

Using the interRAI Data Visualisation Tool

Updated August 2025

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Introduction

Welcome to the **interRAI data visualisation tool user guide**. This guide aims to provide all the information you require to use this interactive tool. The tool is available from <https://www.interrai.co.nz/data-research-and-reporting/data-visualisation>

The interRAI data visualisation tool makes New Zealand interRAI data more accessible to everyone, and it is fit-for-purpose to our stakeholders' needs. The aggregated data presented in this visualisation tool relates to three interRAI assessment types: Contact Assessment (CA), Home Care (HC) and Long-Term Care Facilities (LTCF). The data refers to assessments rather than clients/residents unless specified.

This visualisation runs on Microsoft Power BI, which is designed to allow users to transform and visualise interRAI data freely.

Follow this guide to navigate through the interRAI data visualisation tool page by page. Note that the section named **Page 4: Disease Diagnosis** has detailed information on the built-in tool functionality that applies across all pages.

July 2019 update: As a result of sector feedback, definitions for diseases, outcome scales and CAPs have been incorporated into the tool. Definitions will display when a user hovers their mouse above the column charts. See section Page 4: Disease Diagnosis for further detail.

October 2019 update: National quality indicators for LTCF have been added to the tool.

Page 1: Home Page

This page provides a brief introduction to the interRAI data visualisation tool and interRAI Services in New Zealand. Please note that it may take up to 30–60 seconds to load.

Use the Side panel to navigate directly to any of the report pages. you can also click on the '◀' and '▶' buttons or click on the text '**1 of 8**' at the bottom of the report.



Health New Zealand
 Te Whatu Ora

Last updated: 22 August 2025

Home

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Summary

Demographics

Disease Diagnosis

Outcome Scales

Clinical Assessment Protocols

Social Wellbeing Measures

National Quality Indicators - LTCF

Welcome to the interRAI New Zealand Data Visualisation Tool.

This tool allows you to access interRAI data at national, regional, district and population subgroup level. The interactive nature of this tool means you are in control of the information at the level of detail that you desire.

Data presented in this tool comes from three interRAI assessment types: Contact (CA), Home Care (HC) and Long Term Care Facilities (LTCF) assessments.

For more information visit <http://www.interrai.co.nz> or email interRAI.Data@TeWhatuOra.govt.nz

Disclaimer

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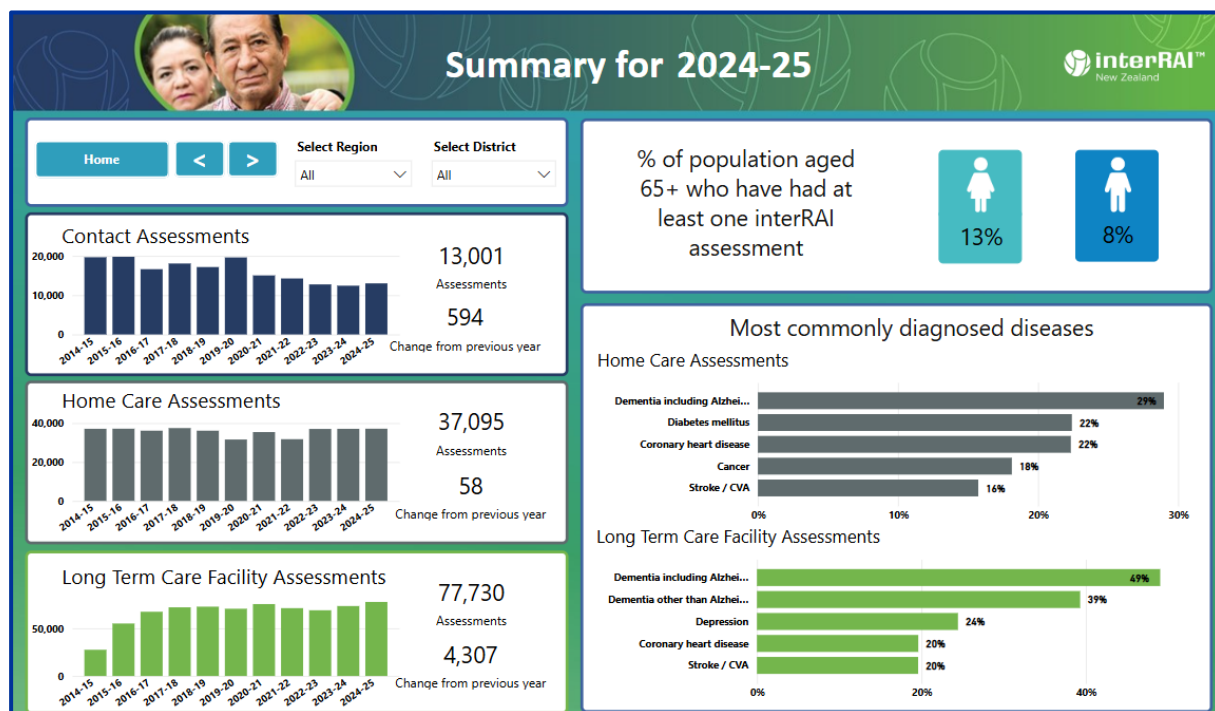
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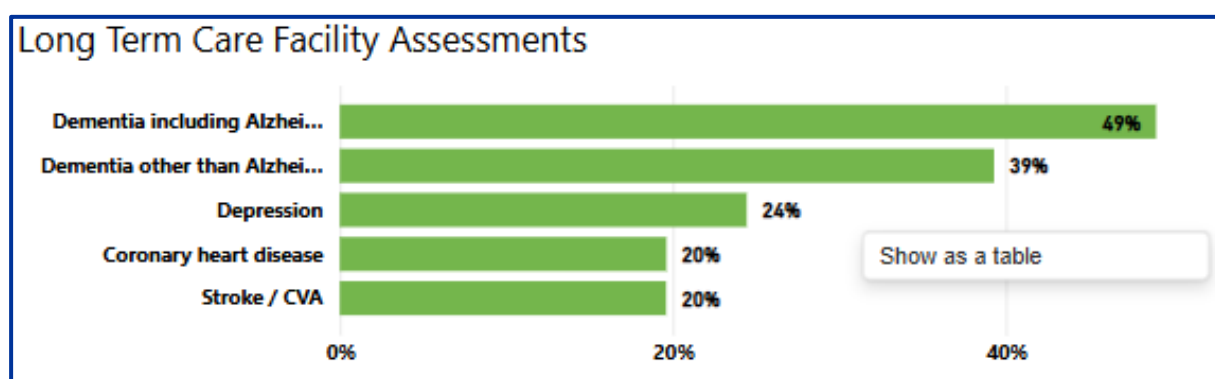
Page 2: Summary

