



RECOMMENDATIONS FOR DOCUMENTATION OF MDS ASSESSMENTS

Standards for documentation of assessment information are the same that apply to other clinical record documentation. The CFR 42 483.75(1), long term care regulations for Clinical Records, indicate that documentation must be completed in accordance with accepted professional standards. The record must be complete, accurately documented, readily accessible and systematically organized. The Interpretive Guidelines for this regulation indicate there must be enough information to show that the facility knows the status of the individual, has adequate plans of care, and provides sufficient evidence of the effects of the care provided. Documentation should provide a picture of the resident's progress, including response to treatment, change in condition, and changes in treatment.

The Revised Long-Term Care RAI User's Manual, December 2002, contains a discussion about documentation on page 1-23. In that discussion, the MDS is referred to as a "primary data source", not a sole source document. It is always expected that information in the clinical record supports and not conflicts with the MDS. Clinical documentation that gives the picture of the resident's care needs and responses to treatment is a standard of practice, is a part of good resident care and staff care planning. In the case of Medicare PPS, documentation must substantiate the need for Part A SNF services and the resident's response to those services.

The second paragraph on page 1-23 deals with the requirement to document resident care, the response to care and that this documentation chronicles, supports and is consistent with the findings as recorded on the MDS.

In addition to the general statements about documentation in this section of the manual, several specific MDS items require additional documentation as part of the coding. For instance:

1. Item A9 Responsibility/Legal Guardian: Page 3-37 directs if there is a court ordered guardianship then the legal document must be in the record.
2. Item B1 Comatose: Page 3-42-43 indicates there must be physician documentation of a diagnosis of coma or persistent vegetative state in order to code.
3. Section E, Mood and Behavior: Page 3-60 indicates it is important to document chronic symptoms as well as new onset. As always, the medical record should support the resident status reported on the MDS. Page 3-63, first clarification 3rd bullet states that the documentation of signs and symptoms is a matter of good clinical practice.
4. Item H3 Continence appliances and programs: Page 3-125 has several things to say regarding documentation. In the first paragraph the term "Program" is defined to mean a specific approach that is organized, planned, documented,

evaluated. In the last sentence of the third paragraph of the clarification it indicates, documentation in the clinical record should evaluate the resident's response to the toileting program.

5. Section I Disease Diagnoses; Page 3-127 under Intent indicates that disease conditions require physician documented diagnoses in the clinical record. It is good clinical practice to have the resident physician provide supporting documentation for any diagnosis.
6. Section K Oral/Nutritional Status: Page 3-150 indicates that if, as a matter of professional judgment, a resident cannot be weighed, use the standard no information code (-). Document the rationale in the resident's record.
7. Item M5 Skin Treatments: Page 3-167, Turning/repositioning programs. The definition of program is a, "specific approach that is organized, planned, documented, monitored and evaluated." On page 3-168, the first clarification indicates that good clinical practice dictates staff should document treatments provided. Flow sheets could be used, but the form and format of such documentation is determined by the facility.
8. Item P3 Nursing rehabilitation/restorative care: Page 3-192 lists the criteria that must be met before any of the nursing restorative programs can be coded. The first two criteria are that measurable objectives and interventions must be documented in the care plan and in the clinical record; and evidence of periodic evaluations by licensed nurse must be present in the clinical record. On page 3-194, the first clarification indicates that good clinical practice would indicate that the results of "reassessment" should be documented in the record.

While the MDS is a source document, not all items can stand alone. There must be corroborative data that is non-conflicting for many items in the clinical record. There needs to be internal consistency within and between MDS items.