Menu](#)).



2. Select the Type, press F9 or lookup to see options.
3. Select the Status, press F9 or lookup to see options.
4. Click Save.



5. Optionally, you can select **Preview**.
6. Click **Print**, select your printer and then click **OK**.

The following example report includes all statuses: Final, Submitted, Draft, Complete and Cancelled.

DATE: 15/01/15 @ 1026		PCS *David Thompson Health TEST 5.67*		PAGE 1	
USER: 049575		List NRS Assessments by Status			
PATIENT		(ROOM - BED)			
		-----COMPLETED-----			
URN	STATUS	TYPE	DATE	TIME	USER
GE0010007/14	TEST567,MH1				(DAHPP312 - 1)
02	FINAL	ADMISSION	15/12/14	1148	049575
GE0010007/14	TEST567,MH1				(DAHPP312 - 1)
03	FINAL	DISCHARGE	16/12/14	0718	049575
GE0010007/14	TEST567,MH1				(DAHPP312 - 1)
04	FINAL	FOLLOW UP	16/12/14	0741	049575
GE0010007/14	TEST567,MH1				(DAHPP312 - 1)
01	X(CANCELLED)	ADMISSION			
GE0010009/14	TEST567,MH3				(DAHPP223 - 1)
01	FINAL	ADMISSION	16/12/14	0742	049575
GE0010009/14	TEST567,MH3				(DAHPP223 - 1)
02	FINAL	DISCHARGE	16/12/14	0751	049575
GE0010009/14	TEST567,MH3				(DAHPP223 - 1)
03	FINAL	FOLLOW UP	16/12/14	0756	049575
GE0010016/14	UDITSMH,MINNIE				(DAHPP236 - 1)
01	FINAL	ADMISSION	15/12/14	1055	049575
GE0010016/14	UDITSMH,MINNIE				(DAHPP236 - 1)
02	FINAL	DISCHARGE	16/12/14	0927	049575
GE0000001/13	UDITSTEST,NRS6				(DAHPP228 - 1)
01	FINAL	ADMISSION	12/01/15	1031	049575
GE0000001/13	UDITSTEST,NRS6				(DAHPP228 - 1)
02	FINAL	DISCHARGE	12/01/15	1416	049575
GE0000001/13	UDITSTEST,NRS6				(DAHPP228 - 1)
03	FINAL	FOLLOW UP	12/01/15	1451	049575
GE0000002/13	UDITSTEST,NRS8				(DAHPP225 - 2)
01	FINAL	ADMISSION	13/01/15	0943	049575
GE0000002/13	UDITSTEST,NRS8				(DAHPP225 - 2)
02	FINAL	DISCHARGE	13/01/15	1024	049575

To print an NRS overdue report

1. Select **List Overdue Assessment Report** from the NRS Menu (see [Accessing the NRS Menu](#)).

NRS Assessments
NRS Assessments
Print NRS Assessments
List by Status Report
List Overdue Assessment Report
Create Electronic Submission File
Submit Corrections/Deletions
Submit Facility Profile
Upload Assessments
View Audit Trail
View Signature Worksheet

The following message appears.

This report will provide a list of all assessments that are behind schedule according to guidelines set forth by CIHI. Specifically, this report checks the following conditions:

- * Admission assessment not finalized within 72 hours of Admission
- * Discharge assessment not finalized and discharge occurred over 72 hours ago
- * Follow Up assessment not finalized within 180 days after discharge

2. Optionally, select **Preview** to preview the report.
3. Click **Print**, select your printer and then click **OK**.

The below example report identifies overdue assessment types and due dates.

DATE: 08/12/08 @ 1322		Palliser PCS *TEST 5.54*		PAGE 1	
USER: 397224		List Overdue NRS Assessments			
Patient		NRS Um	Assessment Type	Assessment Status	Date Due
DJ0000122/07	WOLVERINE, TEST	01	ADMISSION	DRAFT	13/11/08
DJ0000122/07	WOLVERINE, TEST	02	ADMISSION	DRAFT	09/11/08
DJ0000122/07	WOLVERINE, TEST	04	ADMISSION	DRAFT	13/11/08
DJ0000129/07	ABS, KITTY, TEST	02	DISCHARGE	DRAFT	05/03/08
DJ0000153/07	PARKER, ALEX ETHAN	01	ADMISSION	DRAFT	13/12/07
DJ0000156/07	BADGER, TEST	01	ADMISSION	DRAFT	18/04/08

FIM Guidelines

For specific instructions, refer to the most recent *Rehabilitation Minimum Data Set Manual*.

http://www.cihi.ca/cihi-ext-portal/internet/en/document/types-of-care/hospital+care/rehabilitation/nrs_metadata

- **Active Rehab Days:** Days from admission to rehab (unit and program) to date ready for discharge.
- **Admission to Rehab Date:** Date patient is admitted to 2N rehab bed (i.e. facility) and starting official rehab program.
- **Admission FIM Assessment:** Baseline functional assessment done at time of admission to the rehab program. Should be completed within 72 hours of admission.
- **Date of Onset:** Calendar date of onset of the main coded rehab condition that caused the admission to rehab. For acute it equals the date of injury or surgery. For chronic it is the date of the most recent exacerbation or functional loss that resulted in the admission to the rehab unit.
- **Date Ready for Admission to Rehab:** The date the client meets the criteria (med – high on DON) for admission to rehab unit and is ready to start the rehab program. Does not include time on unit/waiting list if prior to client meeting criteria (med - high on DON).
- **Date Ready for Discharge:** Calendar date that the client is ready for discharge from the rehab program. The date that the team (occupational therapy, physical therapy, SLP, nursing, SW, clinical nutrition etc.) all agrees the patient no longer requires rehab level of service (they have either achieved all or most of their goals or deteriorated and can no longer benefit).
- **Days Waiting for Admission:** Days from ready for rehab admission to admission to rehab bed and rehab program.
- **Days Waiting for Discharge:** Days from ready for discharge from rehab program to date formally discharged from facility.
-

Discharge FIM Assessment: Assessment of the functional ability at discharge. Should be completed within 72 hours of ready for discharge from rehab program.

- **Discharge Date:** Date patient is discharged from unit (facility).
- **Facility:** Refers to where the rehab beds are grouped and represents the hospital that submits rehab data to NRS.
- **Follow up FIM:** Functional assessment between 80 and 180 days after discharge from the rehab program.
- **Rehab Program:** The official rehab program delivered in rehab beds.
- **LOS:** Time from admission to facility/program to discharge from the facility.

