RESIDENT ASSESSMENT IS KEY TO REDUCING RISK

Long term care (LTC) facilities are responsible for addressing a resident's needs from admission through discharge. As LTC services expand to include sub-acute care programs and options such as peritoneal dialysis and chemotherapy, accurate assessments and good communication skills are critical components in reducing exposure to potential lawsuits. Well-documented assessments and coordination of care among providers and family can minimize the risks faced by residents who experience a significant change in their condition. During transition from the acute to the long term care setting, such assessments are essential.

Admission to an LTC facility can also be an emotionally charged time for residents and their family or healthcare proxy. A comprehensive, interdisciplinary assessment process helps to bridge potential communication gaps often created by employee turnover or influx of temporary staff. This process also can clarify physical needs and treatment goals throughout the duration of care. The guidelines offered in this article are intended to help your facility make full use of assessment tools to better evaluate residents' health status, document findings and create sound care plans.

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About the Resident Assessment Instrument

The Resident Assessment Instrument (RAI) is a federally mandated, uniform system to evaluate residents and plan their care. Used in the vast majority of long term care facilities, the RAI was part of the comprehensive reforms enacted in the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). The tool represents the best foundation for addressing the full range of resident requirements during the entire period of care. While the RAI and related tools are required only for Medicare- and Medicaid-certified facilities, we recommend them for all LTC organizations because, when utilized correctly, they not only help enhance consistency and quality of care, but they also may reduce your organization's liability exposure related to:

- undiagnosed or untreated changes in a medical condition
- pressure ulcers
- injurious falls
- malnutrition and dehydration
- elopement
- adverse drug reactions
- misuse of chemical or physical restraints
- failure to obtain informed consent

Accurate and timely RAI procedures are essential for every organization. Unfortunately, busy LTC staff and clinicians often lack the time or knowledge to maximize the benefits of the RAI's primary components: the Maximum Data Set (MDS) and the Resident Assessment

Protocols (RAPs). (See "Components of the RAI," p. 2). In order to encourage facility-wide acceptance of the RAI, it is necessary to educate staff about the many institutional uses of these tools, which include:

- determining Medicare/Medicaid eligibility for services
- generating quality indicators for use by government agencies
- aiding in resource allocation
- providing a basis for provider reimbursement
- identifying who uses which services
- selecting appropriate services and settings for residents with various conditions
- tracking frailty in individuals and specific populations over time
- planning and budgeting services and systems
- projecting future facility needs and attendant costs

Components of the RAI

The RAI system primarily comprises the Minimum Data Set and the Resident Assessment Protocols.

The Minimum Data Set (MDS) *is a standardized assessment instrument used to help identify a resident's problems, strengths, needs and preferences. The MDS includes individual assessment items and specifies definitions, time frames and exclusions for the items, as well as response codes for consistent documentation. It covers such areas as cognition, communication, activities of daily living, continence, psychosocial well-being, disease diagnoses and health conditions.*

The Resident Assessment Protocols (RAPs) *are guidelines for additional focused assessment and care planning. After the MDS is completed, responses to MDS items trigger further assessment by the interdisciplinary team using RAPs. Each of the 18 RAPs is a structured framework for developing care plans for treatable conditions, contributing risks factors and interventions. The RAPs also include utilization guidelines to assist in clinical assessment and care planning. The protocols and guidelines are intended for educational use and clinical guidance only.*

By reinforcing the many benefits of the RAI, you can alter the common perception that it is unnecessarily burdensome and less precise than other instruments. Moreover, holding professional staff accountable for assessment deadlines and requirements (see "Assessment Timelines," p. 6) results in stronger documentation, an improved survey outcome and reduced liability for your facility.

Failure to take the RAI seriously can have major consequences. Stiff penalties may be levied against facilities that violate federal law by falsifying data or holding "documentation parties" to correct RAI deficiencies as the survey date nears. Keep in mind that clinical disagreement does not constitute fraud or falsification, as long as a legitimate clinical issue is at stake. The goal is to describe the resident's condition as accurately as possible. If another clinician spots inaccuracies in an MDS, it is acceptable to change the data. However, changes that are not supported by the registered nurse's assessment and are made to secure a higher payment may lead to sanctions.