Page 2 presents key statistics from interRAI New Zealand data for the time period specified in the title.

Use the drop down list on the top left to select **Region** and/or **District** of interest. The Regions and Districts in the drop down list are in geographic order.



To see all data points for a given chart, right click on the chart to bring up a **'Show as a table'** option.

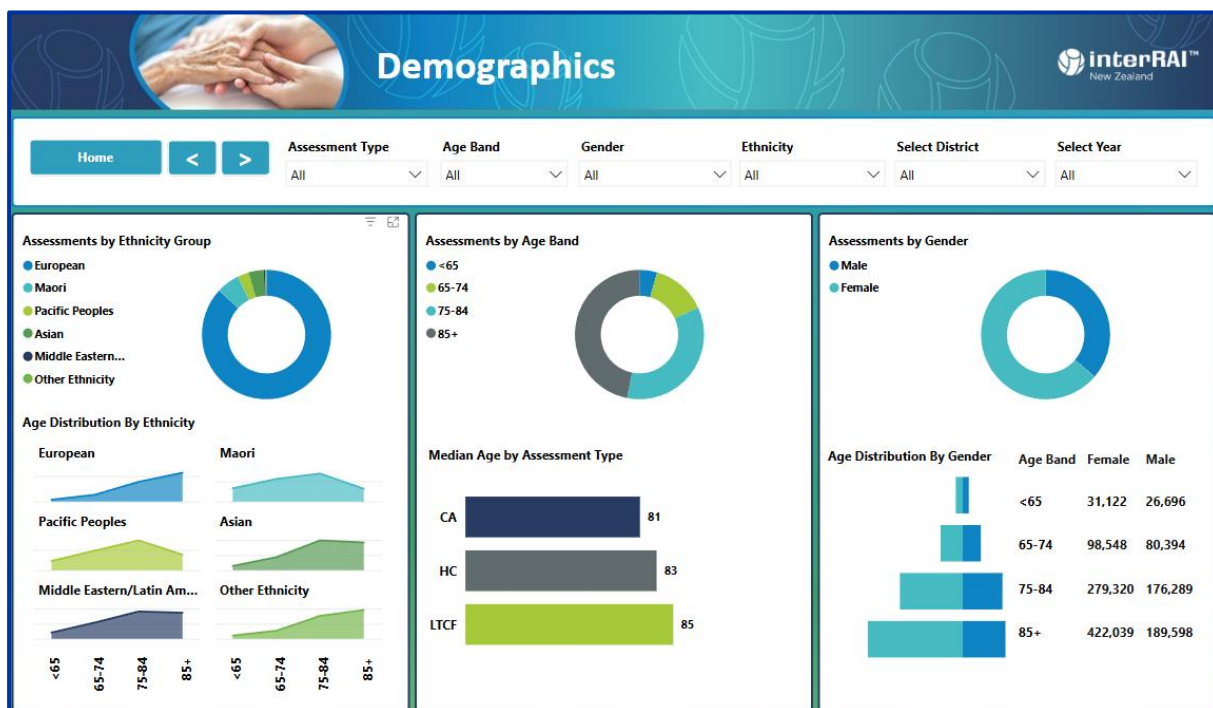


Select this and a new window will appear with the chart accompanied by data in a table format.

Page 3: Demographics

Page 3 includes key statistics describing the demographic information collected from interRAI assessments.

Use the drop down lists on the top bar to filter the data shown.



The three 'Doughnut' charts at the top show the share of assessments completed by Ethnicity, Age Band and Gender. We also show the age distribution of people assessed by Ethnicity and Gender, as well as the Median Age of people assessed by Assessment Type.

There are four genders recorded in the interRAI assessment. To preserve privacy, "Unknown" and "Indeterminate" are obscured.

Ethnicity is shown according to Stats NZ level 1 definition. The six groups are:

- European
- Māori
- Pacific Peoples
- Asian
- Middle Eastern / Latin American / African
- Other Ethnicity

Other Ethnicity includes residual groups.

Page 4: Disease Diagnosis

Page 4 describes the disease diagnosis information collected from interRAI assessments. Much of the functionality also applies to other pages including **Page 5: Outcome Scales**, **Page 6: Clinical Assessment Protocols**, and **Page 7: Social Wellbeing Measures**.

Use the filter panel on the left-hand side to choose the level of detail you would like to see. The column chart will update accordingly.