Date of Onset	Ready for Rehab	Admission to Rehab	Ready for Discharge	Discharge
Average onset days				
	Days waiting for admission			
		Length of stay		
		Change in functional score		
			Days waiting for DC	
		Active rehab days		
		Admission FM	Discharge FM	

Chapter 3: Admission Assessments

An admission assessment must be completed within 72 hours of admission.

To complete an admission assessment

1. Type patient's name in the Patient field.

Note:

You can use the DJ number, or you can use the name of the patient and then press F9 to select the correct patient from a list.

Patient	GE0010017/14 UDITSTEST,NRS1
Assessment Number	N
* Assessment Type	
* Status	
Rehabilitation Patient Group	Admit
	01/10/14

2. In the Assessment Number field do an F9 lookup . If an appropriate assessment is not already initiated, enter the letter "N" (this will input the next available assessment number into this field).

Patient	GE0010017/14 UDITSTEST,NRS1
Assessment Number	01
* Assessment Type	ADMISSION
* Status	
Rehabilitation Patient Group	Admit
	01/10/14

3. Select **ADMISSION** from the Assessment Type drop-down list.

The Status field will be highlighted. An F9 lookup is available in this field if you wish to change the status of your assessment.

DRAFT
COMPLETE
FINAL
X(CANCELLED)

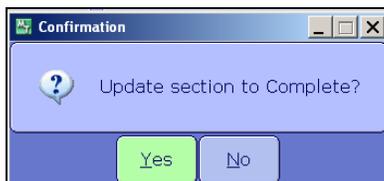
NRS Sections

When the specific field is highlighted that you would like to document, use the right facing arrow on your keyboard or the right facing arrow on your desktop to open that section for documentation.

NRS Sections	Status	Edit Date	Edit Time	Edit User
1. Client Identifier	DRAFT			
2. Sociodemographic-1	DRAFT			
3. Sociodemographic-2	DRAFT			
4. Administrative	DRAFT			
5. Health Characteristics	DRAFT			
6. Activities and Participation	DRAFT			
7. Special Projects	DRAFT			

Once you have completed entering answers for each section use the Save button.

If you have answered all questions in this section you will receive the following pop up to complete section. Click on Yes to file section as complete or No if further editing is needed to this field.

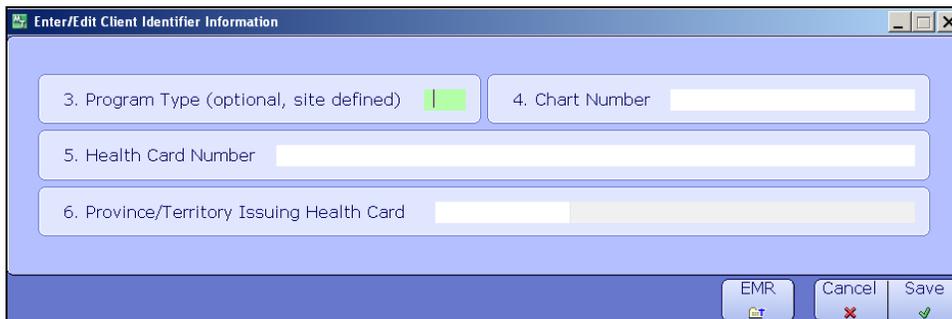


Note:

All sections will remain editable as long as assessment remains in a “Draft” or “Complete” status.

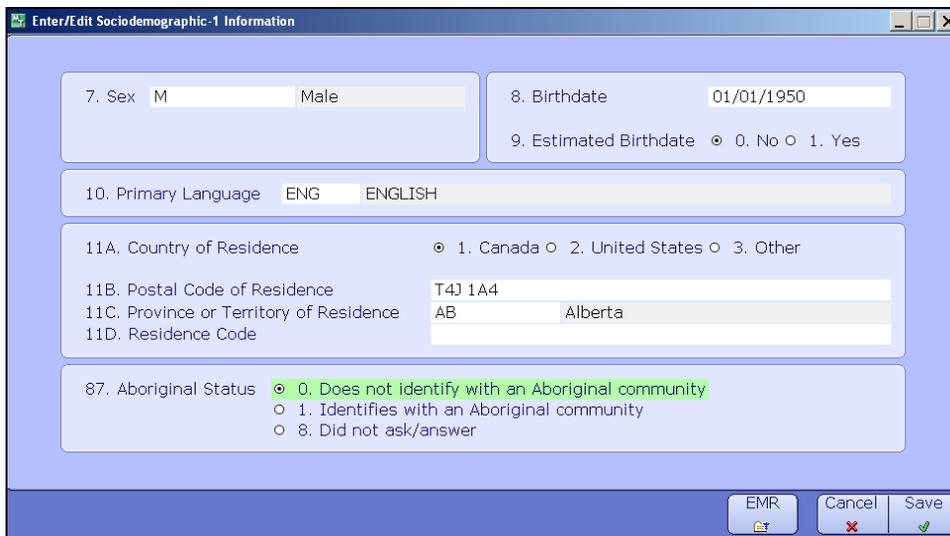
Refer to the following tables for a description of each question in these sections.

Client Identifier



Question	Description
Question 3 Program Type	currently not identified in our site; tab to next field
Question 4 Chart Number	This is the patient’s 10 digit Unit Number and should default in. If no it is also seen in the patient field above. Eg. DJ00001524. Enter this Unit Number, including the correct number of zeros.

Question 5 Health Card Number	This is the patient’s Health card number as given by their province of residence. This field will auto populate from ADM.
Question 6 Province/ Territory Issuing Health Card	This field will auto population from ADM. If not, an F9 lookup is available in this field. Highlight this field and hit F9 scroll through list highlight and enter on appropriate answer to fill field.

Sociodemographic-1


Question	Description
Question 7 Sex	This field will auto population from ADM. This field is the biological sex of the client. An F9 lookup is also available for this section if needed. Type “M” for male, “F” for female or “O” for other.
Question 8 Birthdate	This section will auto populate from ADM with client birthdate.
Question 9 Estimated Birthdate	Is the birthdate confirmed or estimated.
Question 10 Primary Language	This is the client’s primary language spoken or understood on a regular basis. Use the F9 lookup to choose from a list of available languages. Highlight the chosen language and hit enter.

Question	Description
Question 11A Country of Residence	Click on the correct Country.
Question 11B Postal Code of Residence	This section once clicked on will default in from ADM or you can type the postal code in if it is incorrect.
Question 11C Province or Territory of Residence	This field will auto population from ADM. F9 lookup is available. Highlight over appropriate answer and hit enter to fill field.
Question 11D Residence Code	Type in the patient's Postal Code.
Question 87 Aboriginal Status	Click on the appropriate response.