Designing Care Plans

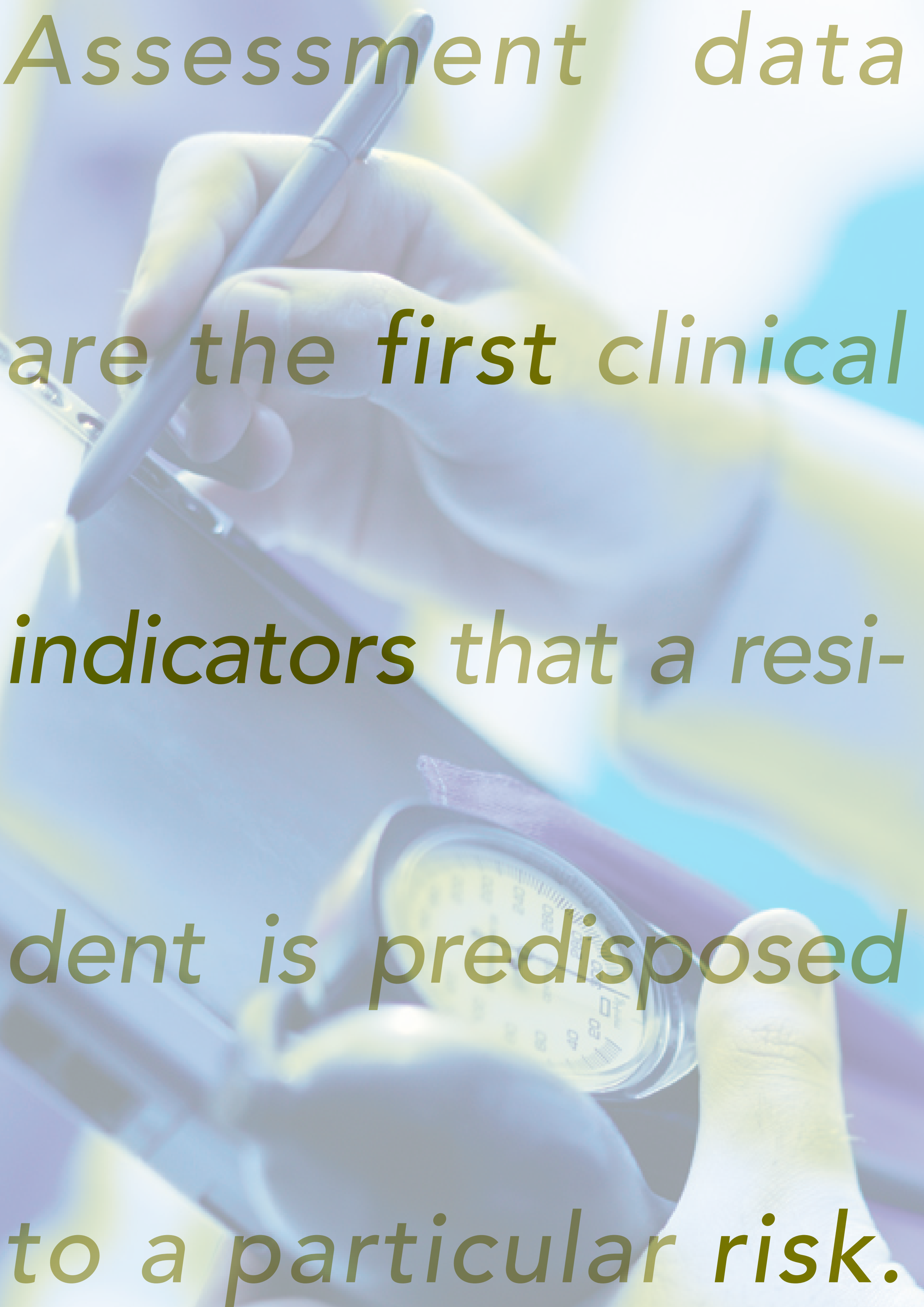
Medicare/Medicaid-certified facilities must develop a resident care plan – based on a thorough evaluation of each resident's strengths, needs and preferences – within seven days after the assessment is completed. A sound plan of care not only benefits the resident, but also helps minimize your facility's exposure to many common allegations, including:

- overuse of physical restraints
- inattention to nutritional problems
- neglect of hearing, vision and dental problems
- overuse of urinary catheters
- deficient treatment of incontinence
- inadequate skin care
- inappropriate use of psychotropic medications
- failure to diagnose mood problems and delirium
- inadequate psychosocial interventions
- lack of effective behavior management programs

The ultimate goal of care planning is to enhance residents' quality of life and prevent, where possible, a decline in their abilities or condition. The plan should consist of resident-centered measures of care and should reflect the quality indicators (QI) identified by the MDS (See "Quality Indicators: Improving the Quality of Care," p. 8). Successful care planning requires a concerted multi-disciplinary effort and a shared commitment to:

- *encourage residents and their family to participate* in the care planning process
- *incorporate objectives and timetables* that demonstrate how and when a resident's medical, nursing and social needs will be met
- *monitor the resident's condition* on a continuous basis
- *review the care plan* to determine if goals, interventions and implementation follow the current assessment
- *revise the care plan* in the event of changes in health status, especially when a new QI is identified

Arrange resident care plan meetings as needed, but at least every 90 days, and include nurses, doctors, therapists, dieticians and social workers, as well as the resident and family. If the family cannot make the meeting, offer an alternative date. If the family still refuses to attend, properly document this fact in the meeting's minutes. If the resident gives permission, you also may wish to extend an invitation to your facility's ombudsman.



*Assessment data are the **first** clinical **indicators** that a resi-dent is predisposed to a particular **risk.***

Care plan meetings are an ideal setting to establish open communication among all parties and to clarify expectations and responsibilities. Keep accurate minutes of these meetings and list invitees and attendees. Here are some issues that your facility may wish to address when planning care:

- *unrealistic expectations* of family members, based on discussions with the attending or acute care physician, that the resident's condition may improve dramatically
- *incomplete orders* upon transfer from an acute care facility, particularly after hours and on weekends
- *administrative review* of care to indicate your facility is capable of providing appropriate measures
- *summary reporting* of test results, medication changes and altered functional status, as well as explanations regarding restraint use and bed position, to the family
- *unclear code status,* which can lead to unwanted CPR and/or transfer to an acute care facility
- *inaction on part of family* to support the plan of care and participate when requested

Assessing and Documenting Specific Risk Factors

LTC administrators, employees and physicians must coordinate their efforts to effectively document and communicate the needs and goals of a resident's treatment. Assessment data are the first clinical indicators that a resident is predisposed to a particular risk. Assessment of risk factors and documentation of interventions taken can help protect residents and defend against later allegations of substandard care. Your staff may benefit from additional in-service training on documenting and communicating the relatively high-risk conditions noted below.

Skin status. Lawsuits related to wound development and subsequent care have been highly publicized due to large payouts from settlements and jury verdicts. Prevention is a matter of assessing a resident for fragile skin integrity and implementing care provisions to relieve pressure, increase mobility and improve nutrition. A baseline evaluation of current skin status by staff and a physician is a key component of any initial admission and continued assessment. Staff should refer to all breaks in the skin as *wounds* rather than *pressure sores* until a physician can assess the condition. Many wounds may be due to unavoidable circumstances.

Standardized assessment scales such as Braden and Norton can be useful, but only if they are promptly and accurately completed, and consistently applied throughout the period of care. The medical record should include notation of existing wounds, including scratches and bruises, as well as whatever treatment and services are necessary to promote healing and to prevent infection and the development of new wounds. Be sure to note and address the underlying medical conditions that may predispose the resident to further skin breakdown, such as diabetes or vascular flow disorders.

Always reassess and document skin condition upon readmission from another facility, as wounds may have developed while the resident was being treated elsewhere. New admissions with pre-existing pressure or ischemic wounds or bruising should be reviewed prior to admission by the Medical and Nursing Directors. This review will enable you to determine whether your facility has adequate resources to treat these wounds. Open communication with the resident/family regarding skin breakdown is a joint responsibility of the physician and caregivers. Finally, photographing new and pre-existing wounds may contribute to your wound care risk management strategy by demonstrating the effectiveness of treatment. However, such photographing must be implemented according to a sound written policy, or it may prove detrimental. (See CNA HealthPro *ALERT Bulletin,* July 2004: "Photographic Wound Documentation: Consistent and Accurate Methods Can Help Reduce Liability.")