Home < >

Select Disease Diagnosis
Alzheimer's disease

Select Assessment Type
All

Select Age Band
All

Select Gender
All

Select Ethnicity Group
All

Select Region
All

Select District
All

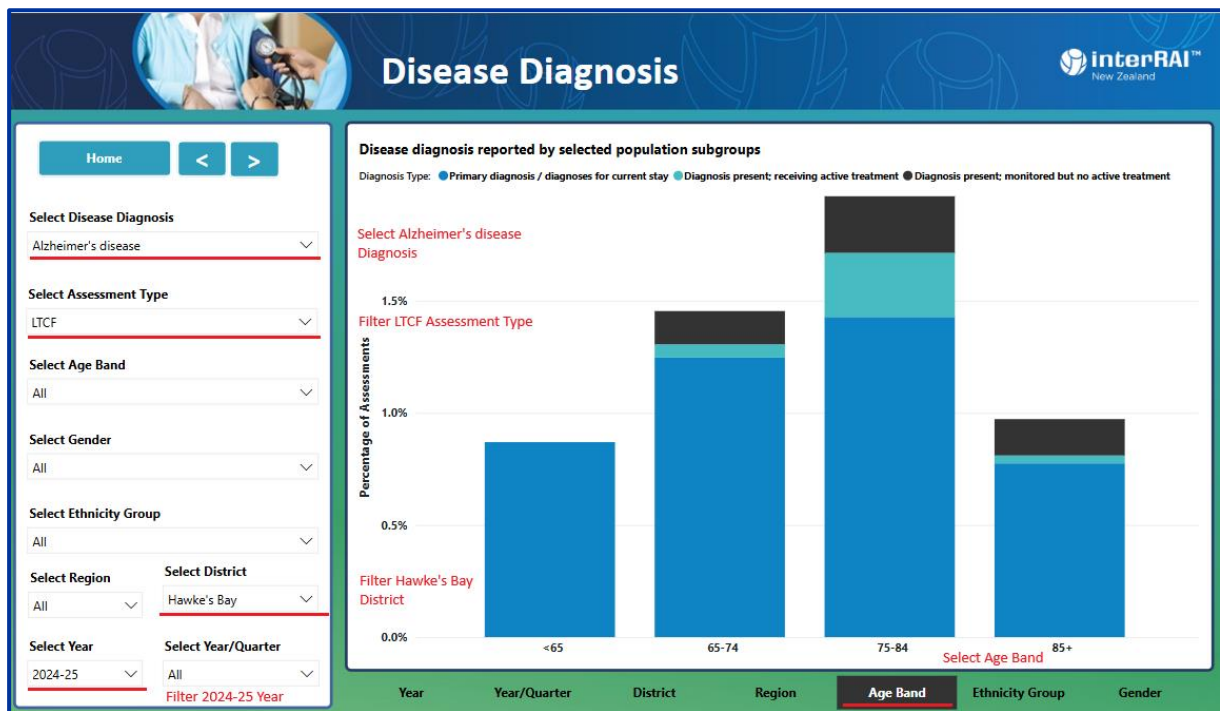
Select Year
All

Select Year/Quarter
All

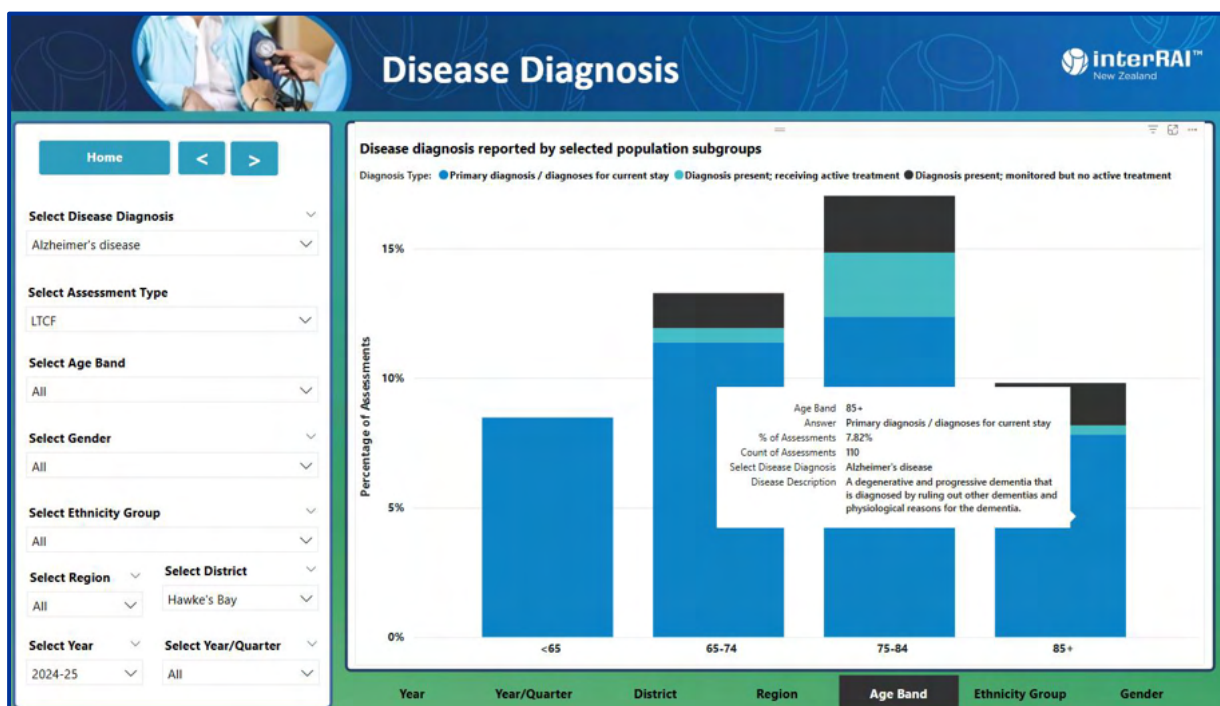
Then by using the bottom panel you can select how the column chart should be split. By default, this is set to years.

