USING

RESIDENT ASSESSMENT AND CARE PLANNING

AS ADVOCACY TOOLS:

A Guide for

Ombudsmen and Other Advocates

Developed by

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National Citizens' Coalition for Nursing Home Reform

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TABLE OF CONTENTS

Additional Resources:

- **Resident Assessment Instrument User's Manual:** -- packet of material on assessment and care planning, including HCFA's Oct. 1995 RAI Manual. Available from NCCNHR, 1424 16th St., NW, Suite 202, Washington, DC, 20036-2211; (202) 332-2275. Cost is $40.

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AN OVERVIEW

The key to achieving quality care for nursing home residents is the resident assessment and care planning process. Through assessment, staff gather information about a resident's life, functioning and needs. With residents/families, staff develop a plan of care which responds to residents' identified care needs. When this process works properly, residents' condition can improve dramatically as facility staff provide the restorative and maintenance services residents need.

All facilities are required, by the **Nursing Home Reform Law** of OBRA '87, to provide care to attain or maintain the highest well-being of each resident through use of the assessment and care planning process. Although the law went into effect October, 1990, facilities are still learning how to conduct assessments and prepare individualized care plans, with full participation from residents, families and appropriate facility staff. Increasingly, consumers are using assessment and care planning as a forum to ask questions, discuss problems in care and identify possible solutions.

Ombudsmen and other advocates can help residents, families and staff listen to each other and learn to work together to achieve the good care residents are entitled to under the law. Ombudsmen can also utilize the assessment and care planning processes in their advocacy work as illustrated in the following examples.

On a typical day phone calls from distressed families come into the office:

- Ms. Zentoff reports that her father is up at night walking around the facility and is taking sleeping pills for the first time in his life. He seems anxious and lethargic.

- Mr. Johnson says that his mother, an 82 year old resident, is slipping in her own urine and falling and as a result of the falls, the facility is restraining her.

- Mrs. Gomez says that her aunt has been moved from the first floor of the facility to the second floor, with all of the confused residents. The aunt, Ms. Sanchez, received only two hours notice prior to the move and is very depressed about living on second floor.

- Ms. Cooper asks for help because her mother Mrs. Smith just received a discharge notice from the facility where she resides. The reason given for the discharge is that the facility can no longer meet her needs.

- Mr. Jacks is concerned that his wife stays in her room and will not participate in facility activities or go to the dining room for meals. Family members note that she also complains her dentures do not fit and she seems to have trouble talking. She is losing weight.

This paper is designed to help ombudsmen and other advocates use assessment and care planning to respond to situations such as these, to achieve quality of care and quality of life for residents, as required by law.

THE LAW AND REGULATIONS

Several provisions of the law, regulations, and guidelines for surveyors set the context for resident assessment and individualized care planning. (See Appendix B.)

■ **Quality of life:**

Nursing homes must treat residents "in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life" with "reasonable accommodation of individual needs and preferences of each resident." Residents have the right to "choose activities, schedules, and health care consistent with interests, assessments and plans of care" and "make choices about aspects of life in the home significant to the individual."

■ **Quality of care:**

Nursing homes must provide care and services to "attain and maintain the highest practicable physical, mental and psychosocial well-being of each resident." Based on a comprehensive assessment of each resident, the facility must assure that residents' abilities "*do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable*" in activities of daily living (ADLs); pressure sores; urinary incontinence; range of motion; psychosocial functioning; nasogastric tubes; nutrition; and drug therapy.

Surveyor guidelines define conditions which demonstrate unavoidable diminution to include:

* "natural progression of the resident's **disease;**

* "deterioration of resident's physical condition associated with the **onset of physical or mental disability** while receiving care to restore or maintain functional abilities;

* "resident's, or his/her surrogate or representative, **refusal of treatment** to restore or maintain functional abilities after aggressive efforts by the facility to counsel and/or offer alternatives to the resident or surrogate or representative. Refusal of such care and treatment should be documented in the clinical record."

■ **Residents' Rights:**

Residents have the right to be fully informed in advance and to participate in decisions about care and treatment. The survey guidelines specify: "The resident should be involved in the assessment and care planning process, including the discussion of diagnoses, treatment options, risks, and prognoses."

■ **Resident Assessment and Care Planning:**

Nursing facilities must "conduct standardized, reproducible assessments of each resident's functional capacity" including their "capability to perform daily life functions and significant impairments" within 14 days of admission. "Each assessment must be conducted or coordinated, with the appropriate participation of health professionals, by a registered nurse." Residents, and family/representatives are involved in care planning.

The care plan must include "measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs."

ASSESSMENT, CARE PLANNING AND DELIVERY OF CARE

Assessment and care planning can prevent decline in a resident's condition and set the stage for restoration and/or maintenance of physical, mental and psychosocial functioning.

- The purpose of assessment is to gather information:

  — to determine the *FACTS* about a person's life and functional abilities and needs, and

  — to *ANALYZE* these facts to determine their causes and their impact on the resident.

ASSESSMENT
(Facts & Analysis)
↓
CARE PLAN
(Strategies)
↓
DELIVERY OF CARE

- Information from the assessment is used to develop an individualized plan of care which describes the *STRATEGIES* the staff will use to meet a resident's needs, and goals. It will also establish time frames for attaining and/or re-evaluating the plan.

Assessment and care planning are inextricably linked and are dynamic processes. They are continuous processes, not discrete events. They occur throughout each resident's stay from admission until discharge. As a care plan is implemented, a resident's condition may improve or decline, requiring another assessment to analyze the resident's new level of functioning and new care needs. If the strategies in the care plan aren't working, a reassessment might be needed to determine if any facts were overlooked or if there might be a different analysis of the assessment information. Just as the practice of medicine isn't an exact science, neither is care planning. Both require some trial and error. A physician may prescribe a treatment and say, "If you aren't better in two weeks, come back and we'll try something else." If a treatment is found which works, the physician builds upon that knowledge the next time you have a similar condition.

→ ASSESSMENT →
↗ ↘
↑ CARE PLAN
↖ ↙
IMPLEMENTATION OF SERVICES

Unless the care plan is implemented, the assessment and care planning processes are useless. Taken together, these processes supply information and create a dialogue to find the means to achieve good care in an environment that supports quality of life for each resident. Assessment and care planning help facilities with questions such as:

- What are this resident's individual needs and preferences?
- How can the environment be adapted to maintain or enhance residents' quality of life?
- How can the staff ensure that a resident's abilities do not diminish?
- How can staff promote resident participation in decisions about care and treatment?

THE RESIDENT ASSESSMENT INSTRUMENT (RAI)

The federal government designated what information all nursing homes must gather to conduct the assessment. Some facilities may use forms which look different than the instrument in Appendix A, but each facility's forms must include at least the items in this national instrument.

The Resident Assessment Instrument (RAI) contains two parts:

(1) Minimum Data Set (MDS) - the *FACTS* -- information staff must gather about each resident

(2) Resident Assessment Protocols (RAPs) - the *ANALYSIS* -- guidance to staff to determine what may be causing a resident's condition.

■ The *FACTS* -- **The MINIMUM DATA SET (MDS):**

The **Minimum Data Set (MDS)** is used to establish a core of holistic knowledge about an individual which may lead to further assessment and provides the basis for individualized care. The MDS contains the following sections:

- Identification Information
- Customary Routine
- Communication/Hearing Patterns
- Physical Functioning
- Psychosocial Well-Being
- Activity Pursuit Patterns
- Health Conditions
- Oral/Dental Status
- Medication Use
- Background Information
- Cognitive Patterns
- Vision Patterns
- Continence in Last 14 Days
- Mood and Behavior Patterns
- Disease Diagnoses
- Oral/Nutritional Status
- Skin Condition
- Special Treatment and Procedures

The **MDS** items focus on a person's everyday functioning to identify *ABILITIES* and needs for *ASSISTANCE* within the context of life experiences and customary routines. For example:

■ Cognitive Patterns asks if the resident knows the location of her own room.

■ Psychosocial Well-Being asks if a resident is unhappy with her roommate.

■ Activities of Daily Living asks staff to note if a resident needs assistance in bathing, dressing and other activities and to what extent residents can function independently.

Although all assessment items affect an individual's **quality of life**, some are specifically designed to do so. **Quality of life** can have a direct bearing on a resident's physical and psychosocial well-being. Here are examples from two sections of the MDS, Psychosocial Well-being and Customary Routines:

■ The Psychosocial Well-Being section asks about a person's attitude toward past roles and life status. This item reveals personal information about a resident and indicates her sense of self-esteem and self-worth. Understanding a person's social patterns and needs is critical to staff efforts to help residents feel at home and emotionally supported.

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVE-MENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED RELATION-SHIPS	Covert/open conflict with or repeated criticism of staff	a.
		Unhappy with roommate	b.
		Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
		NONE OF ABOVE	d.

INFORMATION AT ADMISSION

■ The Customary Routines section covers an individual's daily patterns and preferences and asks if a person usually showers or bathes, stays up late, has a pet, spends most of her time alone or watching TV, or finds strength in her faith. Understanding personal patterns can assist staff to adapt to residents' daily patterns, can provide clues to residents' responses to facility life, and can guide staff in care decisions. Interruptions in life-time patterns cause residents' stress; support of patterns has a positive impact on residents' responses to care.

SECTION AC. CUSTOMARY ROUTINE

1.	CUSTOMARY ROUTINE	*(Check all that apply. If all information UNKNOWN, check last box only.)*	
	(In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home)	CYCLE OF DAILY EVENTS	
		Stays up late at night (e.g., after 9 pm)	a.
		Naps regularly during day (at least 1 hour)	b.
		Goes out 1+ days a week	c.
		Stays busy with hobbies, reading, or fixed daily routine	d.
		Spends most of time alone or watching TV	e.
		Moves independently indoors (with appliances, if used)	f.
		Use of tobacco products at least daily	g.
		NONE OF ABOVE	h.
		EATING PATTERNS	
		Distinct food preferences	i.
		Eats between meals all or most days	j.
		Use of alcoholic beverage(s) at least weekly	k.
		NONE OF ABOVE	l.
		ADL PATTERNS	
		In bedclothes much of day	m.
		Wakens to toilet all or most nights	n.
		Has irregular bowel movement pattern	o.
		Showers for bathing	p.
		Bathing in PM	q.
		NONE OF ABOVE	r.
		INVOLVEMENT PATTERNS	
		Daily contact with relatives/close friends	s.
		Usually attends church, temple, synagogue (etc.)	t.
		Finds strength in faith	u.
		Daily animal companion/presence	v.
		Involved in group activities	w.
		NONE OF ABOVE	x.
		UNKNOWN—Resident/family unable to provide information	y.

■ The *ANALYSIS* -- **The RESIDENT ASSESSMENT PROTOCOLS (RAPs)**:

The **Resident Assessment Protocols (RAPs)** are the *ANALYSIS* of the *FACTS* gathered on the MDS. For example, how can staff assist a resident who is unsteady on her feet unless they know what is causing the unsteadiness? Is the unsteadiness caused by: medication? shoes that don't fit? perceptual problems? an inner ear problem? poor muscle strength? a slippery floor? The RAPs are the "dig deeper" portion of the assessment. They prompt staff to analyze and interpret information, to consider questions such as:

■ Why is Mr. Zentoff wandering? What is this activity communicating?

■ Why is Mrs. Johnson falling?

■ Is Ms. Sanchez's refusal to attend group activities indicative of life-long patterns or associated with some other factor, like incontinence? What does her refusal mean?

■ Did Mrs. Smith's medications cause her inability to find her room and her passivity? How are her actions toward staff related to her customs for bathing and poor verbal skills?

■ Are Mrs. Jacks' dental problems causing her loss of interest in eating or socializing and her difficulty in communicating?