Falls. Injuries related to falls remain a top concern for LTC facilities because they may lead to major disability or even death. The RAI incorporates a fall risk assessment protocol in the MDS and RAPs. However, as the RAI takes time to complete, encourage staff to assess the risk for falls at the time of admission or readmission, including any history of falls. The RAI can be used to reassess fall risk thereafter on a quarterly basis, or if there is a significant change in condition.

Assessment Timelines

The purpose of the admission assessment is to collect baseline information about the resident and assist with an initial admission care plan until the MDS, RAPs and care plan process is completed. Although completion of a pre-admission assessment is not required by federal regulation, it can support the MDS process. It is useful in determining the resident's needs and confirming that your facility has the resources and expertise to provide appropriate care.

Federal law, which applies to Medicare- and Medicaid-certified facilities, specifies that RAI-facilitated assessments must be:

- ***initiated within 24 hours*** *for newly admitted patients and completed within 14 days of admission*
- ***completed within 14 days*** *when residents experience a significant change in physical or mental status, or following a significant correction of a prior full assessment*
- ***repeated annually*** *for all residents to reassess needs and abilities*

A "significant change" is defined as a major decline or improvement in the resident's status that:

- *will not normally resolve itself without further clinical intervention*
- *has an impact on more than one area of the resident's health status*
- *requires interdisciplinary review of the care plan*

Whether or not there is a significant change, the comprehensive assessment must be reviewed at least once every quarter (92 days) to ensure that the assessment is accurate and reflects the resident's current status.

In the event of a lawsuit, care plans, as well as nursing and physical therapy notes, will be scrutinized for inadequacies that may have contributed to the fall. Therefore, you may wish to take these proactive steps to reinforce good fall assessment policy and protocol:

- *promote an interdisciplinary approach* to fall prevention
- *standardize your assessment and care plan formats* to promote greater consistency in documentation
- *educate the resident and family* both orally and in writing about safety precautions taken
- *design care plans* that reflect a resident-specific approach to fall prevention
- *review resident medication regimes* for possible side effects or drug interactions that may contribute to injurious falls
- *conduct a new assessment and adjust the care plan* when a resident falls or has a change in condition
- *reinforce through staff in-service training* the need for scrupulous post-fall assessment and documentation, which may include circumstances of the fall, likely causes of the fall, care plan interventions taken and prompt medical assessment whenever injury is suspected

Nutrition and hydration. This includes a measure of the resident's ability to chew and swallow, as well as special dietary needs and a determination of caloric intake. Potential areas of liability stem from unexplained weight loss, worsening condition due to malnourishment and failure to consult family members regarding interventions such as tube feedings for weight gain.

The nutritional assessment should address factors that place the resident at risk for malnutrition and include a nutritional plan that reflects the resident's health status. Be sure to include an explanation of recent weight loss and obtain copies of laboratory results to establish a baseline upon admission. Residents with dysphagia require early assessment by speech therapy and dietary services to better manage the swallowing dysfunction.

Regularly audit residents' medical records to ensure that staff members are conducting documented reviews of the RAP for Nutritional Status. Notation should include daily food and fluid intake. The attending physician must be promptly notified when significant weight loss or poor oral intake is observed.

Medication administration. A physician-led interdisciplinary assessment team should review all medications when admitting new residents to a facility in order to determine which are clinically indicated. Liability for poor medication management can stem from inappropriate drug use, serious side effects from drug interactions, loose oversight of outside vendor pharmaceutical services or mismanagement of medication errors.

Quality Indicators: Improving the Quality of Care

Quality indicators (QI) are derived from the Minimum Data Set (MDS). Although QIs were originally developed for use in state survey efforts, it was quickly recognized that they could also be useful in measuring quality within a facility. There are currently 30 different QIs, which measure a variety of clinical care issues and risk factors, including predisposition to accidents, use of nine or more scheduled medications, prevalence of indwelling catheters and prevalence of pressure ulcers. As your organization reviews and revises its quality improvement process, keep in mind the following pointers on how to derive the maximum benefit from QI data.