Year Year/Quarter District Region Age Band Ethnicity Group Gender

If for example, you would like to find out the proportion of LTCF assessments completed in 2024-25 for people living in Hawke's Bay District who reported Alzheimer's disease, split by age band, then you can apply the following selections:



If you hover your mouse cursor to the chart area, you should be able to read the exact figure from a pop-up window. The pop-up window will also include the selected disease definition.

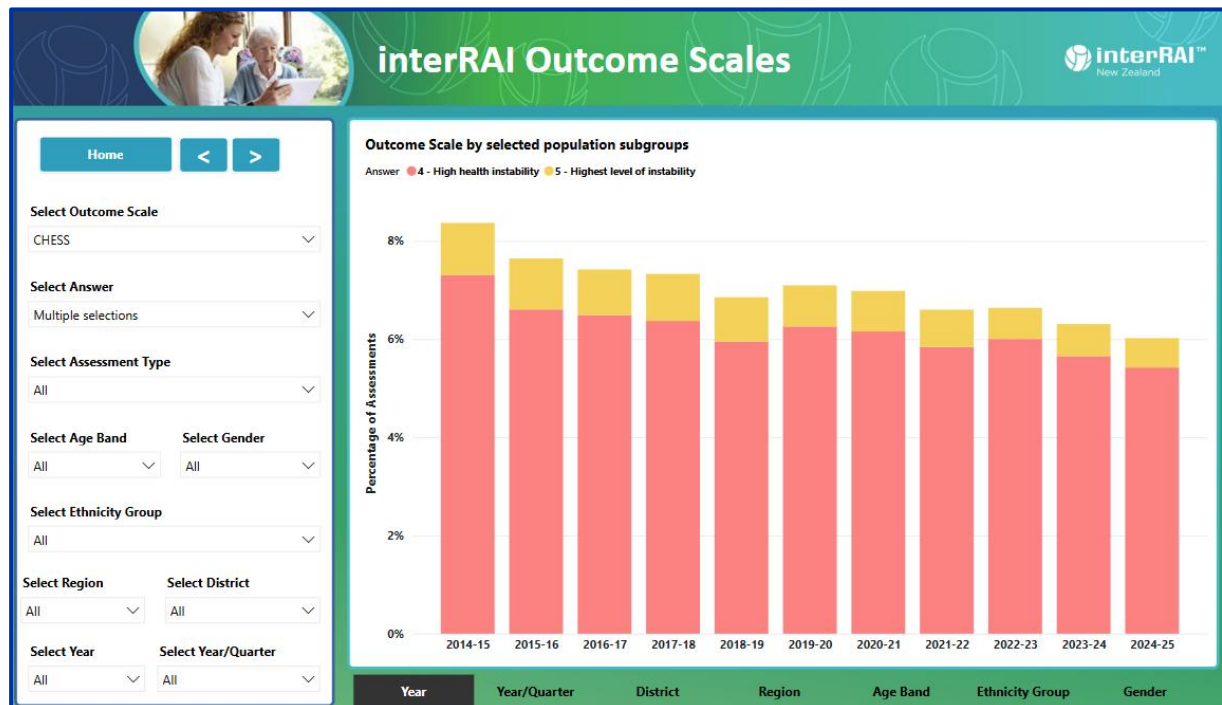


In this example, in 2024-25, 7.82% of LTCF assessments were completed for people aged 85 and over, within Hawke's Bay District, reporting Alzheimer's disease as their primary diagnosis. We can see that Alzheimer's disease is defined as 'A degenerative and progressive dementia that is diagnosed by ruling out other dementias and physiological reasons for the dementia'.

Remember you can also right click and select '**Show data**' to view the information in table format.

Page 5: Outcome Scales

This page has the same functionality as the **Disease diagnosis** page. In addition, there is a filter which allows only certain scores to be shown on the charts. For example, you can see the CHES scale with only 4 and 5 scores.



If you hover your mouse cursor above a section of the column chart, the pop-up box will display the count and percentage of assessments for your selection criteria as well as a definition of the selected outcome scale.

Invalid selection combinations will display no data in the charts, e.g. LTCF and MAPLe.

Page 6: Clinical Assessment Protocols

This page has the same functionality as the **Disease diagnosis** page.

Invalid selection combinations will display no data in the chart, e.g. LTCF and Institutional Risk CAP.