Sociodemographic-2
Page 1

12. Pre-hospital Living Arrangement (Record all that apply)

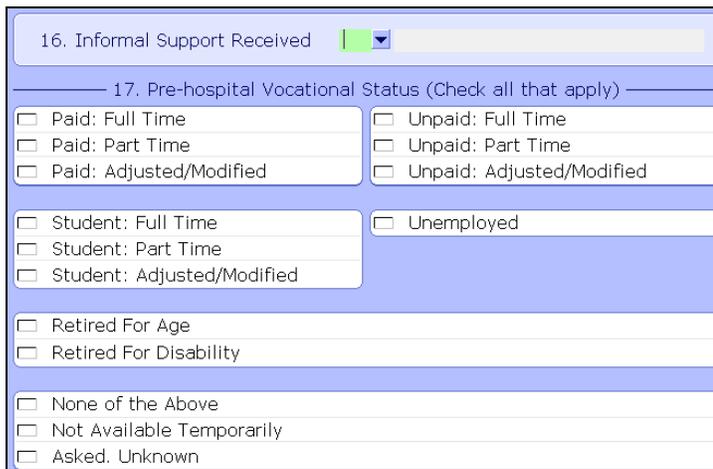
- Living with spouse/partner
- Living with family (includes extended)
- Living with non-family unpaid (includes friends)
- Living with paid attendant
- Living alone
- Living in facility (includes all levels of care except acute)
- Other

- Not available temporarily
- Asked. Unknown

14. Pre-hospital Living Setting

Question	Description
Question 12 Pre Hospital Living Arrangements	<p>The individual or individuals that the client was living with prior to admission. This refers to permanent living arrangements.</p> <p>This section requires you to answer Y to more than one choice. However you will not be able enter Y or N in a question that directly conflicts a previously given answer. Eg. If you have stated Y in Living with spouse/partner then the program will automatically skip over the</p>

	Living alone question.
Question 14 Pre-hospital Living Setting	<p>The type of accommodation the client lived in prior to their admission to the hospital.</p> <p>F9 lookup is available in this field. Highlight the appropriate response on the list and hit enter to fill field. Enter Yes for any appropriate choices. You will receive an error message if answer is in conflict to previous answers on question 12. E.g. If Living in a facility has been answered as Y in question 12 then you will receive an error message in question 14 if you try to choose answer 1. Home (Private House or Apartment).</p>

Page 2


16. Informal Support Received

17. Pre-hospital Vocational Status (Check all that apply)

Paid: Full Time Unpaid: Full Time
 Paid: Part Time Unpaid: Part Time
 Paid: Adjusted/Modified Unpaid: Adjusted/Modified

Student: Full Time Unemployed
 Student: Part Time
 Student: Adjusted/Modified

Retired For Age
 Retired For Disability

None of the Above
 Not Available Temporarily
 Asked, Unknown

Question	Description
Question 16 Informal Support Received	<p>Describes the unpaid assistance in the home (informal support) provided to the client from any individual such as family or friend.</p> <p>Use an F9 lookup to choose appropriate response. Highlight and hit enter to fill field.</p>
Question 17 Pre-hospital Vocational Status	<p>The client's vocational status prior to admission, up to a year prior. This section requires you to enter Yes for any appropriate choices. You can answer Y to more than one choice. However you will not be able enter Y or N in a question that directly conflicts a previously given answer.</p>

Administrative

19A. Admission Class	<input type="text" value=""/>
19B. If Readmission, 1 Month or Less Since Discharge	<input type="radio"/> 0. No <input type="radio"/> 1. Yes
19C. If Yes, Was Readmission Planned	<input type="radio"/> 0. No <input type="radio"/> 1. Yes
30. If (Un)planned Discharge, Discharge Date	<input type="text" value=""/>
20A. Date Ready For Admission Known	<input type="radio"/> 0. No <input type="radio"/> 1. Yes
20B. Date Ready For Admission	<input type="text" value=""/>
21. Admission Date	<input type="text" value=""/>
22. Referral Source	<input type="text" value=""/>
23A. Referral Source Province/Territory	<input type="text" value=""/>
23B. Referral Source Facility Number	<input type="text" value=""/>
Province	<input type="text" value=""/>
Institution	<input type="text" value=""/>

Question	Description
Question 19A Admission Class	The type of inpatient rehabilitation admission. Use an F9 lookup to choose appropriate response. Highlight and hit enter to fill field.
Question 19B And 30	These questions are related directly to question 19A. and deal with readmission. If you choose a response in Question 19A, which does not deal with readmission these questions will be skipped by the system.
Question 20A Date Ready for Admission Known	F9 lookup is available or enter a "0" for No or a "1" for Yes.
Question 20 B Date Ready for Admission	The calendar date the client is considered ready to start a rehabilitation program. If you answered "Yes" to question 20A; then enter here the known date ready for admission. Freetext date DD/MM/YY. If you answered no to question 20A; this questions will be skipped over.
Question 21 Admission Date	The calendar date the client was admitted to the rehabilitation program (DD/MM/YY). This field, when clicked, will default with admission date to the facility. This will usually differ from the admission date to the rehabilitation program. Edit this field to reflect the admission date to the

Question	Description
	rehabilitation program (DD/MM/YY). (This date will default to the Discharge assessment when you click corresponding field.)
Question 22 Referral Source	The facility/ agency/ individual that initiated the referral. Use an F9 lookup to choose appropriate response. Highlight and hit enter to fill field.
Question 23A Referral Source Province/Territory	The Province or Territory from which the client was referred. Use an F9 lookup to choose appropriate response. Highlight and hit enter to fill field.
Question 23B Referral Source Facility Number	Enter here the Province of the facility and the Institution number. F9 lookup is available for these fields. Choose appropriate response, highlight and hit enter to fill field.

– 24. Responsibility For Payment (Check all that apply) –

- Prov/Territorial Plan
- WCB/WSIB
- Other Prov/Territory (Resident of Canada)
- Fed. Gov. - Veteran Affairs Canada
- Fed. Gov. - FNIHB
- Fed. Gov. - Other
- Canadian Resident: Self Pay
- Canadian Resident: Insurance Pay
- Other Country: Self Pay
- Prov. Definition
- Not Available Temporarily
- Asked. Unknown

Question	Description
Question 24 Responsibility for Payment	The payment code that identifies the group responsible for payment of services rendered. These are Yes or No answers. You may answer more than 1 with Yes. Depending on answers, certain questions will be skipped over automatically.

