

Resident Assessment Instrument (RAI)/Minimum Data Set (MDS) Policy

Purpose:

The RAI assists skilled nursing facility staff to consistently and accurately gather information regarding resident needs and strengths, which provides the foundation for an individualized interdisciplinary plan of care. The Long Term Care Facility Resident Assessment Instrument User's Manual (12/02) and accompanying CMS updates sent out since that time set forth these requirements and are to be used as a guide for completion of this process. All members completing any section of the RAI process shall have access to the RAI User's Manual and updates to ensure accuracy of the process.

Policy:

The RAI process is coordinated by an RN and includes an interdisciplinary team of nursing, social services, dietary, rehab/restorative, activities, pharmacy and medical staff. The resident and family/legal guardian are included as integral members of the team and shall be included in the assessment and care planning process.

The RAI process includes accurate and timely completion of the following:

- Initial Admission Assessment within 14 days of admission
- Resident Assessment Protocols (RAPs) within 14 days of admission
- Plan of care within 21 days of admission or within 7 days of completion of MDS and RAPs.
- Quarterly assessments within 92 days of the previous assessment (R2b/Vb2) along with care plan review
- Annual assessment with RAPs within 366 days of the previous full assessment (Vb2) along with care plan review and updates
- Significant Change in Status/Significant Correction assessment with RAPs as identified appropriate by the RN and the care plan team along with care plan review and revision.
- Discharge tracking within 7 days of D/C (either anticipated return or unanticipated return)
- Re-entry tracking within 7 days of readmission after a D/C return anticipated

Responsibilities for RAI Process Coordination (*Options*):

- **Team Leader/Primary Nurse** –The Team Leader/Primary Nurse coordinates the RAI process for their assigned team of residents. This involves coordination of both MDS/RAP completion and development of the initial and primary plan of care for all new and currently assigned residents. The Team Leader/Primary Nurse also leads the portion of the care plan meeting that involves their assigned residents and works with the interdisciplinary team to assure that a comprehensive plan of care is in place and communicated to staff and family. The LPN Team Leader/Primary Nurse requires an RN to oversee the RAI and care planning process for their residents; however the LPN maintains an integral role. Tasks may be delegated to the LPN with appropriate oversight and signatures by the RN.
- **RN RAI Coordinator**-An RN RAI Coordinator oversees the RAI process for all residents in the facility. This involves coordination of both MDS/RAP completion and development of the initial and primary plan of care for all new and current residents in the facility. The RAI Coordinator leads the plan of care meeting for all residents and works with the interdisciplinary team to assure that a comprehensive

plan of care is in place and communicated to staff and family. Task may be delegated to other members of the care plan team with appropriate oversight and signatures by the RN RAI Coordinator

Determination of the Assessment Reference Date and Completion Date

The assessment reference date (ARD) will routinely be set as the 7th day after admission. This date creates the end of the observation period for the assessment process, therefore the MDS and RAPs cannot be completed prior to the ARD. If it is determined that adjustment of the ARD will be beneficial to the resident assessment process then this date may be changed by the RN with input from the care plan team.

The ARD of subsequent routine assessments will be set 7 days prior to the completion date and communicated to team members in writing via the team meeting schedule. All records are to be placed on the resident's medical record with appropriate signatures no later than 7 days after the completion dates as cited above.

Medicare/PPS Assessments

Medicare assessments (5 Day, 14 Day, 30 Day, 60 Day and 90 Day) are to be completed for residents receiving Medicare Part A Skilled Services (services must be provided in a Medicare certified bed). The regulatory requirement for completion of a comprehensive assessment with RAPs applies with either the 5 Day Medicare Assessment or the 14 Day Medicare Assessment and must be completed by day 14 of the resident's stay. A Quarterly Assessment is also required no later than 92 days after the previous full assessment and may accompany the 90 Day Medicare Assessment. The RN will be responsible to determine which Medicare assessment will also function as the comprehensive/quarterly assessment to meet these regulatory requirements. Communication of the Medicare schedule and completion dates will occur as stated in this policy. Selection of an appropriate ARD for all Medicare assessment will involve input from the interdisciplinary team, including rehab services.

RAI Completion Responsibilities

Completion of the RAI process may be assigned to any member of the care plan team so long as coordination of the process is overseen by an RN. The following assignments are recommendations; however changes may be made as appropriate. Communication of any changes in the assignment for a specific resident will be the responsibility of the RN.

- **MDS version 2.0**-Accurate completion requires review of the clinical record; interview of staff, resident, and family members; and observation of the resident in the nursing home environment.

Section AA	Social Services
Section AB	Social Services
Section AC	Social Services
Section AD	Social Services and RN to sign when completed
Section A	Nursing/Social Services
Section B	Nursing/Speech Therapy
Section C	Nursing/Speech Therapy
Section D	Nursing

Section E	Social Services
Section F	Social Services
Section G	Nursing [G-3 Balance reviewed by PT, G-4 Functional reviewed by PT]
Section H	Nursing
Section I	Nursing/Medical Records for ICD-9 coding accuracy
Section J	Nursing
Section K	Dietary/Nursing
Section L	Nursing
Section M	Nursing
Section N	Activities
Section O	Nursing/Pharmacy
Section P	Nursing w/ input from other disciplines as required
Section Q	Social services
Section R	RN Coordinator to date and sign when complete. Other disciplines to date and sign specific to those sections completed on Basic Tracking Form.
Section T*	Nursing/Physical/Occupational Therapy [*required for 5 Day Medicare PPS assessments only]
Section W	Nursing

- **RAP**-Accurate completion requires an understanding of “why” certain MDS items triggered. For each triggered RAP, use the RAP guidelines (see the RAI User’s Manual) to identify areas needing further assessment. Interdisciplinary review is recommended to facilitate a comprehensive review of the resident’s status.