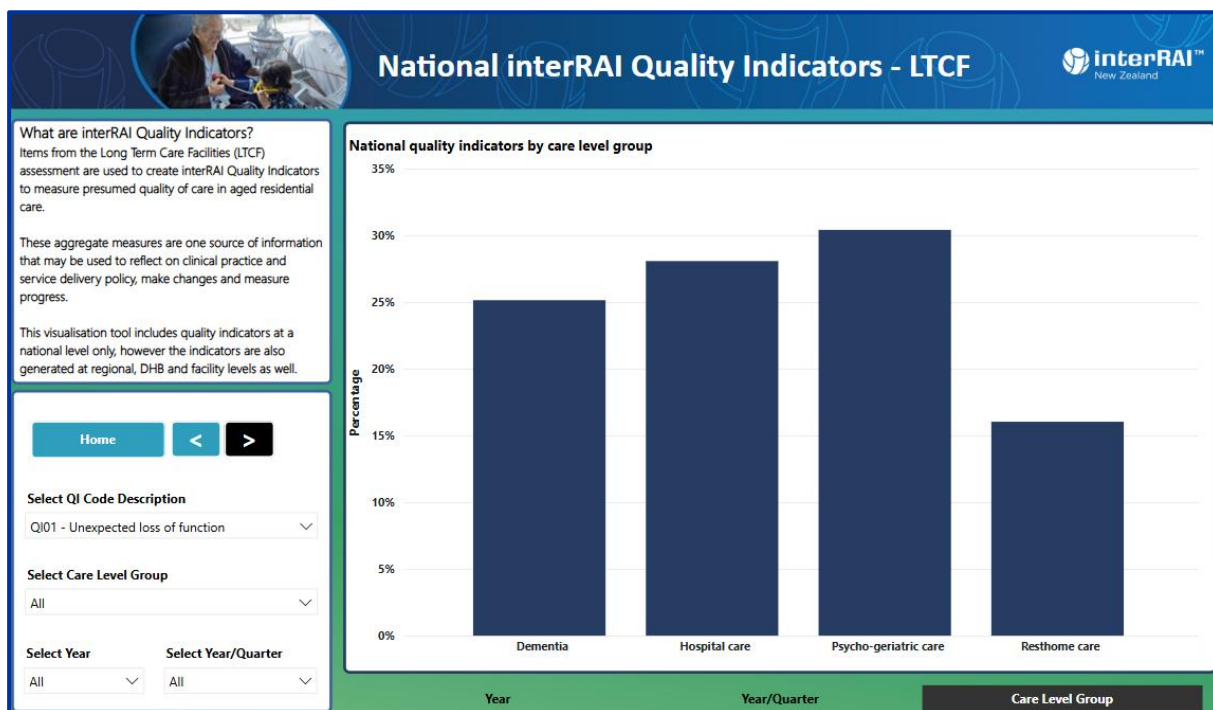
Page 7: Social Wellbeing Measures

This page has the same functionality as the **Disease diagnosis** page.

Page 8: National Quality Indicators - LTCF

This page has similar functionality to the **Disease diagnosis** page. However, the demographic and geographic variables are not available to filter by. Instead national data is presented by level of care.

Descriptions of each quality indicator, the type of indicator (incidence or prevalence) and desired direction (lower or higher) have been incorporated into the tool and can be viewed when hovering over the chart column.



Further information on quality indicators including an education package to help interpret results and definitions explaining each quality indicator are available from the [interRAI website](https://www.interrai.org.nz/).

Appendix

Outcome Scale Definitions

The interRAI software processes the assessment information and creates objective measures called Outcomes and CAPs.

Outcomes show a picture of the person's needs, their clinical and functional status.

Each assessed person has a score on each outcome scale. Usually, the higher score indicates higher urgency or need.

Activities of Daily Living (ADL) Hierarchy

The ADL Hierarchy Scale groups activities of daily living according to the stage of the disablement process in which they occur. Early loss ADLs (for example, dressing) are assigned lower scores than late loss ADLs (for example, eating).

ADL Long Form

Scale from 0 to 28 that provides a summary of the person's ability to perform ADLs. It is based on 7 ADL items – personal hygiene, toilet use, locomotion, eating, dressing, transferring, and bed mobility. The higher the score the greater the difficulty in performing activities.

ADL Short Form

Scale from 0 to 16 that provides a summary of the person's ability to perform ADLs. It is based on 4 ADL items – personal hygiene, toilet use, locomotion, eating. The higher the score the greater the difficulty in performing activities. Validated by Morris, Fries, and Morris 1999.

Aggressive Behaviour

The Aggressive Behaviour Scale (ABS) is a measure of aggressive behaviour based on the occurrence of verbal abuse, physical abuse, socially disruptive behaviour and resistance to care. Scale scores range from 0–12 with higher scores indicative of greater frequency and diversity of aggressive behaviour. A score of 1 to 4 on the ABS indicates mild to moderate aggressive behaviour, whereas scores of 5 or more represents the presence of more severe aggression. This scale has been validated against the Cohen Mansfield Agitation Inventory.

Assessment Urgency

The purpose of this scale is to determine whether or not the person needs further in-depth assessment. This score is calculated by referring to a number of elements in the assessment that relate to the person's physical health, person's mood, the family's ability to cope and the person's dependence with personal hygiene. The scale range is 1–6 with 6 being the most complex. Level 0 is included for those assessments where no score is calculated.

Body Mass Index (BMI)

The Body Mass Index (BMI) is a measurement which represents the ratio of a person's height to weight. In the interRAI assessment suite, it is recorded to monitor nutrition, hydration status, and weight stability over time. The under-nutrition CAP triggers (3 levels) are based on the BMI. It is defined as the weight in kilograms divided by the square of the height in metres (kg/m²).

CHES

The Changes in Health, End-Stage Disease, Signs, and Symptoms Scale was designed to identify individuals at risk of serious decline. It can serve as an outcome where the objective is to minimise problems related to declines in function, or as a pointer to identify persons whose conditions are unstable. CHES, originally developed for use with nursing home residents, has been adapted for use with other instruments in the interRAI suite. It has a 6 point scale from 0 (not at all unstable) to 5 (highly unstable) with higher levels predictive of adverse outcomes such as mortality, hospitalisation, pain, caregiver stress, and poor self-rated health. The CHES Scale is calculated by adding sign and symptom variables up to a maximum of 2, then adding three other variables (Change in decision making, Change in ADL status, and End-stage disease), giving the highest CHES score of 5.

Communication

This scale is derived from expressive and receptive communication. The higher the score on the communication scale, the poorer the communication.

Cognitive Performance Scale (CPS)

The Cognitive Performance Scale (CPS) combines information on memory impairment, level of consciousness, and executive function, with scores ranging from 0 (intact) to 6 (very severe impairment). The CPS has been shown to be highly correlated with the MMSE in a number of validation studies.

Cognitive Performance Scale 2 (CPS2)

The CPS2 scales has a range of 0–8 and is a more sensitive measure than the CPS. It can detect changes particularly in early stages of cognitive decline. Scores for walking, managing finances and medications acknowledge additional challenges for a person living in the community with cognitive loss.