Quality Indicator Review: Key Questions to Ask in the Quality Improvement Process

Is the risk factor/clinical care issue identified by the quality indicator limited to one area of resident care? If so,

- ***focus your quality improvement plans** on making needed policy changes*
- ***reinforce policy changes** through in-service staff training*
- ***provide refresher training** on necessary equipment use or procedure technique*
- ***mentor staff members** having competency issues*

Is the identified issue due to a variety of clinical, administrative and/or operational causes? If so,

- ***promptly correct contributing issues** such as regulatory non-compliance*
- ***re-educate staff about RAI** or about specific deficient areas of clinical assessment*
- ***supervise those staff members** associated with higher documentation deficits*
- ***make referrals to specialists** as needed (e.g., pharmacist, medical director, dietician, etc.)*

Is there a pattern of inaccuracy in scoring the QI? If so,

- ***identify the residents** who have been excluded from the QI measurement*
- ***determine which MDS items** were used to calculate each QI score*

Is your QI score high enough to suggest there may be a quality of care problem at your facility? If so,

- ***remember that high QI scores do not always represent a facility problem** and may simply reflect resident acuity*
- ***support your care processes** with documented standards of clinical practice*
- ***focus quality improvement efforts** on identifying common causes of high scores (e.g., falls and mental status changes may be related to problems in managing medications)*

The interdisciplinary team also must determine whether it is safe for a resident to self-administer medications. The resident's wish to do so should be reviewed by the team when the care plan is drafted, and no later than seven days after the completion of the comprehensive assessment. Note the assessment and determination in the resident's care plan.

Physical restraint. Prior to using physical restraint, assess whether such restraint is necessary and, if so, what is the least restrictive device that can be used under the circumstances. The RAP for Physical Restraint can help staff members evaluate the appropriateness of restraint use. At a minimum, the assessment must take into account the resident's bed mobility, as well as the ability to stand, transfer between positions, go to and from a bed or chair, and reach the toilet.

When restraint use is indicated, there must be written informed consent and a physician's order on record. Once a restraint is applied, the facility must periodically reassess its use according to written policy. If bedrails are used as a safety precaution, due to a change in resident condition, be sure it is properly documented as such and that bedrail use is in compliance with the regulations for your jurisdiction.

Wandering and elopement. All residents should be initially assessed for this risk on admission. Careful documentation of prior history of elopement and other indicators, such as loitering around an exit or watching for an exit opportunity, can be helpful in preventing repeat occurrences. Use precise terminology to define a resident's activity; e.g., "wandering the halls" could be construed in court as looking for an elopement opportunity, when in fact "walking the halls" may be a more accurate description of what was occurring. For a more detailed discussion of risk management strategies for these exposures, see *CareFully Speaking,* Winter 2002: "Resident Elopement: Managing the Liability Risks of Wandering."

Additional Considerations

As your facility strives to improve its assessment policies and protocols, be sure to consider these important issues:

Staffing levels. The 1987 LTC reforms made no recommendations regarding staffing levels necessary to implement the RAI assessment requirements, other than mandating minimum numbers of licensed staff. Regularly monitor your facility's staff-to-resident ratios, especially for certified nursing assistants who perform the vast majority of assessment and care, and increase staff levels where indicated for direct-care staff.

Training needs. Educational programs about the resident assessment process offered through national and state associations often concentrate on how to fill out forms, rather than placing the RAI in the context of quality of care. Focus your own clinical staff training on the link between MDS data, RAP guidelines and quality improvement. (See "Quality Indicators: Improving the Quality of Care," p. 8.) Programs also should instruct staff as to how the RAI can help them identify the causes behind observed deficits and the risk factors associated with rapid physical and mental decline.

Using MDS data. Educate staff about the many potential uses of MDS data, which range from evaluating care interventions to allocating staff resources and benchmarking overall performance. A strong working knowledge of the RAI process encourages a greater commitment to gathering accurate data. Focus administrative training efforts on how MDS data can be used more effectively to plan, manage and evaluate care. Also, examine all assessment forms used by your facility to see if there is any overlap with the MDS and eliminate redundant forms.

Done properly, the Resident Assessment Instrument can help improve your facility's quality of care, as well as your residents' quality of life, and can also contribute to reduced liability exposure. Thorough assessment requires active cooperation on the part of the resident, family members and staff from all relevant disciplines. Ultimately, employees will undertake the RAI process with the seriousness it deserves only if its purpose is well understood and their compliance is closely monitored. Top-down commitment and continuing education are the keys to success.

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