The RN is responsible to review all RAP documentation and make recommendations as appropriate. Assignment of RAP completion is recommended as follow. Indicate on section V of the MDS, which triggered areas will be care planned.

Delirium	Nursing
Cognitive Loss/Dementia	Nursing
Visual Function	Nursing
Communication	Nursing
ADL/Functional Rehab	Nursing
Urinary Incontinence	Nursing
Psychosocial Well Being	Social Services
Mood	Social Services
Behavior	Social Services
Activities	Activities/Therapeutic Recreation
Falls	Nursing/Restorative
Nutrition	Dietary/Dietitian/Nursing
Feeding Tubes	Nursing/Dietitian
Dehydration/Fluid Maintenance	Nursing
Dental Care	Nursing
Pressure Ulcers	Nursing
Psychotropic Drug Use	Nursing
Physical Restraint	Nursing

RAP documentation of relevant assessment information regarding the resident’s status may occur in individual RAP summary notes, interdisciplinary progress notes, or completion of individual assessments/evaluations. Location and date of this documentation must be indicated on section V of the Resident Assessment Protocol Summary.

- **CARE PLAN**-The resident plan of care is considered a dynamic interdisciplinary document. An initial plan of care is to be implemented within 24 hours of the resident's admission to the facility. The formal plan of care is to be completed no later than the 21st day of the resident's stay and should be made available to staff at that time. The initial plan of care will include physician's orders and additional assessments/interventions as deemed appropriate by the admitting RN/charge nurse to ensure resident safety. This may include but is not limited to the following:

- Falls
- Skin
- Elopement Risk
- Incontinence
- Meal consumption
- ADL assistance

Verbal communication regarding the initial and formal plan of care will occur ongoing during shift report and staff rounds. Written communication will be maintained on the following documents and updated as appropriate by the RN or by members of the care plan team as assigned by the RN.

- Physician's Order Sheet (POS)
- Medication Administration Record (MAR)
- Nursing kardex
- Treatment record
- Nurse aide assignment sheet
- Other as specified

Involvement of all direct care staff is encouraged in the care planning process, however revisions to the plan of care should be coordinated by the RN and members of the care plan team.

Interdisciplinary Care Plan Team Meetings:

The weekly plan of care meeting will be the forum for review and evaluation of the resident's plan of care. Meetings will be held the same day and time each week (i.e., every Thursday from 10-12:00). All residents will have a plan of care review initially and then no less than every 90 days. Problem statements, goals and interventions will be reviewed, discussed and dated at that time with revisions made as necessary. Review of a resident's plan of care may be held as often as needed based on recommendations by the care plan team, resident, and/or family/legal guardian. All Medicare Part A residents will be discussed on a weekly basis until discharged from a Medicare Part A status.

All team members are expected to attend the meeting as scheduled and be prepared to discuss the residents based on their assessment findings. Documentation of recommendations from this meeting will be maintained in the resident's clinical record. Follow up from the plan of care meeting will be the responsibility of the team member as assigned during the team meeting. This may vary based on the recommendation and follow up required. Care plan team members are identified as follows:

- RN DON
- RN RAI Coordinator/Team Leader/Primary Nurse
- Social Services
- Activities
- Dietary
- Therapies
- Restorative
- Member of direct care staff assigned to resident (i.e., LPN, Aide)

Determination of Change in Status:

Change in status is often subtle and should be considered as a possibility with any change in the resident's plan of care. The interdisciplinary team, including the resident and family/legal guardian should be involved prior to any change in status determination.

Consideration of change in status should also occur with any of the following event:

- Return to nursing home after an acute hospitalization
- Re-entry from stay at home when D/C'd return was anticipated
- Discharge from Medicare status
- Care changes to terminal/palliative care measures

Criteria for determining a change in status is identified in the RAI User's Manual and should be reviewed prior to pursuit of a change in status assessment. When a resident meet the change in status criteria, the RN will set the ARD and schedule the MDS/RAPs for completion along with care plan revisions. This is to be done within 14 days of the determination in the change in status. Consideration for a change in status should be documented in the resident's record with decision-making rationale included.

Delegation of Responsibilities to Medical Records/Administrative Assistant Personnel:

The following list of responsibilities may be delegated to medical records or administrative assistant personnel. The RN will oversee the accurate completion of these responsibilities.

- Schedule routine MDS assessments (initial, quarterly, annual) to maintain compliance with regulatory time frames
 - Schedule ARD of initial assessments routinely on day 7 of the resident's stay (unless otherwise instructed)
 - Set ARD of subsequent routine assessments 7 days prior to the completion date (unless otherwise instructed)
- Schedule change in status assessments as instructed
- Complete Re-entry and Discharge tracking MDS within 7 days of the event
- Communicate weekly team meeting date, time, and the following to team members:
 - Resident name
 - MDS assessment type (Initial, Quarterly, Annual, Change in status, PPS)
 - ARD

- RAPs due (as applies)
- Completion due date
- Communicate schedule to appropriate family members/legal guardian
- Print appropriate MDS/RAP notes prior to the care plan meeting
- Obtain signatures on completed MDS
- File completed MDS in resident's clinical record
- Transmit completed MDS' to the state on a weekly basis (mandated every 30 days)
- Retrieve and maintain validation reports with each transmission, discuss errors w/ the RN
- Maintain current copies of informational updates on the state's web site
- Maintain current copies of the analytic and "Show Me" QI reports
- Distribute copies of informational updates, current QI reports with administrator, DON, RNs, etc as instructed
- Maintain relationship with soft ware vendor to ensure accurate and timely updates

Approved by: _____ Date: _____