Crisis Identification and Situational Improvement Strategies (CRISIS)

The Crisis Identification and Situational Improvement Strategies (CRISIS) Scale categorises a person by their likelihood of being placed in a LTCF within 90 days of being assessed. Using the decision tree illustrated in Figure 10, the person is assigned a level of risk (between 1 and 5) that indicates their risk of being immediately placed in a long-term care facility.

Deaf/Blind Severity

The Deaf/Blind Severity Index provides a simple summary of two senses: hearing and sight. It assigns individuals to six easily understood ranked categories. A score of 3 or higher indicates some level of dual sensory loss.

Detection of Indicators and Vulnerabilities for Emergency Room Trips (DIVERT)

The Detection of Indicators and Vulnerabilities for Emergency Room Trips (DIVERT) Scale identifies the likelihood of emergency department use. Research shows the higher the score the greater the likelihood of ED presentation within six months of assessment. Scores range from 1 (Lowest risk for future use of emergency department) to 6 (Highest risk for future use of emergency department).

Depression Rating Scale (DRS)

The Depression Rating Scale (DRS) is used as a clinical screen for depression. The higher the score the stronger the clinical indicator. Validation studies were based on a comparison of the DRS with the Hamilton Depression Rating Scale and the Cornell Scale for Depression.

Fracture Risk Scale (FRS)

The Fracture Risk Scale (FRS) identifies a person's risk of hip fractures within one year of being assessed. The range is 0 (no issues) – 11 (ADL dependent). There are some variances in items drawn between the Home Care (HC) and the Long-Term Care Facilities (LTCF) assessments. These relate to the variation in factors often present in the respective settings that influence fracture risk. The FRS ranges from 1 to 8: the higher the score, the higher the risk of a hip fracture.

Functional Hierarchy

The Functional Hierarchy Scale considers and combines both the ADL Hierarchy and IADL Hierarchy Capacity scales to allow for monitoring of individuals from relative independence through episodes of care. The range is 0 (no issues) – 11 (ADL dependent).

IADL Capacity

The Instrumental ADL Scale is based on a sum of eight items: meal preparation, ordinary housework, managing finances, medications, phone use, stairs, shopping, and transportation. Individual items are summed to produce a scale that ranges from 0 to 48, with higher scores indicating a greater difficulty for a person to carry out an activity.

IADL Capacity Hierarchy

The IADL Capacity Hierarchy takes five items from the IADL items and follows the ADL Hierarchy scale in identifying early, mid- and late loss IADL items. The range is 0 (no difficulty) – 6 (all dependence).

IADL Performance

The Instrumental ADL Scale is based on a sum of eight items: meal preparation, ordinary housework, managing finances, medications, phone use, stairs, shopping, and transportation. Individual items are summed to produce a scale that ranges from 0 to 48, with higher scores indicating greater dependence on others for instrumental activities for daily living.

MAPLe

MAPLe differentiates people into five priority levels, based on their risk of adverse outcomes. People in the lowest priority level have no major functional, cognitive, behavioural, or environmental problems and are considered self-reliant. The highest priority level is based on the presence of ADL impairment, cognitive impairment, wandering, behaviour problems, and the interRAI nursing home risk CAP. Research has demonstrated that the five priority levels are predictive of risk: Individuals in the highest priority level are nearly nine times more likely to be admitted to a long-term care facility than are the lowest priority persons. MAPLe also predicts caregiver stress.

Pain

Scale that attempts to define levels of pain. The scale is highly predictive of pain on the Visual Analogue Scale (Fries et al 2001). Pain that is adequately managed does not feature in the scale. Scores range from 0 (No Pain) to 4 (Daily excruciating Pain).

Personal Support Algorithm

The Personal Support Algorithm Scale is designed to help make decisions about how to prioritise community-based support and how to allocate resources. The scale allocates a score between 1 and 6: the higher the score, the greater a person's need for personal support. Research has found that, everyone who falls into the same score group (1 to 6) needs similar support services.

Pressure Ulcer Risk

Scores from 0 (lowest risk) to 8 (highest risk) for development of pressure ulcers. This scale complements the Pressure Area CAP and should always be reviewed when that CAP is triggered.

Rehabilitation Urgency

This score is calculated by looking at whether the person has specialist nursing needs, is dependent with personal hygiene, has had recent hospital visits and has daily pain. The range is 1-4 with 4 being the most urgent. Level 0 is included for those assessments where no score is calculated.

Revised Index for Social Engagement (RISE)

The Revised Index for Social Engagement (RISE) increases staff capacity to measure a resident's social engagement, as it provides a reliable and valid scale that they can use, during daily clinical practice, with residents of all cognitive abilities. The RISE allocate scores between 0 and 6: the higher the score, the more socially engaged the resident is, which conversely makes it a positive indicator compared to other scales.

Service Urgency

This score is calculated by looking at whether the person has specialist nursing needs, is dependent with personal hygiene, has had recent hospital visits and has daily pain. The range is 1-4 with 4 being the most urgent. Level 0 is included for those assessments where no score is calculated.

Vulnerable Persons at Risk

The Vulnerable Persons at Risk (VPR) Scale identifies which people receiving home-based support most need support during emergencies and disasters. A person's VPR Scale score (0-2) is calculated using MDS assessment items that measure impairment, social isolation, and caregiver situation.