Health Characteristics

34. Rehabilitation Client Group (record 1 only using numeric code)

|

80. Most Responsible Health Condition

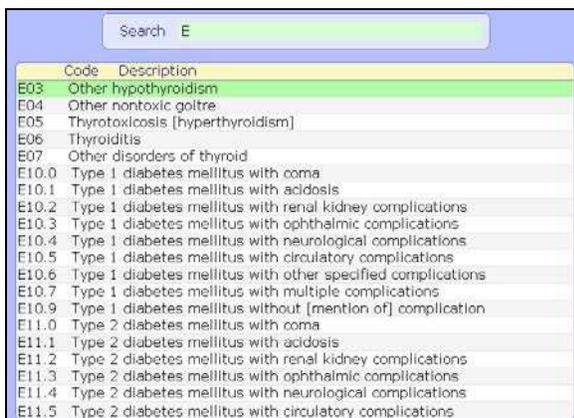
|

Question	Description
Question 34 Rehabilitation Client Group	This is the primary reason for admission to a rehabilitation program. Record only 1 primary Rehabilitation code here. Use F9 lookup for complete list of codes to choose from.
Question 80 Most Responsible Health Condition	Enter here the primary health condition that is related to the rehabilitation. An F9 lookup is available for a complete list. ICD-10-CA Diagnostic Health Conditions listed by Code or Description. See Lookup Codes for more information (same list for questions 81 and 83.)

Lookup Codes

The following look-up-codes are available for questions 80, 81 and 83. Type the first letter of the code and numbers if known.

- **E – lookup** – takes you to the Endocrine section of the code list



- Look up by first word in Description: Enter **D\<** followed by the first 5 letters of the first word in the code description
 - **D\ – lookup - takes you to all codes starting with ‘Traumatic’ under sections S, T, and M**
 - **D\ – lookup - takes you to all codes starting with ‘Type 1’ and ‘Type 2’ diabetes codes under section E**

- D\OTHER – lookup - takes you to all codes starting with ‘Other’ (multiple sections including Other specified diabetes.... in section E)
- D\UNSPEC – lookup - takes you to all codes starting with ‘Unspecified’ (multiple sections including Unspecified diabetes...in section E)
- D\CEREB – lookup – takes you to all codes starting with ‘Cerebral’ in sections G and I

34. Rehabilitation Client Group (record 1 only using numeric code)
 05.3 AMPUTATION:SINGLE LOWER EXTREMITY ABOVE THE KNEE (AK)

80. Most Responsible Health Condition
 D\TRAUMA

F9 directs you to the corresponding alphabetized list of codes.

Search

Description	Code
TRAUMATIC AMPUTATION AT HIP JOINT	S78.0
TRAUMATIC AMPUTATION AT KNEE LEVEL	S88.0
TRAUMATIC AMPUTATION AT LEVEL BETWEEN HIP AND KNEE	S78.1
TRAUMATIC AMPUTATION AT LEVEL BETWEEN KNEE AND ANKLE	S88.1
TRAUMATIC AMPUTATION AT LEVEL BETWEEN SHOULDER AND ELBOW	S48.1
TRAUMATIC AMPUTATION AT SHOULDER JOINT	S48.0
TRAUMATIC AMPUTATION OF BOTH ARMS [ANY LEVEL]	T05.2
TRAUMATIC AMPUTATION OF BOTH FEET	T05.3
TRAUMATIC AMPUTATION OF BOTH HANDS	T05.0
TRAUMATIC AMPUTATION OF BOTH LEGS [ANY LEVEL]	T05.5
TRAUMATIC AMPUTATION OF FOOT AT ANKLE LEVEL	S98.0
TRAUMATIC AMPUTATION OF FOREARM, LEVEL UNSPECIFIED	S58.9
TRAUMATIC AMPUTATION OF HIP AND THIGH, LEVEL UNSPECIFIED	S78.9
TRAUMATIC AMPUTATION OF LOWER LEG, LEVEL UNSPECIFIED	S88.9
TRAUMATIC AMPUTATION OF ONE FOOT AND OTHER LEG [ANY LEVEL, EXCEPT FOOT]	T05.4
TRAUMATIC AMPUTATION OF ONE HAND AND OTHER ARM [ANY LEVEL, EXCEPT HAND]	T05.1
TRAUMATIC AMPUTATION OF OTHER PARTS OF FOOT	S98.3
TRAUMATIC AMPUTATION OF OTHER PARTS OF WRIST AND HAND	S68.8
TRAUMATIC AMPUTATION OF THUMB	S68.0
TRAUMATIC AMPUTATION OF TWO OR MORE FINGERS ALONE (COMPLETE)(PARTIAL)	S68.2

Page 2

81. Pre-admit Co-morbid Health Condition(s)
(record all that apply up to a maximum of 15)

	Code	Description
1	<input type="text"/>	
2	<input type="text"/>	
3	<input type="text"/>	
4	<input type="text"/>	
5	<input type="text"/>	
6	<input type="text"/>	
7	<input type="text"/>	
8	<input type="text"/>	
9	<input type="text"/>	
10	<input type="text"/>	
11	<input type="text"/>	
12	<input type="text"/>	
13	<input type="text"/>	
14	<input type="text"/>	
15	<input type="text"/>	

Question	Description
Question 81 Pre-Admit Co-morbid health conditions	Here you are able to enter any other health conditions that affect the client up to 15. Use same lookup options as question 80 (See Lookup Codes for more information).

Page 3

83. Transfer or Death Health Condition

38. ASIA Impairment (Modified Frankel) Scale

39. Date of Onset

40A. Height (in cm)
40B. Weight (in kg)

86. Pre-admit Comorbid Procedure or Intervention CCI

1.	<input type="text"/>	
2.	<input type="text"/>	
3.	<input type="text"/>	
4.	<input type="text"/>	
5.	<input type="text"/>	

Question	Description
Question 83 Transfer or Death Health condition	Depending on how you have answered your previous questions you may be skipped over this question. This question refers to the most significant health condition that results in transfer from the rehabilitation program to another unit or facility or that results in death. Use the same lookup options as question 80 (see Lookup codes for more information).
Question 38 ASIA Impairment Scale	This question only needs to be filled out for Traumatic Brain Scale Injury; A scale which describes the degree of motor and sensory involvement at admission to rehabilitation for traumatic spinal cord injury. If appropriate use an F9 lookup and highlight the appropriate answer then hit enter.
Question 39 Date of Onset	Date of the onset of the main rehabilitation condition that is coded ion #34 Rehabilitation Client Group. Free text the date of onset of the problem here. DD/MM/YY. For onset of an acute condition note date of surgery or accident; for onset of a chronic condition note the first sign of the symptom.
Question 40A Height	Enter here the current height of the client in centimeters.
Question 40B Weight	Enter here the current weight of the client in kilograms.
Question 86 Pre-admit co-morbid procedure or intervention CCI	These are existing health conditions that affect the client's health/functional status and resource requirements during the time of rehabilitation. Use F9 lookup to have complete list of codes. Highlight appropriate code and hit enter.