The RAPs use the information from the MDS to identify:

- existing problems;
- potential problems; and
- potential for rehabilitation or improvement.

The RAPs contain narrative information about the following areas:

- Delirium
- Visual Function
- ADL Function/Rehab Potential
- Psychosocial Well-Being
- Behaviorial Symptoms
- Falls
- Feeding Tubes
- Dental Care
- Psychotropic Drug Use
- Cognitive Loss/Dementia
- Communication
- Activities
- Mood Status
- Urinary Incontinence/Indwelling Catheter
- Nutritional Status
- Dehydration/Fluid Maintenance
- Pressure Ulcers
- Physical Restraints.

A **"RAP Trigger Legend"** worksheet in chart format visually links MDS items that may warrant further assessment to the pertinent RAP(s). For example, the worksheet may link a resident's loss of balance to a need to analyze her psychotropic drug use and her potential for rehabilitation. Thoughtful use of triggers and RAPs helps staff avoid missing factors which place a resident at risk for developing problems, for experiencing a diminution in abilities.

Here's how the RAP would help the staff assess Mr. Zentoff:

Staff note that Mr. Zentoff walks around the facility at night by marking the MDS under "Section E. Mood and Behavior Patterns." Under E-4 "Behavioral Symptoms", the staff codes his "wandering" with a "3" to indicate he wanders daily or more frequently. This triggers staff to look at "Behavioral Symptoms" RAP. (See Appendix A for MDS and RAP Trigger Legend)

(MDS)

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (*Check for indicators observed in last 30 days, irrespective of the assumed cause*)
0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS
- a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Repress having lived so long; Let me die*"
- b. Repetitive questions—e.g., "*Where do I go; What do I do?*"
- c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")
- d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received
- e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"
- f. Expressions of what appear to be unreasonable fears—e.g., fear of being abandoned, left alone, being with others
- g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack
- h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions
- i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, cleaning, relationship issues

SLEEP-CYCLE ISSUES
- j. Unpleasant mood in morning
- k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE
- l. Sad, pained, worried facial expressions—e.g., furrowed brows
- m. Crying, tearfulness
- n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST
- o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends
- p. Reduced social interaction

2. MOOD PERSISTENCE: One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days
0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered

3. CHANGE IN MOOD: Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

4. BEHAVIORAL SYMPTOMS
(A) *Behavioral symptom: frequency in last 7 days*
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) *Behavioral symptom: alterability in last 7 days*
0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	3	
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)		

5. CHANGE IN BEHAVIORAL SYMPTOMS: Resident's behavior status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

(RAPs)

Resident Assessment Protocol Trigger Legend

Key:
- ● = One item required to trigger
- ❷ = Two items required to trigger
- ✳ = One of these three items, plus at least one other item required to trigger
- ⓐ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A ⓐ	ADL-Maintenance Trigger B ⓐ	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	
E1a to E1e	Indicators of depression, anxiety, sad mood	1,2									●												E1a to E1e
E1a	Negative statements	1,2																		●			E1a
E1e	Withdrawal from activities	1,2								●													E1e
E2	Mood persistence	1,2									●												E2
E3	Change in Mood	2	●																	●			E3
E4aA	Wandering	1,2,3													●								E4aA
E4aA - E4eA	Behavioral symptoms	1,2,3										●											E4aA - E4eA
E5	Change in behavioral symptoms	1,2										●											E5
E5	Change in behavioral symptoms	2	●																	●			E5
F1d	Emotionally overwhelmed	✓								●													F1d

Each RAP contains three sections of content:

I. Problem: Description of key characteristics of the problem condition and how this condition affects nursing home residents.

> *For Mr. Zentoff, staff would see that Section I of the Behaviorial Symptoms RAP describes the potential dangers of "wandering behavior" and explains why it is important not to overuse physical and chemical restraints but to find other interventions to address "behaviors."*

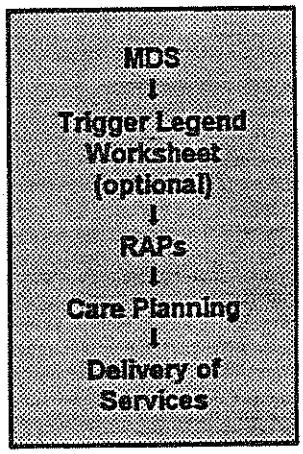
II. Triggers: Reviews the parts of the MDS that trigger the RAP, alerting staff to the resident's potential problems or needs. This section describes symptoms which guide the staff in making a clinical decision to determine if the individual resident might need further assessment in this problem area. Triggers relate symptoms to possible causes.

> *Section II triggers the staff to look at the potential link between medications and behaviors and guides the staff to look for underlying causes and possible interventions.*

III. Guidelines: This section facilitates an assessment of factors that may cause or contribute to the triggered condition. The Guidelines also suggest potential interventions to address the problem.

> *Section III guides staff to observe the behavior to determine any patterns and to review potential causes of the behavior. With Mr. Zentoff the staff knew that the wandering occurred at night. A sleeping pill had been prescribed for this reason before the assessment was completed. Since this RAP asks about changes in familiar routines, the staff talked with Mr. Zentoff and his daughter about specific aspects of his daily routine prior to admission. The staff also reviewed the information on the entire MDS, checking for information that might be related to Mr. Zentoff's wandering during the night. If staff can determine how to restore some of Mr. Zentoff's familiar routines, he would no longer need the medication or "behave" in ways that concern the staff.*

It is through the RAPs that the process of trial and error begins as the assessment team seeks to determine potential causes of conditions that were identified on the MDS. Once the causes are known, interventions can begin. Thus, the RAPs are the primary link between the MDS and care planning.



By the time a RAP is completed, the facility should have information and ideas for addressing the identified problem on the care plan. If the review of the RAP indicates a potential for rehabilitation or that a resident is at risk for developing a problem, staff can pick up some ideas for intervention from the RAP.

The RAPs are also an educational resource for staff and consumers. Advocates will find RAPs useful in suggesting what the facility needs to consider in order to fully understand a resident's condition or identify other approaches that might be tried in care planning.

THE ASSESSMENT PROCESS

The resident assessment process is designed to determine a resident's:

- strengths;
- customary routines;
- functional abilities;
- needs for assistance;
- barriers to improvement, and
- risk for developing a problem or for experiencing a decline in functional ability.

WHO PARTICIPATES IN THE ASSESSMENT?

The assessment works best when conducted by an interdisciplinary team including the staff who have direct interaction with the resident. All of the team need to be involved in the assessment process from the beginning. A comprehensive assessment uses the following sources of information:

- the resident: interviews, observation, and demonstration of abilities;

- staff including nursing assistants from all shifts and health professionals -- the attending physician, the nurse in charge of her care, and others with direct caregiving responsibility, or with knowledge that can guide care for the resident, e.g. nurse, social worker, activity professional, occupational therapist, physical therapist, dietician, and pharmacist;

- the resident's medical records, including social history and other information about the individual; and

- the resident's family and/or close friends (with the resident's permission) if they are needed to assist in evaluating and interpreting residents' needs and helping to carry out a plan of care.

A registered nurse must coordinate the assessment process and verify that it is completed within the required time-frames. **Beware** that some facilities are hiring a nurse solely to complete the assessment forms, an approach that makes it nearly impossible to conduct a useful, accurate assessment that guides care-planning.

WHEN MUST ASSESSMENTS BE CONDUCTED?

The law requires that:

- the assessment be conducted within **fourteen days** of admission and **annually** thereafter;

- a reassessment be conducted whenever there is a **significant change** in the resident's condition, either improvement or decline;

- selected sections of the assessment are to be reviewed on a **quarterly basis**.

WHAT DIFFERENCE DOES THE RESIDENT ASSESSMENT INSTRUMENT (RAI) MAKE?

Prior to the **Nursing Home Reform Law**, the quality and content of assessments varied tremendously from facility to facility and from health professional to health professional. Assessments by each discipline were rarely integrated to provide a complete picture of an individual. Oftentimes the assessment focused on a medical profile without taking into account an individual's strengths, interests and routines.

The following example illustrates differences in the information typically gathered prior to the RAI and what additional information the staff would get from using the RAI.

- Before the RAI:

  Mr. Dennis Zentoff, a widower, was admitted to Shady Hill Nursing Facility in 1986 with a diagnosis of Diabetes, Organic Brain Syndrome and a history of high blood pressure. He was 80 years old and had a daughter who lived nearby, visiting him every Wednesday. He needed assistance with eating, toileting, bathing and had poor balance putting him at risk of falling. He was incontinent at night. His diabetes was managed with insulin. He received a laxative as needed, sleeping medication as needed, and medicine for high blood pressure.

- Now -- Additional Information Gathered With the RAI:

  Mr. Zentoff was a fireman on the evening shift for thirty-two years. After his retirement he kept the same schedule as during his working life. He went to bed at one o'clock in the morning and arose at nine in the morning. He snacked all day long because his meal times never coordinated with the family's as his daughter and son (now deceased) were growing up. His wife died soon after his retirement so he kept to his old schedule. He had learned to control his diabetes even on that schedule by balancing food and insulin. For the past eight years he had to get up at night to go to the bathroom; otherwise he slept well. He was involved in the local boys club, helping those less fortunate children in his neighborhood. He suffered some loss of recent memory which had made it dangerous for him to remain alone. His daughter visited him every week.

The RAI supplies much more information about an individual than traditional assessment processes typically did. From the initial assessment, staff receive information about an individual's past which can help them adapt their routines and environment to **support the resident's current functioning.** It is a tool to assist with individualizing care as well as to determine a person's functional needs. **The RAI helps the nursing facility adapt to the individual.**

PLAN OF CARE

Staff discuss what they learn in the assessment to produce a plan of care -- the *STRATEGIES* for delivery of care. The care plan must be individualized to guide delivery of care for a resident. Care plans have no prescribed format or uniform terminology, but should identify:

- specific **needs/problems**;
- **goals** to work toward for each problem/need;
- **approaches** which will be used to reach each goal;
- **time frames** for reaching and/or reevaluating the goals;
- individuals with the lead **responsibility** for each approach.

GOALS AND APPROACHES: STRATEGIES

The goals and approaches must be **specific, time limited, and measurable**. As a working document designed to guide the daily care each resident receives, it should be written in common language that everyone, including nurse assistants, residents, and families, can easily understand:

- what is to be done;
- when or how often;
- how;
- by whom, and
- for what purpose.

Care plans are dynamic documents, changing when a resident's condition changes or a new approach is needed. A care plan is not a dead end: if the approaches aren't working, other approaches can be tried. If a goal is met, or becomes meaningless, it can be removed. Care plans can address any problem a resident has, even a non-medical one (eg. incompatible roommates).

THE PROCESS

Like the assessment, care planning works best when many people and disciplines are involved:

- the **resident**;
- **family** member(s), friends, advocates or other persons requested by the resident;
- **interdisciplinary team** involving input from the resident's physician, nurse (required by law), social worker, nursing assistants, pharmacist, therapists, and others as needed.

Care plan meetings are a time for:

- encouraging residents and families to **voice their needs**, concerns, interests or hopes;
- helping staff to **get to know** more about each resident;
- brainstorming about **what else** might be done;
- determining if the **root causes** of behaviors and problems have been identified;
- **asking questions** about the assessment (MDS and RAPs) or asking for a re-assessment.

EXAMPLE OF THE DEVELOPMENT OF A CARE PLAN

Look at one example from Mr. Zentoff's care plan: **the need to maintain his ability to walk independently in spite of his unsteadiness on his feet.** Staff put a great deal of thought and discussion into identifying the problem and developing individualized approaches to keep Mr. Zentoff walking independently. The problem identification and the approaches are based on information obtained during the assessment process. Mr. Zentoff's customary routine as well as his preferences were used to individualize the care plan and to guide the staff in adapting to his needs.