Range of Values

The following table defines the range of valid values for each scale and identifies which assessment type each scale is applicable to:

| Outcome Scale | Range of Values | Applicable to: | | |
|--------------------------------------|-----------------|----------------|----|------|
| | | CA | HC | LTCF |
| Assessment - Urgency | 0,1-6 | Y | | |
| Service Urgency | 0,1-4 | Y | | |
| Rehab | 0,1-5 | Y | | |
| ADL Hierarchy | 0-6 | | Y | Y |
| ADL Long Form | 0-28 | | Y | Y |
| ADL Short Form | 0-16 | | Y | Y |
| Aggressive Behaviour | 0-12 | | Y | Y |
| CHESS | 0-5 | Y | Y | Y |
| Cognitive Performance Scale (CPS) | 0-6 | | Y | Y |
| Cognitive Performance Scale 2 (CPS2) | 0-8 | | Y | |
| Communication | 0-8 | | Y | Y |
| CRISIS | 1-5 | | Y | |
| Deaf/Blind Severity | 0-5 | | Y | |
| DIVERT | 0-8 | | Y | |
| Depression Rating Scale (DRS) | 0-14 | | Y | Y |
| Fracture Risk Scale | 1-8 | | Y | Y |
| Functional Hierarchy | 0-11 | | Y | |
| IADL Capacity | 0-48 | | Y | |
| IADL Capacity Hierarchy | 0-6 | | Y | |
| IADL Performance | 0-48 | | Y | |
| MAPLe | 1-5 | | Y | |
| Pain | 0-4 | | Y | Y |
| Personal Support Algorithm | 1-6 | Y | Y | |
| Scale Rise | 0-6 | | | Y |
| Vulnerable Persons at Risk | 0-2 | | Y | |
| Pressure Ulcer Risk | 0-8 | | Y | Y |

Clinical Assessment Protocol (CAP) Definitions

CAP is short for Clinical Assessment Protocol and when they are triggered, they indicate an opportunity for improvement, to slow the rate of decline or help symptoms. Most CAPs trigger at two or three levels. A higher CAP level usually indicates a larger problem, or increased risk of decline.

Abusive Relationship

To identify potential abuse/neglect situations — fearful of a family member, caregiver, close acquaintance, unusually poor hygiene, unkempt appearance, neglected, abused, or mistreated.

Activities

This CAP identifies persons with some cognitive reserve who have either withdrawn from activities or who are uneasy entering into activities and social relationships.

Activities of Daily Living

To improve ADL performance or prevent avoidable functional decline — receive some ADL help; potential to improve self-performance.

Appropriate Medications

To identify and promote appropriate medication management — 9+ medications and 2 of the following: chest pain, dizziness, oedema, shortness of breath, poor health, or recent deterioration.

Behaviour

To prevent, manage behavioural problems — wandering, verbally abusing others, physically abusing others, socially inappropriate, disruptive behaviour, inappropriate disrobing, public sexual behaviour or resisting care.

Bowel Conditions

To facilitate improvement and prevent a decline in bowel function — risk of decline and improvement and bowel continence.

Cardiorespiratory Conditions

To assess and manage cardiorespiratory conditions — symptoms of chest pain, shortness of breath, irregular pulse, dizziness and test results such as BP, respiratory rate, heart rate, and oxygen saturation.

Cognitive Loss

The definition of this CAP changed in the version 9.3 assessment upgrade that occurred in November 2015. This CAP now has only two trigger levels: 0 (not triggered) and 2 (prevent cognitive decline).

Communication

To improve communication ability and to prevent avoidable communication decline — moderate–severe communication issues in understanding/expression.

Dehydration

To identify and treat underlying causes of dehydration — insufficient fluid intake; and diarrhoea, vomiting, delirium, fever, dizziness, syncope, constipation, weight loss.

Delirium

To identify persons with active symptoms of delirium — acute change in mental status and behaviour appears different from usual functioning.

Falls

To identify and change any underlying risk factors for falls — report of a single fall or multiple falls.

Feeding Tube

To identify persons with a feeding tube and manage — has a feeding tube and some residual cognitive abilities/absence of cognitive abilities.

Home Environment Optimisation

To improve the safety of an environment — problems with lighting, flooring, bathroom, toilet, kitchen, heating, disrepair, squalor, and indicators of frailty.

Informal Support

To identify where a person needs help — not independent with meals/housework/shopping/transport and alone for long periods or lives alone and no primary informal helper present.

Institutional Risk

To avoid premature admission to LTCF — identify the person with impaired functioning who is at high-risk of institutional placement.

Instrumental Activities of Daily Living

To improve IADL self-performance and capacity — identify persons who have the capability and interest to carry out instrumental activities of daily living more independently.

Mood

To identify, treat and monitor mood issues — negative statements, persistent anger, expressions of unrealistic fears, repetitive health complaints, repetitive anxious complaints, sad, crying or tearfulness. Depression Rating Scale (DRS) score medium to high.

Pain

To identify and treat underlying reasons for pain — high-risk trigger for people with severe, horrible or excruciating pain or medium-risk trigger for people with daily mild/moderate pain.

Physical Activities Promotion

To increase levels of exercise and physical activity – identify person does less than two hours physical activity over a three- day period; moves and goes up/down stairs without help; increased independence possible.

Physical Restraints

This CAP identifies persons who are physically restrained.

Pressure Ulcer

To prevent, identify and treat pressure ulcers – has or is at risk of developing a pressure ulcer.

Prevention

To prevent illness and disability – blood pressure, colonoscopy, dental exam, hearing exam, fluvax, mammogram, or Pneumovax.

Social Relationship

To identify factors associated with reduced social relationships and facilitate engagement, such as mental health problems and poor health.

Tobacco and Alcohol Use

To identify strategies to help people cease smoking and cut back on excessive drinking.

Under-nutrition

To address and manage under-nutrition based on a person's BMI score.

Urinary Incontinence

To facilitate improvement and prevent decline in bladder function – reoccurring episodes of incontinence, minimal cognitive abilities, locomotion impaired; possibility of improvement.