Activities and Participation

The following Activities and Participation questions are scored using the Functional Independence Measure (FIM) instrument.

Page 1: FIM Elements

Self-Care		
41. Eating	<input type="text" value="1"/>	
42. Grooming	<input type="text" value=""/>	
43. Bathing	<input type="text" value=""/>	
44. Dressing - Upper Body	<input type="text" value=""/>	
45. Dressing - Lower Body	<input type="text" value=""/>	
46. Toileting	<input type="text" value=""/>	
Sphincter		
47. Bladder Management	<input type="text" value=""/>	
48. Bowel Management	<input type="text" value=""/>	
Transfers		
49. Bed, Chair, Wheelchair	<input type="text" value=""/>	
50. Toilet	<input type="text" value=""/>	
51. Tub, Shower	<input type="text" value=""/>	

Question	Description
Questions 41 – 58	F9 lookup will provide the complete list with all the different levels of care. Highlight appropriate choice on the list and hit enter. Or if you know the appropriate number that corresponds to the appropriate level of care you can enter it without doing an F9 lookup.

Refer to the most recent Rehabilitation Minimum Data Set Manual for specific instructions for completing the following fields.

- Question 41-46 Self-Care
- Questions 47-49 Sphincter
- Question 49-51 Transfers
- Question 52-53 Locomotion
- Question 54-55 Communication
- Question 56-58 Social Cognition

Page 2: CIHI Cognitive Elements

59. Impact of Pain	
A. Presence of Pain	<input checked="" type="radio"/> 1. Yes <input type="radio"/> 5. No <input type="radio"/> 8. Client Unable To Answer
B. Intensity of Pain	<input type="radio"/> 2. Severe <input type="radio"/> 3. Moderate <input type="radio"/> 4. Mild
C. Impact on Activities	<input type="radio"/> 2. Most <input type="radio"/> 3. Some <input type="radio"/> 4. A Few <input type="radio"/> 5. None
60. Meal Preparation	<input type="text"/>
61. Light Housework	<input type="text"/>
62. Heavy Housework	<input type="text"/>

Question	Description
Questions 59 – 79	F9 lookup gives choices available. Highlight appropriate response and hit enter to choose. If you know the appropriate number that corresponds to the appropriate level of care you can enter it without using F9.

Refer to the most recent Rehabilitation Minimum Data Set Manual for specific instructions for completing the following fields.

- Question 59 A, B, C Impact of pain
- Question 60 Meal Preparation
- Question 61 and 62 Light Housework and Heavy Housework
- Question 64 Communicating- Verbal or Non Verbal Expression
- Question 65 Communicating- Written Expression
- Question 66 Communicating- Auditory or Non Auditory Comprehension
- Question 67 Communicating- Reading Comprehension
- Question 68 Financial Management
- Question 69 Orientation
- Question 70 General Health Status
- Question 79 Glasses / Hearing Aid

Special Projects (optional field)

The following section relates to any special projects for which you plan to submit data to CIHI.

Question	Description
Question 88 A	The Code is six characters in length Text: Describe your project
Question 88 B	Any supplemental data for the project specific in 88A required to meet the information need of CIHI, the provinces/territories and health care facilities. Special project data can be part of the admission, discharge and/or follow-up records.

You can either go in and Save and Complete as a blank section Save and Complete as previous fields.

Saving your work

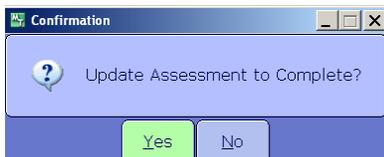
Once you have completed all sections, follow these instructions to save your work.

1. Click the green check mark on the right hand side of the screen or use F12 to save.

Important:

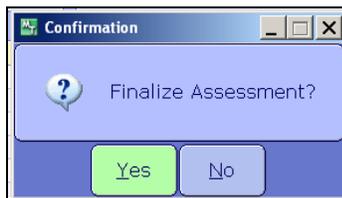
Your work will not be saved if you exit prior to using the green check mark or F12.

2. Click **Yes** to file, and then click **Yes** to update and complete.


Tip:

You can go back to this assessment at any time while the assessment is in 'draft' or 'complete' status. Select it from the F9 lookup in the Assessment Number field.

3. If you have completed all work and do not require further editing to be done click on **Yes** to finalize the assessment.



Editing an Assessment

If you have permissions, you can edit a finalized assessment.

To edit an assessment

1. Open the assessment.
2. Press **Shift + F6** to navigate to the Status field.
3. Select **Final** from the Status drop-down menu.

Patient	GE0010017/14 UDITSTEST_NRS1		
Assessment Number	01		
*Assessment Type	ADMISSION	Rehabilitation Patient Group	1100
*Status	FINAL	Admit	01/10/14
	DRAFT		
	COMPLETE		
	FINAL		
	X(CANCELLED)		
1. Client Identifier	NRS	Status	COMPLETE 15/01/15 1608 049575
2. Sociodemographic-1		Edit Date	COMPLETE 15/01/15 1618 049575
3. Sociodemographic-2		Edit Time	COMPLETE 15/01/15 1721 049575
4. Administrative		Edit User	COMPLETE 15/01/15 1722 049575
5. Health Characteristics			COMPLETE 15/01/15 1724 049575
6. Activities and Participation			COMPLETE 15/01/15 1725 049575
7. Special Projects			COMPLETE 15/01/15 1725 049575

4. Press **F9**, and then select the appropriate status which permits editing (for example, complete).

Chapter 4: Discharge Assessments

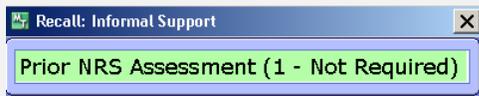
A discharge assessment must be completed within 72 hours of the 'ready for discharge' date from the rehabilitation program. Ensure that the Admission assessment is finalized. The recommend steps differ for completing a discharge for deceased client.

To complete a Discharge Assessment

1. Ensure patient is selected.
2. In the Assessment Number field do an F9 lookup. If an appropriate assessment is not already initiated, enter the letter **N** for new.
3. Select **DISCHARGE** from the Assessment Type drop-down list.

Note:

F5 in many fields will recall the last response to that field and prompt you to accept or exit.



To complete a Deceased Discharge assessment

1. Complete the Client Identifier section.
2. Skip the Sociodemographic sections. (This is to save you work. If these sections are completed prior to identifying 'deceased' in subsequent sections, the fields will be cleared and you will be able to go back and complete these revised sections.)
3. Complete the appropriate fields in the Administrative and the Health Characteristics sections.
4. Complete field 70 in the Activities and Participation section (if you complete any of the FIM elements you have to complete them all).
5. Return to the Sociodemographic sections. You can complete without responding to any fields.

