2007 Nursing Home Surveyor Training Resource

Summarizing Comprehensive Resident Assessment Information

Language in italics is stated verbatim from CMS regulation, interpretive guidelines, or manuals.
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This guidance should be read in conjunction with Appendix PP of the State Operations Manual and in conjunction with the information in the Revised Long-Term Care Facility Resident Assessment Instrument User's Manual Version 2.0.

CMS Guidelines are subject to change. For the most up to date CMS guidelines, please reference:
http://www.cms.hhs.gov/manuals/downloads/som107_Appendicestoc.pdf

CMS State Operations Manual (SOM) Appendix P - Survey Protocol for Long Term Care Facilities in part: *(Rev. 26, 08-17-07)*

❖ What do the regulations say?

F272
§483.20(b)(1) Resident Assessment Instrument. ***A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:***

- *(i) Identification and demographic information*
- *(ii) Customary routine.*
- *(iii) Cognitive patterns.*
- *(iv) Communication.*
- *(v) Vision*
- *(vi) Mood and behavior patterns.*
- *(vii) Psychological well-being.*
- *(viii) Physical functioning and structural problems.*
- *(ix) Continence.*
- *(x) Disease diagnosis and health conditions.*
- *(xi) Dental and nutritional status.*
- *(xii) Skin Conditions.*
- *(xiii) Activity pursuit.*
- *(xiv) Medications.*
- *(xv) Special treatments and procedures.*
- *(xvi) Discharge potential.*
- ***(xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.***
- *(xviii) Documentation of participation in assessment.*

- The regulation does not specify the format of this summary information but makes it clear that it must occur.
- The Interpretive Guidelines for this section indicate that this *corresponds to MDS v 2.0 section V, and refers to documentation concerning which RAPs have been triggered, documentation of assessment information in support of clinical decision making relevant to the RAP, documentation regarding where, in the clinical record, information related to the RAP can be found, and for each triggered RAP, whether the identified problem was included in the care plan.*

Additional regulatory language related to required clinical record documentation can be found in F514:

§483.75(1)(5) Clinical Records. The clinical record must contain—

(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The plan of care and services provided;
(iv) The results of any preadmission screening conducted by the State; and
(v) Progress notes.

❖ What does the Long-Term Care Facility Resident Assessment Instrument User's Manual say about RAP summaries and documentation?

The RAI User's Manual is the reference CMS has directed facilities to use for completing the Resident Assessment Instrument. Information related to RAPs, resident assessment and care plan completion can be found in various places in the manual. Not all references have been quoted here. The complete manual should be reviewed.

Chapter 2 of the RAI User's Manual indicates:

- *After completing the MDS portion of the comprehensive assessment, the assessor(s) then proceed(s) to further identify and evaluate the resident's strengths, problems, and needs through use of the* ***Resident Assessment Protocol Guidelines (RAPs)*** *described in detail in Chapter 4 of this manual and through further investigation of any resident-specific issues not addressed in the RAI. For example, those items that are not automatically triggered, such as Item P4 (side rails), may require further investigation.*
- *Completed along with the MDS, the RAPs provide the foundation upon which the care plan is formulated. There are 18 problem-oriented RAPs, each of which includes MDS-based "trigger" conditions that signal the need for additional assessment and review. Triggers and their definitions for each RAP appear in Appendix C. Also in Appendix C are the RAP Guidelines for additional assessment and review to determine if a care plan is appropriate to address the triggered condition.*

RAPs are required for all comprehensive assessments: the admission assessment, the annual assessment, a significant change in status assessment, and a significant correction of a prior full assessment. RAPs are not required for quarterly assessments, however, as indicated in the RAI User's Manual:

- *The care plan should be revised on an on-going basis to reflect changes in the resident and the care the resident is receiving.*

Chapter 4 of the RAI User's Manual provides a more extensive explanation of the procedures for completing the RAPs and linking the assessment to the care plan. Excerpts from this chapter include:

- *The goal of the RAPs is to guide the interdisciplinary team through a structured comprehensive assessment of a resident's functional status. Functional status differs from medical or clinical status in that the whole of a person's life is reviewed with the intent of assisting that person to function at his or her highest practicable level of well-being. Going through the RAI process will help staff set resident-specific objectives in order to meet the physical, mental and psychosocial needs of residents.*
- *The basis of care delivery is the process of assessment and care planning. Documentation of this process (to ensure continuity of care) is also necessary.*
- *The RAPs provide further assessment of the "triggered" areas; they help staff to look for causal or confounding factors (some of which may be reversible). Use the RAPs to analyze assessment findings and then "chart your thinking." It is important that the RAP documentation include the causal or unique risk factors for decline or lack of improvement. A risk factor increases the chance of having a negative outcome, or complication. The plan of care then addresses these factors with the goal of promoting the resident's highest practicable level of functioning: 1) improvement where possible, or 2) maintenance and prevention of avoidable declines.*
- *RAP assessment documentation should generally describe:*
    - *Nature of the condition (may include presence or lack of objective data and subjective complaints).*
    - *Complications and risk factors that affect the staff's decision to proceed to care planning.*
    - *Factors that must be considered in developing individualized care plan interventions. Include appropriate documentation to justify the decision to care plan or not to care plan for the individual resident.*
    - *Need for referrals or further evaluation by appropriate health professionals.*
- *Documentation about the resident's condition should support clinical decision-making regarding whether or not to proceed with a care plan for a triggered condition and the type(s) of care plan interventions that are appropriate for a particular resident.*
- *The decision to proceed to care planning should also be indicated in the appropriate column on the RAP Summary form.*
- *In order to provide continuity of care for the resident and good communication to all persons involved in the resident's care, it is important that information from*

the assessment that led the team to their care planning decision be clearly documented.
- *The RAP process was developed to reflect good clinical practice and RAP documentation expectations have never changed—RAPs guide further assessment of residents who have or are at risk of developing problems.*

The RAI User's Manual provides clarification related to the documentation of the RAPs. The manual indicates:
- *Reviewing a triggered RAP means doing an in-depth assessment of a resident who has a particular clinical condition in terms of the potential need for care plan interventions.*
- *Written documentation of the RAP findings and decision-making process may appear anywhere in the resident's record. It can be written in discipline specific flowsheets, progress notes, in the care plan summary notes, in a RAP summary narrative, on a RAP questionnaire, etc*
- *As stated in 482.20(b)(1)(xvii), 'Documentation of participation in assessment: The assessment process must include direct observation and communication with the resident , as well as communication with licensed and nonlicensed staff members on all shifts.*
- *No matter where the information is recorded, use the 'Location and Date of RAP Assessment Documentation' column on the RAP Summary form to note where the RAP review and decision-making documentation can be found in the resident's record.*

❖ Are comprehensive assessment requirements addressed in other parts of the SOM?

Yes, the Interpretive Guidelines for F272 and the Interpretive Guidelines for specific Quality of Care or Quality of Life requirement(s) may contain information on conducting a comprehensive assessment of a resident's needs. For example:
- The Interpretive Guidelines for F314, Pressure Ulcers, reference risk assessment tools. The guidelines indicate that*, "Regardless of any resident's total risk score, the clinicians responsible for the resident's care should review each risk factor and potential cause(s) individually to:*
  - *a) Identify those that increase the potential for the resident to develop pressure ulcers;*
  - *b) Decide whether and to what extent the factor(s) can be modified, stabilized, removed, etc., and*
  - *c) Determine whether targeted management protocols need to be implemented.*

  In other words, an overall risk score indicating the resident is not at high risk of developing pressure ulcers does not mean that existing risk factors or causes should be considered less important or addressed less vigorously than those factors or causes in the resident whose overall score indicates he or she is at a higher risk of developing a pressure ulcer."

❖ **Are checklists considered to be a comprehensive assessment?**

Generally a "checklist" is not a comprehensive assessment. If a "checklist" also includes a summary of relevant data about the resident and what this means to the resident, together these could provide a comprehensive assessment.

❖ **If a survey team determines there is not an adequate assessment of a resident's risk factors, what deficiencies might be issued?**

Surveyors are directed to issue the appropriate assessment tag along with the quality of care requirement when a facility is not in compliance with both requirements (Independent but Associated Deficiency Citations, S&C 05-20). The surveyors are directed to review the clinical record documentation and interview facility staff to determine if the facility has documentation of assessment information in support of clinical decision making relevant to the RAPs and the resident's needs.