Range of Values

The following table defines the range of valid values for each CAP, and identifies which of the assessment types each CAP is applicable to:

| CAP | Range of Values | Applicable to: | | |
|--|-----------------|----------------|----|------|
| | | CA | HC | LTCF |
| Functional Performance CAPS | | | | |
| 1. Physical Activities Promotion | 0-1 | | Y | Y |
| 2. Instrumental Activities of Daily Living | 0-1 | | Y | |
| 3. Activities of Daily Living | 0-2 | | Y | Y |
| 4. Home Environment Optimisation | 0-1 | | Y | |
| 5. Institutional Risk | 0-1 | | Y | |
| 6. Physical Restraints | 0-2 | | | Y |
| Cognition/Mental Health CAPS | | | | |
| 7. Cognitive Loss | 0,2 | | Y | Y |
| 8. Delirium | 0-1 | | Y | Y |
| 9. Communication | 0-2 | | Y | Y |
| 10. Mood | 0-2 | | Y | Y |
| 11. Behaviour | 0-2 | | Y | Y |
| 12. Abusive Relationship | 0-2 | | Y | |
| Social Life CAPs | | | | |
| 13. Activities | 0-1 | | | Y |
| 14. Informal Support | 0-1 | | Y | |
| 15. Social Relationship | 0-1 | | Y | Y |
| Clinical Issues CAPs | | | | |
| 16. Falls | 0-2 | | Y | Y |
| 17. Pain | 0-2 | | Y | Y |
| 18. Pressure Ulcer | 0-3 | | Y | Y |
| 19. Cardiorespiratory Conditions | 0-1 | | Y | Y |
| 20. Under-nutrition | 0-2 | | Y | Y |
| 21. Dehydration | 0-2 | | Y | Y |
| 22. Feeding Tube | 0-2 | | Y | Y |
| 23. Prevention | 0-2 | | Y | Y |
| 24. Appropriate Medications | 0-1 | | Y | Y |
| 25. Tobacco and Alcohol Use | 0-1 | | Y | Y |
| 26. Urinary Incontinence | 0-3 | | Y | Y |
| 27. Bowel Conditions | 0-2 | | Y | Y |

Disease Definitions

Alzheimer's disease

A degenerative and progressive dementia that is diagnosed by ruling out other dementias and physiological reasons for the dementia.

Anxiety

A non-psychotic mental disorder. There are five types, which include generalised anxiety disorder, obsessive-compulsive disorder, panic disorder, phobias and post-traumatic stress disorder.

Bipolar disorder

Includes documentation of clinical diagnosis of either manic depression or bipolar disorder. "Bipolar disorder" is the current term for manic-depressive illness.

Cancer

Any malignant growth or tumour caused by abnormal and uncontrolled cell division. The malignant growth or tumour may spread to other parts of the body through the lymphatic system or the blood stream.

Chronic obstructive pulmonary disease

Any long-standing condition that impairs airflow in and out of the lungs.

Congestive heart failure

A condition in which the heart cannot pump out all of the blood that enters it, which leads to an accumulation of blood in the vessels, fluid in the body tissues, and lung congestion.

Coronary heart disease

A chronic condition marked by thickening and loss of elasticity of the coronary artery, and caused by deposits of plaque containing cholesterol, lipid material, and lipophages.

Dementia including Alzheimer's disease

Includes diagnosis of Alzheimer's disease and/or Dementia other than Alzheimer's disease.

Dementia other than Alzheimer's disease

Includes diagnoses of organic brain syndrome (OBS) or chronic brain syndrome (CBS), senility, senile dementia, multi-infarct dementia, and dementia related to neurological diseases other than Alzheimer's (such as Pick's, Creutzfeldt-Jakob, Huntington's disease, etc.).

Depression

A mood disorder often characterised by a depressed mood (for example, the person feels sad or empty; appears tearful); decreased ability to think or concentrate; loss of interest or pleasure in usual activities; insomnia or hypersomnia; loss of energy; change in appetite; feelings of hopelessness, worthlessness, or guilt. May include thoughts of death or suicide.

Diabetes mellitus

Any of several metabolic disorders marked by persistent thirst and excessive discharge of urine. Includes insulin-dependent diabetes mellitus (IDDM) and diet-controlled diabetes mellitus (NIDDM or AODM).

Hemiplegia

Paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral haemorrhage, thrombosis, embolism, or tumour. There must be a diagnosis of hemiplegia in the person's record to code this item.

Hip fracture

Includes any hip fracture that occurred during the past 30 days (or since the last assessment, if it was less than 30 days ago) that continues to have a relationship to current status, treatments, monitoring, etc. Hip fracture diagnoses also include femoral neck fractures, fractures of the trochanter, and subcapital fractures.

Multiple sclerosis

A disease in which there is demyelination throughout the central nervous system. Typical symptoms are weakness, incoordination, paraesthesia, speech disturbances, and visual complaints.

Other fracture

Any fracture other than hip (for example, wrist) due to any condition, such as falls or weakening of the bone as a result of cancer. Fracture to have occurred during the past 30 days (or since the last assessment, if it was less than 30 days ago).

Paraplegia

Paralysis (temporary or permanent impairment of active motion) of the lower part of the body, including both legs.

Parkinson's disease

A disorder of the brain characterised by tremor; muscle rigidity; and difficulty with walking, movement, and coordination.

Pneumonia

Inflammation of the lungs, most commonly of bacterial or viral origin.

Quadriplegia

Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs and trunk.

Schizophrenia

A disturbance characterised by delusions, hallucinations, disorganised speech, grossly disorganised behaviour, disordered thinking, or flat affect. This category includes schizophrenia subtypes (for example, paranoid, disorganised, catatonic, undifferentiated, residual).

Stroke / CVA

A sudden rupture or blockage of a blood vessel within the brain, causing serious bleeding or local obstruction.

Urinary tract infection

Includes chronic and acute symptomatic infection(s) in the last 30 days. Code only if there is current supporting documentation and significant laboratory findings in the clinical record.