NRS Sections

When the specific field is highlighted that you would like to document, use the right facing arrow on your keyboard or the right facing arrow on your desktop to open that section for documentation.

Refer to the following tables for a description of each question in these sections.

NRS Sections	Status	Edit Date	Edit Time	Edit User
1. Client Identifier	DRAFT			
2. Sociodemographic-1	DRAFT			
3. Sociodemographic-2	DRAFT			
4. Administrative	DRAFT			
5. Health Characteristics	DRAFT			
6. Activities and Participation	DRAFT			
7. Special Projects	DRAFT			

Client Identifier

3. Program Type (optional, site defined)	4. Chart Number GE00010386
5. Health Card Number 000000000	8. Birthdate 01/01/1950
	9. Estimated Birthdate <input type="radio"/> 0. No <input type="radio"/> 1. Yes
21. Admission Date 01/10/14	

Question	Description
Question 3 Program Type	currently not identified in our site; tab to next field
Question 4 Chart Number	This field will auto populate. This is the patient's 10 digit Unit Number. Enter this Unit Number, including correct number of zeros.
Question 5 Health Card Number	This field will auto populate. This is the patient's Health card number as given by their province of residence.
Question 8 Birthdate	This field will auto populate from ADM with client birthdate or use freetext to correct MM/DD/YY.
Question 9 Estimated Birthdate	This field will auto populate.
Question 21 Admission Date	This field will auto populate.

Sociodemographic-1

13. Post-Discharge Living Arrangements-Record all that apply

Living with spouse/partner

Living with family (Includes extended)

Living with non-family unpaid (includes friends)

Living with paid attendant

Living alone

Living in facility (includes all levels of care except acute)

Other

Identified living arrangement(s) is/are transitional or temporary

Living in acute care

Not available temporarily

Asked. Unknown

15. Post-discharge Living Setting

Question	Description
Question 13 Post Discharge Living Arrangements (Record all that Apply)	<p>The individual(s) the client will be living with after discharge from the rehabilitation facility/unit. This section requires you to check any appropriate choices. You click on more than one choice. However you will not be able enter a question that directly conflicts a previously given answer.</p> <p>For example, if you have stated client Living with spouse/partner then the program will automatically skip over the Living alone question.</p>

Sociodemographic-2

16. Informal Support Received

18. Post-discharge Vocational Status (Check all that apply)

Paid: Full Time

Paid: Part Time

Paid: Adjusted/Modified

Unpaid: Full Time

Unpaid: Part Time

Unpaid: Adjusted/Modified

Student: Full Time

Student: Part Time

Student: Adjusted/Modified

Unemployed

Retired For Age

Retired For Disability

None of the Above

Not Available Temporarily

Asked. Unknown

Question	Description
Question 16 Informal Support	Describe the unpaid assistance provided to the client from any individual including family, friend or neighbor. Do an F9 lookup to choose from a

Question	Description
Received	list of appropriate responses. Highlight answer and hit enter.
Question 18 Post- discharge Vocational Status (check all that apply)	<p>This is the client’s actual or expected vocational status upon discharge assessment.</p> <p>This section requires you to click on any appropriate choices. You can click on more than one choice. However you will not be able to click on a question that directly conflicts a previously given answer.</p>

Administrative
Page 1

Page 1 Page 2 Page 3 Page 4 Page 5
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Question	Description
Question 19A Admission class	This is the type of inpatient rehabilitation admission. F9 lookup to choose from a list of appropriate responses. Highlight answer and hit enter.
Question 24 Responsibility for Payment	The payment code that identifies the group responsible for payment of services rendered. This requires Yes answers. You may answer Y to more than one field. Depending on answers, certain questions will be skipped over automatically.

Page 2

Question	Description
Question 25 Service Interruptions	Service interruptions (30 days or less) occur when the service is temporarily suspended by the facility due to a change in the client’s health status. If the client is readmitted to the program within 30 days, this is considered the same admission. Client is allowed up to 3 interruptions in service totaling 90 days. Fill in this question only if the above is applicable for the client. Freetext in dates as required.

Page 3

Question	Description
Question 28 Provider Types	F9 lookup for options

Page 4

Question	Description
Question 29 Date Ready for Discharge	Freetext DD/MM/YY in here the date the client is ready for discharge from the program.
Question 30 Discharge Date	The actual date of discharge from the program DD/MM/YY.
Question 31 Reason for Discharge	F9 lookup to choose from a list of appropriate responses. Highlight answer and hit enter.
Question 32 Referred To	F9 lookup to choose from a list of appropriate responses. Highlight answer and hit enter.
Question 33A Referred to Province/Territory	The Province or Territory to which the client was referred. F9 lookup to choose from a list of appropriate responses. Highlight answer and hit enter.
Question 33B Referred to Facility Number	<ul style="list-style-type: none"> Province and Institution Number. An F9 lookup in both these fields provides appropriate answers to choose from. Highlight the response needed and hit enter.

Health Characteristics

Page 1 Page 2

Page 1

Question	Description
Question 29 Date Ready for Discharge	Freetext DD/MM/YY in here the date the client is ready for discharge from the program.
Question 34 Rehabilitation Client Group: (record 1 only using numeric code)	This is the primary reason for admission to a rehabilitation program. This should auto-populate from the Admission assessment.
Question 80 Most Responsible Health Condition	Refers to the primary health condition that is related to the rehabilitation. This should auto-populate from the Admission assessment.
Question 83 Transfer or Death Health condition	Depending on how you answered the previous questions you may be skipped over this question. To answer this question use the F9 lookup and highlight the appropriate answer then hit enter. See Lookup Codes for more information.
Question 40A Height	Enter the current height of the client in cm.
Question 40B Weight	Enter the current weight of the client in kg.

Page 2

Question	Description
Question 82 Post-admit Co-morbid Health Condition(s) (Record all that apply up to 15.)	Health conditions that arise after admission and during the rehab stay that affect the client's health functional status and resource requirements during the rehabilitation program. To answer this question use the F9 lookup and highlight the appropriate answer then hit enter.

Activities and Participation

[Page 1](#)
[Page 2](#)
[Page 3](#)
[Page 4](#)

Page 1: FIM Elements

Refer to the most recent Rehabilitation Minimum Data Set Manual for specific instructions for completing these fields.

Question	Description
Self-Care Questions 41-58	Use F9 lookup to choose the appropriate answer depending on level of assistance required. Highlight answer and hit enter to fill field.

Page 2: CIHI Cognitive Elements

Question	Description
Question 59 – 79	Use F9 lookup to choose the appropriate answer depending on level of assistance required. Highlight answer and hit enter to fill field.

