

RAI-MDS 2.0 LTC Homes – Practice Requirements

Preamble

Implementation of the Resident Assessment Instrument – Minimum Data Set 2.0 (RAI-MDS 2.0) was initiated in the province of Ontario in June 2005 to improve the care of residents in LTC homes by standardizing the assessment and care planning process.

This document was originally communicated to RAI-MDS LTC Homes by Tim Burns, Director of Performance Improvement and Compliance Branch on October 31, 2007 to support the effective and streamlined implementation of RAI-MDS 2.0. The purpose of this document was to outline the expectations and RAI-MDS 2.0 practice requirements for Ontario Long-Term Care Homes.

1. The Resident Assessment Instrument - Minimum Data Set (RAI-MDS) 2.0 is the standardized assessment tool for admission, quarterly, significant change in health status and annual assessments for each resident.
2. The use of other assessment tools, in addition to RAI-MDS 2.0 should only be necessary following the MDS assessment and Resident Assessment Protocols (RAPs) analysis when clinicians, based on their clinical judgment, make a decision to make a referral and/or conduct further assessment for the development of a comprehensive resident plan of care.
3. The Minimum Data Set (MDS) and Resident Assessment Protocols (RAPs) cannot be completed prior to the Assessment Reference Date (ARD). The ARD is the last day of the observation period. The ARD should be set with input from the interdisciplinary care team.
4. Each new resident must be assessed by the interdisciplinary care team using the MDS 2.0 Full Assessment within 14 days of admission.
5. Each resident's care and service needs shall be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the ARD of the previous assessment.
6. Any significant change in resident's condition, either decline or improvement, shall be reassessed along with RAPs by the interdisciplinary care team using the MDS Full Assessment by the 14th day following the determination that a significant change in status has occurred.
7. A 'significant change in the resident's health status' resulting in the completion of a Full MDS Assessment in the same quarter in which the annual or quarterly assessment is due, may replace the quarterly or annual assessment for that period.
8. Criteria for determining a significant change in status is identified in the Resident Assessment Instrument (RAI) MDS 2.0 and RAPs Canadian Version User's Manual, Second Edition, March 2005, pp 3-7, 3-8, 3-9. A "significant change" is defined as a major change in the resident's health status that:
 - Is not self-limiting
 - Impacts on more than one area of the resident's health status; and
 - Required interdisciplinary review and/or revision of the care plan.
9. For new admissions:
 - A written plan of care shall be initiated for each new resident within 24 hours of admission and be finalized by the interdisciplinary care team by day 21 maximum from admission or 7 days maximum after the date at VB2.
 - Resident assessment protocols (RAPs) must be generated and reviewed and RAPs assessment summaries must be completed for triggered RAPS and non-triggered clinical conditions by day 14 maximum.

10. For all other assessments (quarterly, significant change in the resident's health status):
 - The care plan must be reviewed by the interdisciplinary care team and where necessary revised, within 14 days of the assessment ARD or within 7 days maximum following the date at VB2.
 - RAPs must be generated and reviewed and RAPs assessment summaries must be completed for triggered RAPs and non-triggered clinical conditions within 7 days maximum of the Assessment Reference Date (ARD).
11. Where a significant change in the resident's health has resulted in the completion of a Full Assessment, then the Full Assessment may replace the Quarterly Assessment for that quarter.
12. Each resident is assessed annually by the interdisciplinary care team using the MDS Full Assessment within 366 days of the ARD of the previous Full Assessment, along with RAPs and care plan review and update.
13. The MDS 2.0 assessment instrument is a primary source document and includes the following requirements:
 - With the exception of medical diagnoses, test results or examinations, physician orders, nursing rehabilitation and therapies, duplicate documentation is not required to support all MDS assessment items
 - RAI-MDS 2.0 assessment information comes from multiple sources: observations, review of clinical records, plans of care, as well as interviews with the resident, significant others and team members
 - The MDS assessment and RAI outputs (outcome scales, quality indicators) identify actual and potential resident care needs and provide the evidence on which to conduct the critical analysis of RAPs and to base decisions related to care planning.
14. For quarterly and significant change in status assessments that do not take the place of the full annual assessment, the following standard statement may be used for 'existing' triggered RAPs that have no clinical and/or care plan changes.

This is an existing RAP. The resident is responding to the interventions as outlined in the care plan. His/her clinical assessment has not changed from the last assessment. Care plan goals and interventions have been reviewed by the care team members and continue to be effective in (preventing, proving or maintaining) the RAP problem.

15. For the initial admission and annual full assessments, all RAPs must be reviewed and treated as new and no standard statement may be used.
16. Care plan interventions shall be implemented and evaluated for their effectiveness. There shall be evidence in the health care record to support the decision for no changes in the plan of care.
17. The RAPs assessment summaries and plan of care for triggered RAPs may be combined, if the goals of care, risk factors, care interventions, and treatments are all interrelated. Combined RAPs assessment summaries and plan of care may be used for comprehensive admission, quarterly, annual and/or significant change in health status assessment.