- **Mr. Zentoff was included** in the care planning process. He had indicated to the nurse assistant that he felt adrift in the institution and didn't know what to do with himself. The staff had a care planning goal of keeping him safely mobile and Mr. Zentoff agreed with this goal, saying he wanted to be as independent as possible. At the conference a number of options were discussed including gardening, exercise classes, a walking program or rounds with the security force. He chose the rounds with security, using his keen eye to look for fires.

- An **interdisciplinary team** was used. A physical therapist was asked to assess Mr. Zentoff's mobility in order to strengthen his unsteady gait and to provide for daily exercise. The therapist decided Mr. Zentoff didn't need therapy but that he did need to be encouraged to walk daily. Thus, Mr. Zentoff went on rounds with the security guard. The latter decision was made with input from the activities director, the nurse, the social worker, physical therapist, nursing assistant on the evening shift, and Mr. Zentoff.

- **Including the nurse assistant** in the care planning discussion was a key ingredient to the team's ability to develop a successful care plan. Outside of relatives and friends, the evening nurse assistant was the person who knew Mr. Zentoff the best. Usually it is the day aide, but Mr. Zentoff was a night owl, so the evening assistant was included. It was she who knew what his work had been and realized that putting him to bed at eight in the evening would be traumatic and against his lifelong habit. Nurse assistants on all shifts were consulted to identify strengths and problems occurring throughout the twenty-four hour period.

- **Mr. Zentoff's Care Plan for Walking**

Problem: Muscle weakness limiting Mr. Zentoff's mobility.

Goal	Approaches	Disciplines	Re-evaluation
For Mr. Zentoff to walk the length of the building three times at least five days a week.	Walk on evening rounds with security guard on all three floors at least five times a week. S.G. and Mr. Z will report to evening nurse assistant.	Nursing Security guards Activities Physical therapy	October 25, 1991 (2 weeks)

- **Elements of This Care Plan**

  - The care plan **problem** is how to maintain current functioning. It has a prevention focus.

  - The **goal** is specific, measurable and written in a way that anyone can understand.

  - The **approach** is written to show respect for the resident, is individualized, and reflects the input of many disciplines. The actual days on which Mr. Zentoff is to walk are not specified because he should have choice and flexibility. It may be that he wants to walk more often than five times a week.

  - It is clearly the **responsibility** of the evening nurse assistant to take account of the fact that the walk was accomplished.

  - The **date for re-evaluation** is clear.

- **Individualized Care**

As a result of the resident assessment process and care planning, Mr. Zentoff received care tailored to meet his needs and compatible with his lifelong routines and preferences. His care plan guided the staff in assisting him as described below.

> *Nurse assistants cued him to eat, dress and bathe, before retiring as he had always done, and to use the toilet. He went to bed at his customary time and got up late, missing breakfast. He and the dietitian worked out a way for him to get his protein and vegetables at meal times and fill in the rest of his food in divided amounts during the day and evening. He took only his insulin and blood pressure medicines. He did not require sleeping pills or laxatives. He got up, with the assistance of a nurse assistant to use the bathroom at night. He spent his days socializing with other residents and the staff and went on evening rounds with the security staff.*

ADVOCACY TO SUPPORT RESIDENT AND FAMILY PARTICIPATION

EDUCATION AND INFORMATION -- Residents and families need to know:

- What the care planning process is, why it's important for them to participate, that there's a connection between **assessment, care planning and care** they receive, and what is in **the care plan.**

- That they don't have to accept care plan goals identified by the facility; that residents have the right to have staff **identify alternatives** if something about a care approach bothers them and they can **refuse treatment** and **decide what goals are important** to them.

- That residents **can bring up non-medical issues**, such as personal routines and preferences.

- That residents **can ask for a review** of, or a change in, their care plans at any time.

- That they need to be **continually talking with staff about care** and how residents are feeling.

PLANNING AND PREPARATION -- Educate residents and families that:

- they may talk about their condition to a physician, staff, family member **before the meeting.**

- they may **develop their own agenda** of points and questions to raise at the meeting.

- residents may ask others to be present (eg. family members/advocates as well as facility staff).

- they should be assertive in asking questions and in making their views known at the meeting and they should know what they want addressed and be prepared to respond to ideas presented.

ADVOCACY -- Advocate for a meaningful process where:

- **Staff see each resident as a *PARTICIPANT IN* and the *FOCAL POINT OF* care** delivered, not as the recipient of the nursing home's plan.

- **Staff work with residents** and families to enhance their participation in care planning by:

  - talking about ways to make the care planning process more comfortable and beneficial;
  - **giving them information** about the process;
  - **conducting a mock care plan meeting** to de-mystify the process; and
  - **talking prior to their care plan meeting** to review the resident's assessment and records.

- **Every resident** who can be, and wants to, **is included** in care plan process. Even residents with dementia or limitations in communication skills can participate in care planning to some extent.

- **Residents' goals, preferences, and ideas** are incorporated into care plans and care plans are implemented and changed as necessary.

WORKING WITH FAMILY, FRIENDS AND LEGAL REPRESENTATIVES

Families need support and assistance to advocate for their family member and to understand the importance of resident self-determination. If family members do not agree with a resident's wishes, help the family and resident work through their differences. Often, disagreements are the result of lack of adequate information or poor communication.

- Do family members understand why the resident made these choices or what lies behind them?

- Does the resident understand the consequences of her choices?

- Would the resident make different decisions if she had more information about the consequences and other options?

- Are residents decisions based on informed consent; are they aware of potential harm, the risks and benefits of their decisions?

- Do families recognize the resident's need to take risks in order to protect her freedom?

Health care decisions are each person's own choice, unless someone is legally appointed to make those decisions. Even then, it is essential that a resident's wishes, concerns, and responses be paramount.

For residents who have decision-making capacity:

- **Ask the resident if any family members are to be involved** in the care planning meeting.

- Encourage family to **talk** with the resident **about her goals and preferences** before the meeting.

- Encourage the family and the resident to go with a **unified agenda**.

- Help the family **support the resident** at the meeting and afterwards as the plan is implemented.

For residents who do not have decision making capacity or who have a legally appointed representative, **encourage family members or the representative to:**

- **Be informed** about the resident's assessment and care plan.

- **Talk with the resident** before the meeting and **be alert to her non-verbal cues**.

- **Support resident participation** in the care planning meeting to the extent possible.

- Use her knowledge of the resident to make **choices** they think the resident would make.

ROLE OF THE OMBUDSMAN IN CARE PLANNING MEETINGS

The ombudsman is present to support residents/families in making the care planning process work for residents, not to supplant residents, family or facility staff. Staff, family members and residents are asking ombudsmen to assume a variety of roles in care planning. **Before ombudsmen agree to attend a care planning meeting, they need to be clear about their role and purpose.**

To offer guidance to individual ombudsmen, **State Long Term Care Ombudsman Programs** may need to address program management questions such as:

- **When does an ombudsman attend a care plan meeting?**
- **What is the ombudsman's role in care planning?**

These issues require discussion and decision-making regarding:

- ethical considerations,
- resident and family empowerment, and
- resource allocations.

SITUATIONS OMBUDSMAN PROGRAMS NEED TO THINK THROUGH INCLUDE:

- Whose needs are being met when an ombudsman attends a care planning meeting -- residents' or facility staff? Why do the facility staff want the ombudsman to attend? Does a resident need the support and/or advocacy skills of the ombudsman?

- Does an ombudsman attend a care planning meeting at the invitation of facility staff when neither the resident nor the resident's family will be present and the resident cannot give the ombudsman permission to represent him or her? Is there an extension to care planning of the ombudsman's role in representing residents who can't give consent? If so, what is the role of the ombudsman? When does an ombudsman become involved?

- What is the role of ombudsmen in care planning discussions? Is the ombudsman's advocacy role compromised if s/he agrees with the care plan that is developed? Is there EVER a situation in which an ombudsman would/could approve a care plan on behalf of a resident?

- If residents begin **routinely** asking ombudsmen to attend their care planning meetings, how do ombudsmen respond? Is the ombudsman's role to teach and empower residents to participate without an ombudsman's presence?

- Does the ombudsman sign anything in a care planning meeting?

PRINCIPLES FOR CARE PLANNING

Care plans should:

(1) Properly identify the problem
- Watch for care plans that:
  - (-) incorrectly label problems
  - (-) mis-label a resident's efforts to communicate as a "problem behavior"
  - (-) are driven by staff problems, not residents' problems
  - (-) mis-label a resident's decision as a problem

(2) Be Specific and Individualized
- Watch for care plans that:
  - (-) have goals and approaches that are meaningless because they are too broad or are not individualized

(3) Be Written in Common Language that Everyone Can Understand
- Watch for care plans that:
  - (-) are written in professional jargon that nursing assistants and residents cannot understand or implement

(4) Have the Resident's Agreement
- Watch for care plans that:
  - (-) have problems that do not reflect the resident's concerns or have solutions that will not work for the resident

(5) Be Supportive of Residents' Well-being, Functioning and Rights
- Watch for care plans that:
  - (-) are for staff, not for residents
  - (-) cause anxiety to residents or do not adapt the facility to residents' needs
  - (-) say what the resident will do instead of what the staff will do

(6) Utilize a Team Approach Based on Problems Identified in the Assessment
- Watch for care plans that:
  - (-) do not address needs identified in the assessment
  - (-) contain conflicting goals from different disciplines
  - (-) do not use referrals to other agencies or professionals as needed

(7) Be Re-evaluated and Revised Routinely
- Watch for care plans that:
  - (-) never change

On the following pages, we provide concrete examples of how these principles could be incorporated into a care plan and what to watch for if care plans are not being developed or used correctly.

(■) Items to **watch for** are followed by examples which indicate
- (-) a need for questioning and
- (+) ones which are more positive.

• PROPERLY IDENTIFY THE PROBLEM

▪ Watch for care plans that **incorrectly label problems**.

(-) The problem is "*resident refuses activities*" with no attempt to discover why or to find an activity that the resident would enjoy.

(+) A nurse assistant heard the resident say that the sing-alongs in the facility were not her kind of music or idea of leisure activities. The problem is not her refusal of activities but that the **activities offered are not individualized** to meet her needs. Approaches would include working with her to identify activities she would enjoy.

▪ Watch for care plans which mistakenly identify **as problems/behaviors** a residents **methods of communicating**. This may show that the facility doesn't understand the resident's needs.

(-) The problem is "*resident calls out*" and the goal is to eliminate the calling out.

(+) By contrast, the problem is that the **facility doesn't understand** what the resident needs or wants when she calls out. The goal is to learn why she calls out and to respond to her needs. Approaches include asking staff who come in contact with her to pay close attention and interact with her when she calls out to determine what she needs and offer immediate assistance. Another approach is for staff to ask her, and family if appropriate, to identify what she is expressing and how to respond.

▪ Watch for **problems and goals** that have been **identified by the staff**, but are **NOT** considered problems by the resident.

(-) The problem is "*resident wears her slippers all morning.*" This apparently doesn't bother the resident and there are no problems with her care. Whenever staff try to convince her to put on shoes before noon, she adamantly refuses.

(+) By contrast, since the resident prefers slippers until noon, this should only be noted to alert staff so that she will be assisted to dress as she pleases.

▪ Watch for care plans which **label** a resident's **decision-making as a problem**.

(-) The problem is "Resident is anti-social," -- she wants to eat supper in her room.

(+) She wants to eat in her room to watch a TV show which comes on during supper. Instead of labelling her "anti-social" the staff need to know why she wants dinner in her room so they can assist her and meet her needs as part of her daily routine.