Special Projects (optional field)

The following section relates to any Special Projects for which you plan to submit data to CIHI. Refer to the most recent Rehabilitation Minimum Data Set Manual for specific instructions for completing these fields.

Question	Description
Question 88 A	The Code is 6 characters in length, Text: Describe your project.
Question 88 B	Any supplemental data for the project specific in 88A required to meet the information need of CIHI, the provinces/territories and health care facilities. Special project data can be part of the admission, discharge and/or follow-up records.

You can either go in and Save and Complete as a blank section Save and Complete as previous fields.

Saving your Work

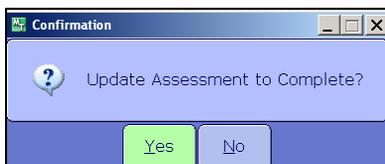
Once you have completed all sections, follow these instructions to save your work.

1. Click **Save** or use **F12** to save.

Important:

Your work will not be saved if you exit prior to using the green check mark or F12.

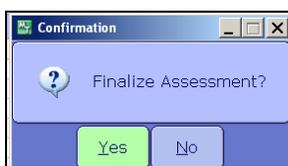
2. Click **Yes** to file, and then click **Yes** to update and complete.



Tip:

You can go back to this assessment at any time while the assessment is in 'draft' or 'complete' status. Select it from the F9 lookup in the Assessment Number field.

3. If you have completed all work and do not require further editing to be done click on **Yes** to finalize the assessment.



Editing an Assessment

If you have permissions, you can edit a finalized assessment.

To edit an assessment

1. Open the assessment.
2. Press **Shift + F6** to navigate to the Status field.
3. Select **Final** from the Status drop-down menu

Patient: GE0010017/14 UDI/STEST,NRS1					
Assessment Number 01					
*Assessment Type: ADMISSION	Rehabilitation Patient Group: 1100				
*Status: FINAL	Admit: 01/10/14				
*Status dropdown menu: DRAFT COMPLETE FINAL X(CANCELLED)					
NRS	FINAL	Status	Edit Date	Edit Time	Edit User
1. Client Identifier	X(CANCELLED)	COMPLETE	15/01/15	1608	049575
2. Sociodemographic-1		COMPLETE	15/01/15	1618	049575
3. Sociodemographic-2		COMPLETE	15/01/15	1721	049575
4. Administrative		COMPLETE	15/01/15	1722	049575
5. Health Characteristics		COMPLETE	15/01/15	1724	049575
6. Activities and Participation		COMPLETE	15/01/15	1725	049575
7. Special Projects		COMPLETE	15/01/15	1725	049575

4. Press **F9**, and then select the appropriate status which permits editing (for example, complete).

Chapter 5: Follow up Assessments

A follow up assessment must be completed between 80 and 180 days after discharge from the rehabilitation program if a facility decides to include this component of the data set.

To complete a follow up assessment

1. Type patient's name in the Patient field.

Note:

You can use the DJ number, or you can use the name of the patient and then press F9 to select the correct patient from a list.

Patient	GE0010017/14 UDITSTEST,NRS1		
Assessment Number	N		
*Assessment Type		Rehabilitation Patient Group	
*Status		Admit	01/10/14

2. In the Assessment Number field do an F9 lookup. If an appropriate assessment is not already initiated, enter the letter "N" and this will input the next available assessment number into this field.
3. Select **FOLLOW UP** from the Assessment Type drop-down list.

NRS Sections

When the specific field is highlighted that you would like to document, use the right facing arrow on your keyboard or the right facing arrow on your desktop to open that section for documentation.

Refer to the following tables for a description of each question in these sections.

NRS Sections	Status	Edit Date	Edit Time	Edit User
1. Client Identifier	DRAFT			
2. Sociodemographic-1	DRAFT			
3. Sociodemographic-2	DRAFT			
4. Administrative	DRAFT			
5. Health Characteristics	DRAFT			
6. Activities and Participation	DRAFT			
7. Special Projects	DRAFT			

Client Identifier

Question	Description
Questions 3,4,5,8 and 21	These questions can all be retrieved from previous finalized assessments. <ol style="list-style-type: none"> 1. Place cursor in the specific field and hit F5. A pop-up containing the answer used in the previous assessment appears. 2. Choose Accept to populate the field with information from the previous assessment. OR Choose Exit to leave the field blanks.
Question 30 Discharge Date	Enter in the date here that the client left the rehabilitation program. Freetext or T-# of days will default the date that it was expired 30 days ago.
Question 72 Follow-up Assessment Date	Free text in here the date that this assessment is being completed.
Question 74 Respondent Type	Enter in here the client who responds to the majority of the questions on the follow up assessment. F9 lookup will provide a list of possible choices. Highlight the appropriate answer and hit enter.

Sociodemographic
Page 1

Question	Description
Question 11B Postal Code of Residence	This will default in from ADM.
Question 11C province or Territory of Residence	This will default in from ADM.
Question 76 Follow Up Living Arrangements (Record all that	Answer this question based on whom the client is living with at the time of the follow up assessment. This section requires you to enter Y or N for all given choices. You can answer Y to more than one choice. However

Question	Description
Apply)	you will not be able enter Y or N in a question that directly conflicts a previously given answer. For example, If you have stated Y in Living with spouse/partner then the program will automatically skip over the Living alone question.
Question 77 Follow Up Living Setting	This refers to the type of setting the client is living in at the time of the assessment. Do an F9 lookup in this field for all available choices. Highlight the appropriate response and hit enter

Page 2

Question	Description
Question 16 Informal Support Received	Describe the unpaid assistance provided to the client from any individual including family, friend or neighbor. Do an F9 lookup in this field for all available choices. Highlight the appropriate response and hit enter.
Question 78 Follow Up Vocational Status (Check all that Apply)	This is the client's actual vocational status at the time of the assessment. This section requires you to enter Y or N for any appropriate choices. You can answer Y to more than one choice. However you will not be able enter Y or N in a question that directly conflicts a previously given answer.

Health Characteristics

34. Rehabilitation Client Group	
01.1	STROKE:LEFT BODY INVOLVEMENT (RIGHT BRAIN)
73A. Hospitalization Since Discharge	<input checked="" type="radio"/> 0. No <input type="radio"/> -50. Not available temporarily <input type="radio"/> 1. Yes <input type="radio"/> -70. Asked unknown
73B. Days In Hospital (Total Number)	
85. Health Condition Reason(s) For Hospitalization	
1.	
2.	
3.	

Question	Description
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Question	Description
Question 34 Rehabilitation Client Group	This is the primary reason for admission to a rehabilitation program. Do an F9 lookup in this field for all available choices. Highlight the appropriate response and hit enter.
Question 73A Hospitalization Since Discharge	Enter a Y or N answer. An F9 lookup gives available answers. Highlight appropriate response and hit enter.
Question 73B Days in hospital (Total Number)	This question may be skipped if the answer to 73A was no. If answer in 73 A was Yes enter here the total number of days client has been hospitalized since discharge from rehabilitation program. Total of all days combined even if hospitalized more than once.
Question 85 Health Condition Reason(s) For Hospitalization	Use an F9 lookup when in this field to see a list of available Health Conditions. Use this field to record the reason or reason(s) why the client was hospitalized since discharge from.

Activities and Participation
Page 1: FIM Elements

Refer to the most recent Rehabilitation Minimum Data Set Manual for specific instructions for completing this field.

Question	Description
Self-Care Questions 41-58	Use F9 lookup to choose the appropriate answer depending on level of assistance required. Highlight answer and hit enter to fill field.

Page 2: CIHI Cognitive Elements

Question	Description
Question 59 - 79	Use F9 lookup to choose the appropriate answer depending on level of assistance required. Highlight answer and hit enter to fill field.

Refer to the most recent Rehabilitation Minimum Data Set Manual for specific instructions for completing these fields.

Follow up Assessment
Pages 1 and 2

Question	Description
Question 75 Reintegration in Normal Living Index	This measures both the client's perception of their own capabilities as well as objective indicators of physical, social and psychological performance. These can be answered by patient and/or proxy. Use an F9 lookup to choose from the available answers. Highlight the most appropriate response and hit enter to fill field.

Saving Your Work

Once you have completed all sections, follow these instructions to save your work.

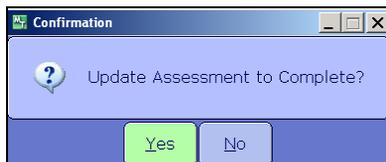
To save your work

1. Click the green check mark on the right hand side of the screen or use F12 to save.

Important:

Your work will not be saved if you exit prior to using the green check mark or F12.

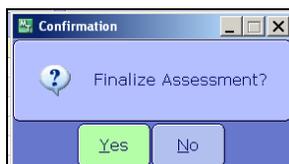
2. Click **Yes** to file, and then click **Yes** to update and complete.



Tip:

You can go back to this assessment at any time while the assessment is in 'draft' or 'complete' status. Select it from the F9 lookup in the Assessment Number field.

3. If you have completed all work and do not require further editing to be done click on **Yes** to finalize the assessment.



Editing an Assessment

If you have permissions, you can edit a finalized assessment.

To edit an assessment

1. Open the assessment.
2. Press **Shift + F6** to navigate to the Status field.
3. Select **Final** from the Status drop-down menu.



Patient: GE0010017714 UDITSTEST,NRS1		Assessment Number: 01		
* Assessment Type	ADMISSION	Rehabilitation Patient Group	1100	
* Status	FINAL	Admit	01/10/14	
	DRAFT			
	COMPLETE			
	FINAL			
	X(CANCELLED)			
NRS	Status	Edit Date	Edit Time	Edit User
1. Client Identifier	COMPLETE	15/01/15	1603	049575
2. Sociodemographic-1	COMPLETE	15/01/15	1618	049575
3. Sociodemographic-2	COMPLETE	15/01/15	1721	049575
4. Administrative	COMPLETE	15/01/15	1722	049575
5. Health Characteristics	COMPLETE	15/01/15	1724	049575
6. Activities and Participation	COMPLETE	15/01/15	1725	049575
7. Special Projects	COMPLETE	15/01/15	1725	049575

4. Press **F9**, and then select the appropriate status which permits editing (for example, complete).

Chapter 6: Submission of NRS Assessments

Submission of data to CIHI is done by specific users within a Facility. In other words not all users will have access to the Submission routines within Meditech. Submission to CIHI is done on a Quarterly basis. An example of data submission timelines is as below.

Timeline	Action
April 1 – June 30	Data collection
July 31	Data due at CIHI
Aug 1 -3	Submission/error reports sent to facilities
Aug 4 - 14	Data corrections resubmitted to CIHI
Aug 15 – 30	Comparative reports generated and sent to facilities

It is important to remember that prior to Submission of data to CIHI a Facility profile including Key contact, Site coordinator, Data entry contacts and Facility name must be sent to CIHI.

The reports generated by the submission of the NRS data to CIHI include: The following Report types are issues from CIHI 8 weeks after the end of a quarter. Summary Reports, Submission/error Reports, Comparative Admission, Discharge and Follow up assessments completed by the facility, peers or nationally.

To use the NRS Meditech system to create a Submission File for CIHI

1. From your NRS desktop go to the NRS Menu (see [Accessing the NRS Menu](#)). Click on the **Create Electronic Submission File** routine.
2. In the **Include All Finalized forms for Quarter** field use the F9 lookup to enter in the appropriate Quarter you are reporting for. The year is also modifiable. Press **ENTER**. A list of clients that have had finalized assessments completed on them in the chosen reporting quarter appears.

to be corrected and or deleted; then by using the green check mark or F12 you can create a File that you then will be able to submit to CIHI.

For further information on Submitting to CIHI please contact your CIHI representative or call CIHI at 1-613-241-7860 or visit the Website at www.cihi.ca.

Appendix A: Getting around Meditech

Using the keyboard

The keyboard is an input device used to enter text and to select functions. The following table defines keyboard functions available in Meditech.

Keyboard Key	Function
Enter	<ul style="list-style-type: none"> • select information from a list • start a search • at times, can be used to move through fields
Tab	move through fields on a screen
Shift + Tab	move backwards through fields on a screen
CapsLock	locks the keyboard to make any letters you type appear as capital letters <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Note: MEDITECH must be typed in capital letters in many fields.</p> </div>
Num Lock	activates the numeric keypad on the right side of the keyboard
Backspace	removes text to the left of the cursor
Delete	removes text to the right of the cursor
Arrow keys	<ul style="list-style-type: none"> • navigate up or down in lists • activates certain Meditech special functions
Alt	Hold down the Alt key while pressing an underlined letter to select a file tab.

Desktop shortcuts

Keyboard Shortcuts

Meditech is both mouse-controlled or keyboard-command-controlled and depends of the preference of the user. The special function keys described below are keyboard shortcuts, which perform specified functions within the Meditech Client Server System.

Click the highlighted keys below to learn about the important keyboard functions.



Screen elements

Meditech uses many functions similar to Windows® operating systems.

Meditech title bars

The first title bar displays the following:

- Meditech logo
- full name of the individual logged on to the software

Appendix B: Downtime Procedures

If Meditech is unavailable, please wait until Meditech is available to continue with NRS processes. If you require more detailed information on Meditech downtime procedures reference the downtime manual.