- **SPECIFIC and INDIVIDUALIZED**

  - Watch for meaningless problems, goals, or approaches -- **too broad** or not individualized.

    (-) The problem is "*socially withdrawn*" [too broad] and the goal is, "*Resident will go out of the room 1x weekly.*" The approach is, "*The activity director will document number of times a week resident is out of her room.*" What does "out of her room" mean? Where will she go? What will be done to address the problem of being "socially withdrawn"? Is she really socially withdrawn and if so, why? Does this bother her?

    (+) By contrast, if the problem is "*an absence of social interaction*" and the **resident agrees** that she would like more interaction with residents and others, then a goal might be, "*Support resident's desire to participate in discussions with other residents at least twice a week.*" One approach could be: "*The activity director will ask Mrs. X to join in the small group discussion of current events Tuesday and Thursday mornings.*" The approach relates to the resident's interest in news and draws on her knowledge of events acquired by reading the daily paper and watching the nightly news.

- **WRITTEN IN COMMON LANGUAGE EVERYONE CAN UNDERSTAND**

  - Watch for care **plans** that are **written for the professional staff**: all of the language is medical or clinical terms instead of common, easily understood words.

    (-) "Gait training with appropriate assistive device: walker."

    (+) "Teach the resident to walk with a three prong walker."

- **RESIDENT AGREEMENT**

  - Watch for **care plans which do not reflect problems/needs the resident has expressed** or which have goals and plans that do not suit her.

    (-) Lack of privacy is an issue that several residents have raised yet none of their care plans say anything about how to support residents' privacy.

    (+) Residents need to be free to mention issues that are important to them in the care planning meeting and have their issues addressed. If privacy issues exist, some care plans should include goals, problems and approaches to address the specific concerns. A problem might be, "*Resident always feels she is on display, that she has no privacy.*" The goal might be, "*Increase resident's visual privacy;*" one approach would be, "*All facility staff will keep the resident's room divider extended unless the resident requests that it be moved.*" Another approach would be, "*Housekeeping staff will make an appointment with resident within two weeks to rearrange the resident's furniture to create more visual privacy.*"

• SUPPORT RESIDENTS' WELL-BEING, FUNCTIONING AND RIGHTS

▪ Watch for approaches which are **for the staff**, not for residents and which **are not supportive of residents rights or quality of life.**

(-) An example is using manipulative methods, such as behavior modification, to make the resident manageable for the staff. "If you sit quietly in the social area for two hours, you will get hot tea at snack time."

(+) By contrast, "Resident will be encouraged to sit in the dining room and take nourishment during afternoon tea." The staff know that the music played during afternoon tea has a calming effect on the resident, that she likes tea and being with other people during that time of day. This care plan approach uses staff knowledge of the resident 's routines and preferences to identify a pleasant way to soothe her. The staff isn't trying to change her behavior by offering or withholding "privileges" for their convenience. The staff is considering the resident's well-being.

▪ Watch for **approaches** which **cause anxiety** for the resident or do not seek to adapt the facility to meet the needs/preferences of the individual.

(-) A resident is told, "If you can't get up by 9:00 we won't have time to give you a shower." Another resident is told, "We're going to have to talk to your son about getting you to wear some decent looking clothes."

(+) Both issues need to be discussed with residents. After explanations, brainstorming, and listening, some approaches respectful and accommodating of each resident's preferences and feelings could be identified. Approaches might be:

"Assist the resident with her shower in the evening before getting ready for bed."

"The social worker will talk with the resident about getting new clothes that fit better now that her weight has stabilized and will offer assistance to obtain clothes if needed."

▪ Watch for care plans which say, "the **resident will do...**", when the staff or facility needs to make the change in order to address the resident's need.

(-) "Mrs. Jones will take her bath without hitting the nurse assistants."

(+) Facility staff need to determine what Mrs. Jones is communicating by her hitting. It might be that she is accustomed to a shower and has always disliked sitting in a tub. The hitting behavior may be Mrs. Jones's way of expressing her fear of the strange looking tub which doesn't look like the bathtub in her home. One of these approaches might be appropriate depending upon what Mrs. Jones is expressing.

"Mrs. Jones will be offered her choice of a bath or a shower."

"Mrs. Jones will be offered a bath in the tub on Wing C (a regular household tub)."

- **TEAM APPROACH TO PROBLEMS IDENTIFIED IN THE ASSESSMENT**

  - Watch for care plans which **do not address problems/needs identified in the assessment.**

    (-) The MDS indicates a resident is unhappy with his roommate and has a sad, anxious mood; yet neither of these is addressed on his care plan.

    (+) By contrast, a care plan problem is, "Resident wants another roommate." A goal might be "Resident agrees to work with staff to identify a compatible roommate." Approaches could determine why he wants another roommate and to help problem-solve with him to accommodate his needs and his current roommate's needs.

    (+) The care plan identifies his sadness and anxiety as a problem. Approaches would determine the causes of his mood and respond with appropriate treatment. Resolving his differences with his roommate might also resolve his mood.

    (-) A physical therapist has identified that the resident needs specific daily exercises. The therapist has trained some nurse assistants to assist with these exercises, but the exercises are rarely done and are not on the care plan.

    (+) A care plan could identify the specific daily exercises the therapist recommends at a time acceptable to the resident so staff know when and how they should be done.

  - Watch for care plans which contain **conflicting goals** from various disciplines.

    (-) The dietary goal is: "Resident will be encouraged to eat only food presented at meals in order to lose 5 pounds." The activity goal for the same resident is: "Staff will assist resident to participate in her preferred activities - cooking and baking."

    (+) It is important to know if the resident agrees with the goal of losing 5 pounds. If so, while the activity goal may address the resident's interests, it works against the weight loss goal. The activity professional, food services personnel and the resident need to decide jointly how to meet the dietary goal and the activity goal. Approaches could include preparing low-calorie foods in the cooking activity, finding another activity she would like as well or better than cooking or finding another way to lose weight (eg. through exercise) instead of dieting. **Incompatible goals must be resolved during care planning by creative thinking and discussion involving everyone.**

  - Watch for care plans which **do not use referrals** to agencies or professionals as needed.

    (-) "Resident is very tearful and says she is tired of living." The care plan approaches include: listening to the resident, expressing empathy, and offering encouragement.

    (+) Care plan approaches should attempt to find the cause of her depression and if needed, refer her to a mental health counselor, to a physician to screen for underlying physiological causes, or to a senior centers or civic organizations for activity.

• RE-EVALUATION AND REVISION

Care plans are dynamic documents, changing as the resident changes and as new approaches are learned and found to be effective. There is an element of trial and error in care planning. **Care plans should reflect continual evolution and innovation in addressing a resident's needs.**

▪ Watch for care plans that NEVER change.

(-) Short term goals remain on care plans without changing approaches or evaluating their effectiveness. Goals and approaches remain on care plans for YEARS without any changes and without an objective re-evaluation.

(+) "Resident agrees to walk the length of the building on way to each meal, three times a day, at least five days a week. Reevaluate in two weeks on October 26, 1992." At the time of re-evaluation, the resident and the staff will discuss whether this goal or the approaches need to be changed.

There may be "in between" or "initial" care plans which provide guidance for the staff before the full care planning team meets either to develop the first complete care plan after admission or to revise the care plan after a significant change in the resident's condition.

▪ Watch for evidence that care plans are **revised due to changes that occur** with residents during the three month interval for review of care plans.

(-) The problem/need statement is, "Resident needs assistance in getting to the dining room." The approach is, "Resident will be transported to the dining room in a wheelchair for meals." Since the care plan meeting, the resident has been receiving physical therapy and can now walk to the dining room for two of the three meals. The care plan hasn't been reviewed so the resident continues to be taken to the dining room in a wheelchair for every meal.

(+) There is a revision noted on the care plan which states, "Resident agrees to walk to the dining room for breakfast and dinner." The approaches are revised to indicate that staff will offer assistance if needed. Although this change didn't require a full care plan meeting, the care plan is current with the resident's condition and demonstrates that the implementation of the original care plan is being monitored and adjusted as needed.

USING CARE PLANNING TO RESOLVE PROBLEMS

In addition to supporting **resident participation** in the care planning process, ombudsmen can use care planning as a **tool in advocacy** as part of the problem-solving process. Care plan meetings may be helpful for advocacy when:

- **Residents (and families) need information.**

  Residents' concerns or questions about their care or medications may already be addressed on their care plan, but they haven't been informed about the facility's approach.

- **Residents (and families) have concerns about the delivery of services.**

  Since care planning is interdisciplinary, a care plan meeting can address concerns in more than one department with just one meeting attended by activities, dietary, social services, laundry, housekeeping as well as nursing.

- **The facility is acting in a way that does not comply with state and federal standards.**

  It may be productive to attempt to change the situation through direct complaint resolution with facility staff, instead of using the state's complaint process. This is often helpful in cases such as improper use of restraints, right to refuse treatment, preferences for daily schedules and other residents rights provisions.

- **The facility's complaint resolution process has failed.**

  When a resident has used the facility's grievance process, isn't satisfied with the results, and turns to the ombudsman, care planning may provide another alternative for resolution within the facility. Care planning IS NOT the last option, but it may be used even when other attempts at remedies haven't worked.

- **A resident receives a discharge notice.**

  While the appeal process is working, a care plan meeting may succeed in getting the staff to take another look at the resident and his/her needs and desires. Sometimes care plan meetings and further assessment can help identify the underlying cause and solutions for the issue that was precipitating the discharge.

- **You want to bring several people together, each of whom has a role in the resident's care.**

  Ask for the individuals you think should be involved in the discussion to be present, including staff such as maintenance or housekeeping, if pertinent to the issue. Having everyone together in one place may expedite problem resolution and make the resolution "official" by having it documented on the care plan. This can be helpful when a specific problem needs to be addressed. It is also a useful strategy when a change in the resident's condition has been noticed but staff have neither analyzed why the change has occurred nor altered their care of the resident.

CASE EXAMPLES

In the INTRODUCTION, we described situations drawn from ombudsman case files in which care planning was an effective advocacy tool for problem-solving. Here's how they worked out.

- ***Mr. Johnson's mother, an 82 year old resident, is slipping in her own urine and falling because the facility does not use incontinence briefs. As a result of the falls, the facility is restraining her.***

The ombudsman learned that the facility doesn't have an incontinence program for residents. As a result, Mr. Johnson's mother had fallen almost weekly, slipping in her own urine. Mr. Johnson spoke to the Director of Nursing and the administrator and had written a letter of grievance to the owner about this and had not received a response. Mr. Johnson is his mother's legal representative.

The ombudsman suggested a care conference as a way of getting Mr. Johnson's concerns properly addressed on the care plan. While waiting for the care conference the ombudsman had Mr. Johnson's permission to contact the facility about the restraints. The DoN agreed to have Mrs. Johnson in incontinence briefs when she is out of bed and to release her from the restraints.

At the care conference, the staff amended the care plan to include efforts to determine the cause of the incontinence and to assist Mrs. Johnson to become continent if possible. In the interim, she will be on a bladder training program and wear incontinence briefs to avoid falls. **Mrs. Johnson stopped falling after this care plan was implemented.**

- ***Mrs. Gomez says her aunt, Ms. Sanchez, was moved from the first to the second floor, with the confused residents. She received only two hours notice to move and is very depressed living on the second floor.***

The ombudsman suggested a care conference to discuss the move and Ms. Sanchez's reaction. At the care conference the social worker said Ms. Sanchez was transferred because of "depression" and that Ms. Sanchez did not participate in activities, preferring to "sit in the hall and watch the world go by." The ombudsman asked the staff for documentation of the diagnosis of depression and asked the staff to address Ms. Sanchez's concerns about her current living situation.

It was decided that Ms. Sanchez's door would be closed at night to keep a wanderer out of her room and that she would come down to the first floor for activities and meals. Staff came to understand that Ms. Sanchez was more of an observer than a participator and sitting in the hall was very entertaining for her. A re-evaluation was scheduled in two months if problems persisted. After, the facility produced a psychological evaluation dated two weeks after the care conference, diagnosing Ms. Sanchez as depressed. The doctor ordered Haldol and Elavil which Ms. Sanchez said made her feel strange. The problems on the second floor continued. The ombudsman told Ms. Sanchez of her right to refuse the medicine, and a new care conference was scheduled.

At the second conference, the ombudsman pointed out that the diagnosis of depression was made from an evaluation after the first care conference. Ms. Sanchez said her depression resulted from the move. After much discussion, it was decided that the medication orders for Haldol and Elavil would be discontinued and Ms. Sanchez would receive the first available bed on the first floor. **Ms. Sanchez is now residing on the first floor and is contentedly busy watching other people.**

• ***Ms. Cooper asks for help because her mother Mrs. Smith just received a discharge notice from the facility. The reason given for the discharge is that the facility can no longer meet her needs.***

The ombudsman visited Mrs. Smith several times, reviewed her medical record, and talked with her daughter numerous times. Based upon her investigation the ombudsman noted a change in Mrs. Smith's behavior after February 15th and that she had been given a medication to sedate her. Mrs. Smith began to have difficulty finding her room and began cursing and hitting the staff who bathed her. No assessment had been conducted since this date. The ombudsman asked for a care conference. It was scheduled for the day before Mrs. Smith was to be evicted.

At the conference, the administrator insisted on eviction. Ms. Cooper wanted her mother's eyes checked. She felt that Mrs. Smith had cataracts and that might be causing her mother to be disruptive. At the ombudsman's insistence a care plan was developed which included:

- Mrs. Smith would stay in the facility for 30 more days;
- a medical assessment, including lab tests, would be done;
- the chemical restraint would be reduced because of dizziness;
- if Mrs. Smith had another outburst, the care conference team would reconvene;
- Mrs. Smith's cataracts would be taken care of in 30 days.

The lab tests showed that Mrs. Smith had a urinary tract infection, often a cause of atypical behavior symptoms. **Two weeks after medication was administered for the UTI, the chemical restraint was discontinued. Mrs. Smith had cataract surgery and enjoys seeing better again. She is doing well in the facility.**

• ***Mr. Jacks is concerned that his wife stays in her room and will not participate in facility activities or go to the dining room for meals. Family members note that she also complains her dentures do not fit and she seems to have trouble talking. She is losing weight.***

By reviewing the resident's record, the Ombudsman ascertained that Mrs. Jacks had lost six pounds over the past month and that the charge nurse had not used the "Nutrition" RAP prior to care planning. Mr. Jacks asked for a care conference to discuss Mrs. Jacks weight loss and invited the Ombudsman to attend. The day nurse aide, dietitian, charge nurse, social worker and activity director also attended.

Using the Nutrition and Dental RAPS, the ombudsman asked if there was a link between the weight loss and poor denture fit and if the dentures had been evaluated. The nurse agreed to have the dentures evaluated and refitted if necessary. The dietitian agreed to provide foods that did not require chewing until then. Mr. Jacks agreed to bring Mrs. Jack's favorite coffee milk shakes three times a week until she regained her weight. Further evaluation, using the RAPS, would be done if needed. **Once her dentures fit, Mrs. Jacks resumed social activities and a healthy weight.**

*** Cases adapted from ombudsman files from Santa Barbara, California and Detroit, Michigan.**

CONCLUSION

Resident assessment and care planning are the keys to developing care routines that are individualized to meet the needs of each resident. The individualized approach is necessary if staff are to provide care which truly assists residents to maintain their current level of functioning and improve whenever possible. Depression, restraints, bedsores, immobility and incontinence are not an automatic function of old age. Such conditions are often avoidable if the causes are really understood and preventive and restorative care are part of daily practice.

For a care plan to be useful it must be tailored to each resident's own needs and strengths. The participation of residents and their representatives (family, friends, advocates and ombudsmen) is essential to achieve individualized service delivery.

Ombudsmen and other advocates can:

- empower residents and families to participate in care planning,

- help residents, families, and facilities view these processes as opportunities for dialogue and innovation, and

- remind everyone that individual residents are the focus of assessment, care planning and implementation.

Only by using assessment and care planning to their fullest potential, can facilities meet the requirements of federal law to provide quality of care and quality of life to each resident.

APPENDIX A

THE MINIMUM DATA SET

AND

TRIGGER LEGEND WORKSHEET

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME⊙	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER⊙	1. Male 2. Female
3.	BIRTHDATE⊙	Month — Day — Year
4.	RACE/⊙ ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY⊙ AND MEDICARE NUMBERS⊙ [C in 1st box if non med. no.]	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO.⊙	a. State No. b. Federal No.
7.	MEDICAID NO. [*"+" if pending, "N" if not a Medicaid recipient*]⊙	
8.	REASONS FOR ASSESSMENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior assessment 5. Quarterly review assessment 0. *NONE OF ABOVE* b. *Special codes for use with supplemental assessment types in Case Mix demonstration states or other states where required* 1. *5 day assessment* 2. *30 day assessment* 3. *60 day assessment* 4. *Quarterly assessment using full MDS form* 5. *Readmission/return assessment* 6. *Other state required assessment*
9.	SIGNATURES OF PERSONS COMPLETING THESE ITEMS:	
a. Signatures	Title	Date
b.		Date

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

⊙ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter [a] = When letter in box, check if condition applies

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1.	DATE OF ENTRY	*Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date* Month — Day — Year	
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other	
3.	LIVED ALONE (PRIOR TO ENTRY)	0. No 1. Yes 2. In other facility	
4.	ZIP CODE OF PRIOR PRIMARY RESIDENCE		
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	*(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)*	
		Prior stay at this nursing home	a.
		Stay in other nursing home	b.
		Other residential facility—board and care home, assisted living, group home	c.
		MH/psychiatric setting	d.
		MR/DD setting	e.
		NONE OF ABOVE	f.
6.	LIFETIME OCCUPATION(S) [Put "/" between two occupations]		
7.	EDUCATION (*Highest Level Completed*)	1. No schooling 2. 8th grade/less 3. 9-11 grades 4. High school 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree	
8.	LANGUAGE	*(Code for correct response)* a. Primary Language 0. English 1. Spanish 2. French 3. Other	
		b. If other, specify	
9.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem? 0. No 1. Yes	
10.	CONDITIONS RELATED TO MR/DD STATUS	*(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely)*	
		Not applicable—no MR/DD (Skip to AB11)	a.
		MR/DD with organic condition	
		Down's syndrome	b.
		Autism	c.
		Epilepsy	d.
		Other organic condition related to MR/DD	e.
		MR/DD with no organic condition	f.
11.	DATE BACKGROUND INFORMATION COMPLETED	Month — Day — Year	

SECTION AC. CUSTOMARY ROUTINE

1.	CUSTOMARY ROUTINE (*in year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home*)	*(Check all that apply. If all information UNKNOWN, check last box only)*	
		CYCLE OF DAILY EVENTS	
		Stays up late at night (e.g., after 9 pm)	a.
		Naps regularly during day (at least 1 hour)	b.
		Goes out 1+ days a week	c.
		Stays busy with hobbies, reading, or fixed daily routine	d.
		Spends most of time alone or watching TV	e.
		Moves independently indoors (with appliances, if used)	f.
		Use of tobacco products at least daily	g.
		NONE OF ABOVE	h.
		EATING PATTERNS	
		Distinct food preferences	i.
		Eats between meals all or most days	j.
		Use of alcoholic beverage(s) at least weekly	k.
		NONE OF ABOVE	l.
		ADL PATTERNS	
		In bed/clothes much of day	m.
		Wakens to toilet all or most nights	n.
		Has irregular bowel movement pattern	o.
		Showers for bathing	p.
		Bathing in PM	q.
		NONE OF ABOVE	r.
		INVOLVEMENT PATTERNS	
		Daily contact with relatives/close friends	s.
		Usually attends church, temple, synagogue (etc.)	t.
		Finds strength in faith	u.
		Daily animal companion/presence	v.
		Involved in group activities	w.
		NONE OF ABOVE	x.
		UNKNOWN—Resident/family unable to provide information	y.

END

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:			
a. Signature of RN Assessment Coordinator			Date
b. Signature	Title	Sections	Date
c.			Date
d.			Date
e.			Date
f.			Date
g.			Date

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1.	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	ROOM NUMBER	
3.	ASSESSMENT REFERENCE DATE	a. *Last day of MDS observation period* Month — Day — Year b. Original (0) or corrected copy of form (enter number of correction)
4a.	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) Month — Day — Year
5.	MARITAL STATUS	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced
6.	MEDICAL RECORD NO.	
7.	CURRENT PAYMENT SOURCES FOR N.H. STAY	*(Billing Office to indicate; check all that apply in last 30 days)* Medicaid per diem a. Medicare per diem b. Medicare ancillary part A c. Medicare ancillary part B d. CHAMPUS per diem e. VA per diem f. Self or family pays for full per diem g. Medicaid resident liability or Medicare co-payment h. Private insurance per diem (including co-payment) i. Other per diem j.
8.	REASONS FOR ASSESSMENT *[Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed]*	a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior assessment 5. Quarterly review assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment 9. Reentry 0. *NONE OF ABOVE* b. *Special codes for use with supplemental assessment types in Case Mix demonstration states or other states where required* 1. *5 day assessment* 2. *30 day assessment* 3. *60 day assessment* 4. *Quarterly assessment using full MDS form* 5. *Readmission/return assessment* 6. *Other state required assessment*
9.	RESPONSIBILITY/ LEGAL GUARDIAN	*(Check all that apply)* Legal guardian a. Other legal oversight b. Durable power of attorney/health care c. Durable power attorney/financial d. Family member responsible e. Patient responsible for self f. *NONE OF ABOVE* g.
10.	ADVANCED DIRECTIVES	*(For those items with supporting documentation in the medical record, check all that apply)* Living will a. Do not resuscitate b. Do not hospitalize c. Organ donation d. Autopsy request e. Feeding restrictions f. Medication restrictions g. Other treatment restrictions h. *NONE OF ABOVE* i.

SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	*(Persistent vegetative state/no discernible consciousness)* 0. No 1. Yes (If yes, skip to Section G)
2.	MEMORY	*(Recall of what was learned or known)* a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem
3.	MEMORY/ RECALL ABILITY	*(Check all that resident was normally able to recall during last 7 days)* Current season a. Location of own room b. Staff names/faces c. That he/she is in a nursing home d. *NONE OF ABOVE* are recalled e.
4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	*(Made decisions regarding tasks of daily life)* 0. *INDEPENDENT*—decisions consistent/reasonable 1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only 2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required 3. *SEVERELY IMPAIRED*—never/rarely made decisions
5.	INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS	*(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time].* 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)
6.	CHANGE IN COGNITIVE STATUS	Resident's cognitive status, skills, or abilities have changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	*(With hearing appliance, if used)* 0. *HEARS ADEQUATELY*—normal talk, TV, phone 1. *MINIMAL DIFFICULTY* when not in quiet setting 2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly 3. *HIGHLY IMPAIRED*/absence of useful hearing
2.	COMMUNICATION DEVICES/ TECHNIQUES	*(Check all that apply during last 7 days)* Hearing aid, present and used a. Hearing aid, present and not used regularly b. Other receptive comm. techniques used (e.g., lip reading) c. *NONE OF ABOVE* d.
3.	MODES OF EXPRESSION	*(Check all used by resident to make needs known)* Speech a. Writing messages to express or clarify needs b. American sign language or Braille c. Signs/gestures/sounds d. Communication board e. Other f. *NONE OF ABOVE* g.
4.	MAKING SELF UNDERSTOOD	*(Expressing information content—however able)* 0. *UNDERSTOOD* 1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts 2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests 3. *RARELY/NEVER UNDERSTOOD*
5.	SPEECH CLARITY	*(Code for speech in the last 7 days)* 0. *CLEAR SPEECH*—distinct, intelligible words 1. *UNCLEAR SPEECH*—slurred, mumbled words 2. *NO SPEECH*—absence of spoken words
6.	ABILITY TO UNDERSTAND OTHERS	*(Understanding verbal information content—however able)* 0. *UNDERSTANDS* 1. *USUALLY UNDERSTANDS*—may miss some part/intent of message 2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication 3. *RARELY/NEVER UNDERSTANDS*
7.	CHANGE IN COMMUNICATION/ HEARING	Resident's ability to express, understand, or hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

☐ = When box blank, must enter number or letter

a. = When letter in box, check if condition applies

SECTION D. VISION PATTERNS

1.	VISION	(*Ability to see in adequate light and with glasses if used*) 0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books 1. *IMPAIRED*—sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)	a.
		Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes	b.
		NONE OF ABOVE	c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	(*Code for indicators observed in last 30 days, irrespective of the assumed cause*) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	
		VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*" b. Repetitive questions—e.g., "*Where do I go; What do I do?*" c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*") d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*" f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	
		h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues SLEEP-CYCLE ISSUES j. Unpleasant mood in morning k. Insomnia/change in usual sleep pattern SAD, APATHETIC, ANXIOUS APPEARANCE l. Sad, pained, worried facial expressions—e.g., furrowed brows m. Crying, tearfulness n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking LOSS OF INTEREST o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends p. Reduced social interaction	
2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	
3.	CHANGE IN MOOD	Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	
4.	BEHAVIORAL SYMPTOMS	(A) *Behavioral symptom frequency in last 7 days* 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) *Behavioral symptom alterability in last 7 days* 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered	(A) (B)
		a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)	
		e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	
5.	CHANGE IN BEHAVIORAL SYMPTOMS	Resident's behavior status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED RELATIONSHIPS	Covert/open conflict with or repeated criticism of staff	a.
		Unhappy with roommate	b.
		Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—(*Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup*)
   - 0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
   - 1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
   - 2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
   - 3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
     - —Weight-bearing support
     - —Full staff performance during part (but not all) of last 7 days
   - 4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
   - 8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(*Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification*)
- 0. No setup or physical help from staff
- 1. Setup help only
- 2. One person physical assist
- 3. Two+ persons physical assist
- 8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) *Code for most dependent in self-performance and support.* (A) BATHING SELF-PERFORMANCE codes appear below	(A) (B)
		0. Independent—No help provided	
		1. Supervision—Oversight help only	
		2. Physical help limited to transfer only	
		3. Physical help in part of bathing activity	
		4. Total dependence	
		8. Activity itself did not occur during entire 7 days *(Bathing support codes are as defined in Item 1, code B above)*	
3.	TEST FOR BALANCE (see training manual)	*(Code for ability during test in the last 7 days)* 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help	
		a. Balance while standing	
		b. Balance while sitting—position, trunk control	
4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	*(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury)* (A) *RANGE OF MOTION* 0. No limitation 1. Limitation on one side 2. Limitation on both sides (B) *VOLUNTARY MOVEMENT* 0. No loss 1. Partial loss 2. Full loss	(A) (B)
		a. Neck	
		b. Arm—including shoulder or elbow	
		c. Hand—including wrist or fingers	
		d. Leg—including hip or knee	
		e. Foot—including ankle or toes	
		f. Other limitation or loss	
5.	MODES OF LOCOMOTION	*(Check all that apply during last 7 days)*	
		Cane/walker/crutch a.	Wheelchair primary mode of locomotion d.
		Wheeled self b.	
		Other person wheeled c.	*NONE OF ABOVE* e.
6.	MODES OF TRANSFER	*(Check all that apply during last 7 days)*	
		Bedfast all or most of time a.	Lifted mechanically d.
		Bed rails used for bed mobility or transfer b.	Transfer aid (e.g., slide board, trapeze, cane, walker, brace) e.
		Lifted manually c.	*NONE OF ABOVE* f.
7.	TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them 0. No 1. Yes	
8.	ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident believes he/she is capable of increased independence in at least some ADLs	a.
		Direct care staff believe resident is capable of increased independence in at least some ADLs	b.
		Resident able to perform tasks/activity but is very slow	c.
		Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings	d.
		NONE OF ABOVE	e.
9.	CHANGE IN ADL FUNCTION	Resident's ADL self-performance status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

SECTION H. CONTINENCE IN LAST 14 DAYS

1.	CONTINENCE SELF-CONTROL CATEGORIES *(Code for resident's PERFORMANCE OVER ALL SHIFTS)* 0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]* 1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week 3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week 4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time	
a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	
2.	BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days a.	Diarrhea c.
			Fecal impaction d.
		Constipation b.	*NONE OF ABOVE* e.

3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan a.	Did not use toilet room/commode/urinal f.
		Bladder retraining program b.	Pads/briefs used g.
		External (condom) catheter c.	Enemas/irrigation h.
		Indwelling catheter d.	Ostomy present i.
		Intermittent catheter e.	*NONE OF ABOVE* j.
4.	CHANGE IN URINARY CONTINENCE	Resident's urinary continence has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1.	DISEASES	*(If none apply, CHECK the NONE OF ABOVE box)*			
		ENDOCRINE/METABOLIC/NUTRITIONAL		Hemiplegia/Hemiparesis	v.
				Multiple sclerosis	w.
		Diabetes mellitus	a.	Paraplegia	x.
		Hyperthyroidism	b.	Parkinson's disease	y.
		Hypothyroidism	c.	Quadriplegia	z.
		HEART/CIRCULATION		Seizure disorder	aa.
		Arteriosclerotic heart disease (ASHD)	d.	Transient ischemic attack (TIA)	bb.
				Traumatic brain injury	cc.
		Cardiac dysrhythmias	e.	PSYCHIATRIC/MOOD	
		Congestive heart failure	f.	Anxiety disorder	dd.
		Deep vein thrombosis	g.	Depression	ee.
		Hypertension	h.	Manic depression (bipolar disease)	ff.
		Hypotension	i.		
		Peripheral vascular disease	j.	Schizophrenia	gg.
		Other cardiovascular disease	k.	PULMONARY	
		MUSCULOSKELETAL		Asthma	hh.
		Arthritis	l.	Emphysema/COPD	ii.
		Hip fracture	m.	SENSORY	
		Missing limb (e.g., amputation)	n.	Cataracts	jj.
		Osteoporosis	o.	Diabetic retinopathy	kk.
		Pathological bone fracture	p.	Glaucoma	ll.
		NEUROLOGICAL		Macular degeneration	mm.
		Alzheimer's disease	q.	OTHER	
		Aphasia	r.	Allergies	nn.
		Cerebral palsy	s.	Anemia	oo.
		Cerebrovascular accident (stroke)	t.	Cancer	pp.
				Renal failure	qq.
		Dementia other than Alzheimer's disease	u.	*NONE OF ABOVE*	rr.
2.	INFECTIONS	*(If none apply, CHECK the NONE OF ABOVE box)*			
		Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.	Septicemia	g.
				Sexually transmitted diseases	h.
		Clostridium difficile (c. diff.)	b.	Tuberculosis	i.
		Conjunctivitis	c.	Urinary tract infection in last 30 days	j.
		HIV infection	d.	Viral hepatitis	k.
		Pneumonia	e.	Wound infection	l.
		Respiratory infection	f.	NONE OF ABOVE	m.
3.	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	a. _____			
		b. _____			
		c. _____			
		d. _____			
		e. _____			

SECTION J. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	*(Check all problems present in last 7 days unless other time frame is indicated)*			
		INDICATORS OF FLUID STATUS		Dizziness/Vertigo	f.
				Edema	g.
				Fever	h.
		Weight gain or loss of 3 or more pounds within a 7 day period	a.	Hallucinations	i.
				Internal bleeding	j.
		Inability to lie flat due to shortness of breath	b.	Recurrent lung aspirations in last 90 days	k.
		Dehydrated; output exceeds input	c.	Shortness of breath	l.
				Syncope (fainting)	m.
		Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days	d.	Unsteady gait	n.
				Vomiting	o.
		OTHER		*NONE OF ABOVE*	p.
		Delusions	e.		

2.	PAIN SYMPTOMS	*(Code the highest level of pain present in the last 7 days)*	
		a. FREQUENCY with which resident complains or shows evidence of pain	
		0. No pain (*skip to J4*)	
		1. Pain less than daily	
		2. Pain daily	
		b. INTENSITY of pain	
		1. Mild pain	
		2. Moderate pain	
		3. Times when pain is horrible or excruciating	
3.	PAIN SITE	*(If pain present, check all sites that apply in last 7 days)*	
		Back pain	a.
		Bone pain	b.
		Chest pain while doing usual activities	c.
		Headache	d.
		Hip pain	e.
		Incisional pain	f.
		Joint pain (other than hip)	g.
		Soft tissue pain (e.g., lesion, muscle)	h.
		Stomach pain	i.
		Other	j.
4.	ACCIDENTS	*(Check all that apply)*	
		Fell in past 30 days	a.
		Fell in past 31-180 days	b.
		Hip fracture in last 180 days	c.
		Other fracture in last 180 days	d.
		NONE OF ABOVE	e.
5.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating)	a.
		Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem	b.
		End-stage disease, 6 or fewer months to live	c.
		NONE OF ABOVE	d.

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS	Chewing problem	a.
		Swallowing problem	b.
		Mouth pain	c.
		NONE OF ABOVE	d.
2.	HEIGHT AND WEIGHT	*Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes* a. HT (in.) ___ b. WT (lb.) ___	
3.	WEIGHT CHANGE	a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes	
		b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes	
4.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods	a.
		Regular or repetitive complaints of hunger	b.
		Leaves 25% or more of food uneaten at most meals	c.
		NONE OF ABOVE	d.
5.	NUTRITIONAL APPROACHES	*(Check all that apply in last 7 days)*	
		Parenteral/IV	a.
		Feeding tube	b.
		Mechanically altered diet	c.
		Syringe (oral feeding)	d.
		Therapeutic diet	e.
		Dietary supplement between meals	f.
		Plate guard, stabilized built-up utensil, etc.	g.
		On a planned weight change program	h.
		NONE OF ABOVE	i.
6.	PARENTERAL OR ENTERAL INTAKE	*(Skip to Section L if neither 5a nor 5b is checked)*	
		a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days 0. None 1. 1% to 25% 2. 26% to 50% 3. 51% to 75% 4. 76% to 100%	
		b. Code the average fluid intake per day by IV or tube in last 7 days 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day	

SECTION L. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
		Has dentures or removable bridge	b.
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)	c.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingiva); swollen or bleeding gums: oral abcesses; ulcers or rashes	e.
		Daily cleaning of teeth/dentures or daily mouth care—by resident or staff	f.
		NONE OF ABOVE	g.

SECTION M. SKIN CONDITION

			Number at Stage
1.	ULCERS (Due to any cause)	*(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.]*	
		a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
2.	TYPE OF ULCER	*(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)*	
		a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue	
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
3.	HISTORY OF RESOLVED ULCERS	Resident had an ulcer that was resolved or cured in LAST 90 DAYS 0. No 1. Yes	
4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	*(Check all that apply during last 7 days)*	
		Abrasions, bruises	a.
		Burns (second or third degree)	b.
		Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	c.
		Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster	d.
		Skin desensitized to pain or pressure	e.
		Skin tears or cuts (other than surgery)	f.
		Surgical wounds	g.
		NONE OF ABOVE	h.
5.	SKIN TREATMENTS	*(Check all that apply during last 7 days)*	
		Pressure relieving device(s) for chair	a.
		Pressure relieving device(s) for bed	b.
		Turning/repositioning program	c.
		Nutrition or hydration intervention to manage skin problems	d.
		Ulcer care	e.
		Surgical wound care	f.
		Application of dressings (with or without topical medications) other than to feet	g.
		Application of ointments/medications (other than to feet)	h.
		Other preventative or protective skin care (other than to feet)	i.
		NONE OF ABOVE	j.
6.	FOOT PROBLEMS AND CARE	*(Check all that apply during last 7 days)*	
		Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems	a.
		Infection of the foot—e.g., cellulitis, purulent drainage	b.
		Open lesions on the foot	c.
		Nails/calluses trimmed during last 90 days	d.
		Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)	e.
		Application of dressings (with or without topical medications)	f.
		NONE OF ABOVE	g.

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	*(Check appropriate time periods over last 7 days)* Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:	
		Morning	a.
		Afternoon	b.
		Evening	c.
		NONE OF ABOVE	d.
(If resident is comatose, skip to Section O)			
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None	
3.	PREFERRED ACTIVITY SETTINGS	*(Check all settings in which activities are preferred)*	
		Own room	a.
		Day/activity room	b.
		Inside NH/off unit	c.
		Outside facility	d.
		NONE OF ABOVE	e.
4.	GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)	*(Check all PREFERENCES whether or not activity is currently available to resident)*	
		Cards/other games	a.
		Crafts/arts	b.
		Exercise/sports	c.
		Music	d.
		Reading/writing	e.
		Spiritual/religious activities	f.
		Trips/shopping	g.
		Walking/wheeling outdoors	h.
		Watching TV	i.
		Gardening or plants	j.
		Talking or conversing	k.
		Helping others	l.
		NONE OF ABOVE	m.

5.	PREFERS CHANGE IN DAILY ROUTINE	*Code for resident preferences in daily routines* 0. No change 1. Slight change 2. Major change	
		a. Type of activities in which resident is currently involved	
		b. Extent of resident involvement in activities	

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICATIONS	(*Record the number of different medications used in the last 7 days; enter "0" if none used*)	
2.	NEW MEDICATIONS	(*Resident currently receiving medications that were initiated during the last 90 days*) 0. No 1. Yes	
3.	INJECTIONS	(*Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used*)	
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(*Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*) a. Antipsychotic b. Antianxiety c. Antidepressant d. Hypnotic e. Diuretic	

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1.	SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—*Check treatments or programs received during the last 14 days*	
		TREATMENTS	
		Chemotherapy	a.
		Dialysis	b.
		IV medication	c.
		Intake/output	d.
		Monitoring acute medical condition	e.
		Ostomy care	f.
		Oxygen therapy	g.
		Radiation	h.
		Suctioning	i.
		Tracheostomy care	j.
		Transfusions	k.
		Ventilator or respirator	l.
		PROGRAMS	
		Alcohol/drug treatment program	m.
		Alzheimer's/dementia special care unit	n.
		Hospice care	o.
		Pediatric unit	p.
		Respite care	q.
		Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)	r.
		NONE OF ABOVE	s.
		b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily)* [Note—count only post admission therapies] (A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days	DAYS (A) / MIN (B)
		a. Speech - language pathology and audiology services	
		b. Occupational therapy	
		c. Physical therapy	
		d. Respiratory therapy	
		e. Psychological therapy (by any licensed mental health professional)	
2.	INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	(Check all interventions or strategies used in last 7 days—no matter where received)	
		Special behavior symptom evaluation program	a.
		Evaluation by a licensed mental health specialist in last 90 days	b.
		Group therapy	c.
		Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage	d.
		Reorientation—e.g., cueing	e.
		NONE OF ABOVE	f.
3.	NURSING REHABILITATION/ RESTORATIVE CARE	*Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.)*	
		a. Range of motion (passive)	
		b. Range of motion (active)	
		c. Splint or brace assistance	
		TRAINING AND SKILL PRACTICE IN:	
		d. Bed mobility	
		e. Transfer	
		f. Walking	
		g. Dressing or grooming	
		h. Eating or swallowing	
		i. Amputation/prosthesis care	
		j. Communication	
		k. Other	

4.	DEVICES AND RESTRAINTS	(*Use the following codes for last 7 days:*) 0. Not used 1. Used less than daily 2. Used daily	
		Bed rails	
		a. — Full bed rails on all open sides of bed	
		b. — Other types of side rails used (e.g., half rail, one side)	
		c. Trunk restraint	
		d. Limb restraint	
		e. Chair prevents rising	
5.	HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). (*Enter 0 if no hospital admissions*)	
6.	EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). (*Enter 0 if no ER visits*)	
7.	PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (*Enter 0 if none*)	
8.	PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change.* (*Enter 0 if none*)	
9.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission)? 0. No 1. Yes	

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes	
		b. Resident has a support person who is positive towards discharge 0. No 1. Yes	
		c. Stay projected to be of a short duration— discharge projected within 90 days (do not include expected discharge due to death) 0. No 2. Within 31-90 days 1. Within 30 days 3. Discharge status uncertain	
2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support	

SECTION R. ASSESSMENT INFORMATION

1.	PARTICIPATION IN ASSESSMENT	a. Resident: 0. No 1. Yes b. Family: 0. No 1. Yes 2. No family c. Significant other: 0. No 1. Yes 2. None	

2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete ___ — ___ — ____ (Month / Day / Year)

	Title	Sections	Date
c. Other Signatures			
d.			Date
e.			Date
f.			Date
g.			Date
h.			Date

SECTION T. SUPPLEMENT—CASE MIX DEMO

1. SPECIAL TREATMENTS AND PROCEDURES

a. RECREATION THERAPY—*Enter number of days and total minutes of recreation therapy administered (for at least 15 minutes a day) in the last 7 days (Enter 0 if none)*

	DAYS (A)	MIN (B)
(A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days		

Skip unless this is a Medicare 5 day or initial admission assessment.

b. ORDERED THERAPIES—*Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service?*
0. No 1. Yes

If not ordered, skip to item 2

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?

2. WALKING WHEN MOST SELF SUFFICIENT

Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:
- Resident received physical therapy involving gait training (P.1.b.c)
- Physical therapy was ordered for the resident involving gait training (T.2.b)
- Resident received nursing rehabilitation for walking (P.3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

(FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)

a. Furthest distance walked without sitting down during this episode.

0. 150+ feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. Time walked without sitting down during this episode.

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31+ minutes

c. Self-Performance in walking during this episode.

0. *INDEPENDENT*—No help or oversight
1. *SUPERVISION*—Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE*—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE*—Resident received weight bearing assistance while walking

d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. Parallel bars used by resident in association with this episode.

0. No 1. Yes

3. CASE MIX GROUP

Medicare _____ State _____

SECTION U. MEDICATIONS—CASE MIX DEMO

List all medications that the resident received during the last 7 days. Include scheduled medications that are used regularly, but less than weekly .

1. **Medication Name and Dose Ordered.** Record the name of the medication and dose ordered.
2. **Route of Administration (RA).** Code the Route of Administration using the following list:

1=by mouth (PO)	5=subcutaneous (SQ)	8=inhalation
2=sub lingual (SL)	6=rectal (R)	9=enteral tube
3=intramuscular (IM)	7=topical	10=other
4=intravenous (IV)		

3. **Frequency.** Code the number of times per day, week, or month the medication is administered using the following list:

PR=(PRN) as necessary	2D=(BID) two times daily (includes every 12 hrs)	QO=every other day
1H=(QH) every hour		4W=4 times each week
2H=(Q2H) every two hours	3D=(TID) three times daily	5W=five times each week
3H=(Q3H) every three hours	4D=(QID) four times daily	6W=six times each week
4H=(Q4H) every four hours	5D=five times daily	1M=(Q month) once every month
6H=(Q6H) every six hours	1W=(Q week) once each wk	2M=twice every month
8H=(Q8H) every eight hours	2W=two times every week	C=continuous
1D=(QD or HS) once daily	3W=three times every week	O=other

4. **Amount Administered (AA).** Record the number of tablets, capsules, suppositories, or liquid (any route) per dose administered to the resident. Code 999 for topicals, eye drops, inhalants and oral medications that need to be dissolved in water..
5. **PRN-number of days (PRN-n).** If the frequency code for the medication is "PR", record the number of times during the last 7 days each PRN medication was given. Code STAT medications as PRNs given once.
6. **NDC Codes.** Enter the National Drug Code for each medication given. Be sure to enter the correct NDC code for the drug name, strength , and form. The NDC code must match the drug dispensed by the pharmacy.

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6. NDC Codes

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Key:
- ● = One item required to trigger
- ❷ = Two items required to trigger
- ✱ = One of these three items, plus at least one other item required to trigger.
- ⓐ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A ⓐ	ADL-Maintenance Trigger B ⓐ	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints
B2a	Short term memory	1		●																		B2a
B2b	Long-term memory	1		●																		B2b
B4	Decision making	1,2,3		●																		B4
B4	Decision making	3						●														B4
B5a to B5f	Indicators of delirium	2	●																	●		B5a to B5f
B6	Change in cognitive status	2	❷																	●		B6
C1	Hearing	1,2,3				●																C1
C4	Understood by others	1,2,3				●																C4
C6	Understand others	1,2,3		●		●																C6
C7	Change in communication	2																		●		C7
D1	Vision	1,2,3			●																	D1
D2a	Side vision problem	3			●																	D2a
E1a to E1p	Indicators of depression, anxiety, sad mood	1,2									●											E1a to E1p
E1n	Repetitive movement	1,2																		●		E1n
E1o	Withdrawal from activities	1,2								●												E1o
E2	Mood persistence	1,2									●											E2
E3	Change in Mood	2	●																	●		E3
E4aA	Wandering	1,2,3													●							E4aA
E4aA - E4eA	Behavioral symptoms	1,2,3										●										E4aA - E4eA
E5	Change in behavioral symptoms	1										●										E5
E5	Change in behavioral symptoms	2	●																	●		E5
F1d	Establishes own goals	✓								●												F1d
F2a to F2d	Unsettled relationships	✓								●												F2a to F2d
F3a	Strong ID-past roles	✓								●												F3a
F3b	Lost roles	✓								●												F3b
F3c	Daily routine different	✓								●												F3c
G1aA - G1jA	ADL self-performance	1,2,3,4					●															G1aA - G1jA
G1aA	Bed mobility	2,3,4,8																	●			G1aA
G2A	Bathing	1,2,3,4					●															G2A
G3b	Balance while sitting	1,2,3																		●		G3b
G6a	Bedfast	✓																	●			G6a
G3a,b	Resident staff believe capable	✓					●															G3a,b
H1a	Bowel incontinence	1,2,3,4																	●			H1a
H1b	Bladder incontinence	2,3,4							●													H1b
H2b	Constipation	✓																		●		H2b
H2d	Fecal impaction	✓																		●		H2d
H3c,d,e	Catheter use	✓							●													H3c,d,e
H3g	Use of pads/liners	✓							●													H3g
I1i	Hypotension	✓																		●		I1i
I1j	Peripheral vascular disease	✓																	●			I1j
I1ee	Depression	✓																		●		I1ee
I1j	Cataracts	✓			●																	I1j
I1l	Glaucoma	✓			●																	I1l
I2	UTI	✓															●					I2
I3	Dehydration diagnosis	276.5															●					I3
J1a	Weight fluctuation	✓															●					J1a
J1c	Dehydrated	✓															●					J1c
J1d	Insufficient fluid	✓															●					J1d
J1f	Dizziness	✓													●					●		J1f
J1h	Fever	✓															●					J1h
J1i	Hallucinations	✓																		●		J1i
J1j	Internal bleeding	✓															●					J1j
J1k	Lung aspirations	✓																		●		J1k
J1m	Syncope	✓																		●		J1m

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

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Proceed to RAP Review once triggered

MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A @	ADL-Maintenance Trigger B @	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints
J1n	Unsteady gait	✓																			●	J1n
J4a,b	Fall	✓													●						●	J4a,b
J4c	Hip fracture	✓																			●	J4c
K1b	Swallowing problem	✓																			●	K1b
K1c	Mouth pain	✓																●				K1c
K3a	Weight loss	1														●						K3a
K4a	Taste alteration	✓														●						K4a
K4c	Leave 25% food	✓														●						K4c
K5a	Parenteral/IV feeding	✓														●		●				K5a
K5b	Feeding tube	✓															●	●				K5b
K5c	Mechanically altered	✓														●						K5c
K5d	Syringe feeding	✓														●						K5d
K5e	Therapeutic diet	✓														●						K5e
L1a,c,d,e	Dental	✓																	●			L1a,c,d,e
L1f	Daily cleaning teeth	Not ✓																	●			L1f
M2a	Pressure ulcer	2,3,4														●						M2a
M2a	Pressure ulcer	1,2,3,4																		●		M2a
M3	Previous pressure ulcer	1																		●		M3
M4c	Impaired tactile sense	✓																		●		M4c
N1a	Awake morning	✓											❷									N1a
N2	Involved in activities	0											❷									N2
N2	Involved in activities	2,3										●										N2
N5a,b	Refuses change in daily routine	1,2										●										N5a,b
O4a	Antipsychotics	1-7																		✻		O4a
O4b	Antianxiety	1-7													●					✻		O4b
O4c	Antidepressants	1-7													●					✻		O4c
O4d	Diuretic	1-7																●				O4d
P4c	Trunk restraint	1,2													●						●	P4c
P4c	Trunk restraint	2																	●			P4c
P4d	Limb restraint	1,2																			●	P4d
P4e	Chair prevents rising	1,2																			●	P4e

APPENDIX B

EXCERPTS FROM FEDERAL LAW AND REGULATIONS

ON

RESIDENTS' RIGHTS

QUALITY OF LIFE

RESIDENT ASSESSMENT

AND

QUALITY OF CARE

OMNIBUS BUDGET RECONCILIATION ACT OF 1967 AS AMENDED THROUGH 1991 MEDICAID REQUIREMENTS

(1) Quality of Life

(A) In general

A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

(c) Requirements relating to residents' rights

(1) General Rights

(A) Specified Rights

A nursing facility must protect and promote the rights of each resident, including each of the following rights:

(i) Free Choice

The right to choose a personal attending physician, to be fully informed in advance about care and treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(ii) Free From Restraints

The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed--

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

(v) Accommodation of needs

The right--

(i) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

(ii) to receive notice before the room or roommate of the resident in the facility is changed.

(D) Use of psychopharmacologic drugs

Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan [included in the written plan of care described in paragraph (2)] designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs.

Omnibus Budget Reconciliation Act of 1967, as Amended

(b) Requirements relating to provision of services

(2) Scope of services and activities under plan of care
A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in accordance with a written plan of care which--

(A) describes the medical, nursing and psychosocial needs of the resident and how such needs will be met;
(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and
(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

(4) Provision of services and activities

(A) In general
To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)--

(i) nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident;
(ii) medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident;
(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals) to meet the needs of each resident;
(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;
(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental and psychosocial well-being of each resident;
(vi) routine dental services (to the extent covered under the State plan) and emergency dental services to meet the needs of each resident; and
(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise provided or arranged for (or required to be provided or arranged for) by the State.

The services provided or arranged by the facility must meet professional standards of quality.

Omnibus Budget Reconciliation Act of 1987, as Amended

(3) Resident's assessment

(A) Requirement

A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment--

(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A) of this section;

(iii) uses an instrument which is specified by the State under subsection (e)(5) of this section; and

(iv) includes the identification of medical problems.

(B) Certification

(i) In general

Each assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

(ii) Penalty for falsification.

(I) An individual who willfully and knowingly certifies under clause (I) a material and false statement in a resident assessment is subject to a civil penalty of not more than $1,000 with respect to each assessment.

(II) An individual who willfully and knowingly causes another individual to certify under clause (I) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with resoect to each assessment.

(III) The provisions of section 1320a-7a of this title (other than subsections [a] and [b]) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1320a-7a(a) of this title.

(iii) Use of independent assessors

If a State determines, under a survey under subsection (g) of this section or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

(C) Frequency

(i) In general

Such an assessment must be conducted--

(I) promptly upon (but no later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than Ocober 1, 1991, for each resident of the facility on that date;

(II) promptly after a significant change in the resident's physical or mental condition; and

(III) in no case less often than once every 12 months.

(ii) Resident Review

The nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

(D) Use

The results of such an assessment shall be used in developing, reviewing and revising the resident's plan of care under paragraph (2).

APPENDIX C

ASSESSMENT AND CARE PLANNING:

A GUIDE FOR RESIDENTS AND FAMILIES

ASSESSMENT AND CARE PLANNING: THE KEY TO GOOD CARE
A Guide for Nursing Home Residents and Their Families

WHY DO YOU NEED TO KNOW ABOUT ASSESSMENT AND CARE PLANNING?

Every person in a nursing home has a right to good care, under the law. The law says the home must help people "attain or maintain" their highest level of well-being - physically, mentally and emotionally. To give good care staff must assess each resident and plan care to support each person's life-long patterns, and current interests, strengths and needs. Resident and family involvement in care planning give staff information they need to make sure residents get good care.

WHAT IS A RESIDENT ASSESSMENT?

Assessments gather information about how well residents can take care of yourselves and when you need help in "functional abilities" -- how well you can walk, talk, eat, dress, bathe, see, hear, communicate, understand and remember. Staff also ask about residents' habits, activities and relationships so they can help residents live more comfortably and feel more at home.

The assessment helps staff look for what is causing a problem. For instance, poor balance could be caused by medications, sitting too much, weak muscles, poor fitting shoes, a urinary infection or an ear ache. Staff must know the cause in order to give treatment.

WHAT IS A PLAN OF CARE?

A plan of care is a strategy for how the staff will help a resident. It says what each staff person will do and when it will happen (for instance -- The nursing assistant will help Mrs. Jones walk to each meal to build her strength.) Care plans must be reviewed regularly to make sure they work and must be revised as needed. For care plans to work, residents must feel like they meet your needs and must be comfortable with them. Care plans can address any medical or non-medical problem (example: incompatibility with a a roommate).

WHAT IS A CARE PLANNING CONFERENCE?

A care planning conference is a meeting where staff and residents/families talk about life in the facility -- meals, activities, therapies, personal schedule, medical and nursing care, and emotional needs. Residents/families can bring up problems, ask questions, or offer information to help staff provide care. All staff who work with a resident should be involved -- nursing assistants, nurse, physician, social worker, activities staff, dietician, occupational and physical therapists.

WHEN ARE CARE PLANNING CONFERENCES HELD?

Care planning meetings must occur every three months, and whenever there is a big change in a resident's physical or mental health that might require a change in care. The care plan must be done within 7 days after an assessment. Assessments must be done within 14 days of admission and at least once a year, with reviews every three months and when a resident's condition changes.

WHAT SHOULD YOU TALK ABOUT AT THE MEETING?

Talk about what you need, how you feel; ask questions about care and the daily routine, about food, activities, interests, staff, personal care, medications, how well you get around. Staff must talk to you about treatment decisions, such as medications and restraints, and can only do what you agree to. You may have to be persistent about your concerns and choices. For help with problems, contact your local "ombudsman," advocacy group or others listed on the next page.

HOW RESIDENTS AND THEIR FAMILIES CAN PARTICIPATE IN CARE PLANNING

Residents have the right to make choices about care, services, daily schedule and life in the facility, and to be involved n the care planning meeting. Participating is the only way to be heard.

Before the meeting:

* Tell staff how you feel, your concerns, what help you need or questions you have; plan your agenda of questions, needs, problems and goals for yourself and your care.
* Know, or ask your doctor or the staff, about your condition, care and treatment.
* Ask staff to hold the meeting when your family can come, if you want them there.

During the meeting:

* Discuss options for treatment and for meeting your needs and preferences. Ask questions if you need terms or procedures explained to you.
* Be sure you understand and agree with the care plan and feel it meets your needs. Ask for a copy of your care plan; ask with whom to talk to if you need changes in it.

After the meeting:

* See how your care plan is followed; talk with nurse aides, other staff or the doctor about it.

FAMILIES:

* Support your relative's agenda, choices and participation in the meeting.
* Even if your relative has dementia, involve her/him in care planning as much as possible. Always assume that she/he may understand and communicate at some level. Help the staff find ways to communicate with and work with your relative.
* Help watch how the care plan is working and talk with staff if questions arise.

A Good Care Plan Should:

* Be specific, individualized and written in common language that everyone can understand;
* Reflect residents' concerns and support residents' well-being, functioning and rights; Not label residents' choices or needs as "problem behaviors";
* Use a multi-disciplinary team approach and use outside referrals as needed;
* Be re-evaluated and revised routinely - Watch for care plans that never change.

IF YOU NEED HELP CONTACT:

Prepared by the National Citizens' Coalition for Nursing Home Reform
1424 16th Street N.W., Suite 202, Washington, DC, 20036; (202) 332-2275 — July, 1992

PROSPECTIVE PAYMENT SCHEDULE

ASSESSMENT SCHEDULE FOR NEWLY ADMITTED AND READMITTED MEDICARE BENEFICIARIES

Day 0	Represents the period prior to admission
Day 1	Patient admission day and notification of "Non-coverage"
Day 5	Last day for Assessment Reference Date for the Medicare 5 Day Assessment
Day 14	Last day for Assessment Reference Date for the Medicare 14 day Assessment(In accordance with Federal requirements at § 483.20, RAPs must be completed with the 5 day or the 14 day assessment)
Day 29	Last day for Assessment Reference Date for the Medicare 30 day assessment (RAPs not required for Medicare unless a Significant Change in Status has occurred)
Day 59	Last day for Assessment Reference Date for the Medicare 60 day assessment (RAPs not required for Medicare unless a Significant Change in Status has occurred)
Day 89	Last day for Assessment Reference Date for Medicare 90 day assessment (RAPs not required for Medicare unless a Significant Change in Status has occurred)
Day 100	100 Last possible day of Medicare coverage. Staff should return to the State-required MDS assessment schedule

MEDICARE ASSESSMENT SCHEDULE

Medicare MDS assessment type	Reason for assessment (AA8b code)	Assessment reference data	Number of days authorized for coverage and payment	Applicable medicare payment days
5 day	1	Day 1-8*	14	1 through 14
14 day	7	Day 11-14**	16	15 through 30
30 day	2	Day 21-29	30	31 through 60
60 day	3	Day 50-59	30	61 through 90
90 day	4	Day 80-89	10	91 through 100

*If a patient expires or transfers to another facility before day 8, the facility will still need to prepare an MDS as completely as possible for the RUG-III classification and Medicare payment purposes. Otherwise the days will be paid at the default rate.

**-RAPs follow federal rules; RAPs must be performed with either the 5-day or 14-day assessment.

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