

CENTRAL STATE HOSPITAL
POLICY

SUBJECT: **COMPREHENSIVE CLIENT ASSESSMENT: CRAIG CENTER**

ANNUAL REVIEW MONTH: October

RESPONSIBLE FOR REVIEW: Director of Nursing

LAST REVISION DATE: April 2009

I. GENERAL

The purpose of this policy is to ensure compliance with the Omnibus Budget Reconciliation Act of 1987 (OBRA) governing nursing facilities. A comprehensive assessment must be completed on all admissions to nursing facilities. The Centers for Medicare/Medicaid Services (CMS) is responsible for specifying the Resident Assessment Instrument (RAI). This instrument is a standardized system comprised of the Minimum Data Set (MDS) and Resident Assessment Protocols (RAP), including triggers which result in a comprehensive and standardized assessment of each client's functional capabilities.

II. BASIC COMPONENTS OF A COMPREHENSIVE ASSESSMENT

- A. A description of the client's physical and mental strengths and deficits.
- B. A listing of the client's equipment/staff assistance needs.
- C. Identified risk factors.

III. DEFINITIONS

- A. MDS - Minimum Data Set
A minimum set of screening and assessment elements needed to comprehensively assess an individual nursing home client.
- B. Triggers
Levels of measurement (coding categories) of MDS elements that serve to identify clients who may require further evaluation using Resident Assessment Protocols.
- C. RAP - Resident Assessment Protocols
Structured framework for organizing MDS elements and additional clinically

relevant information about an individual that contributes to care planning.

IV. **FREQUENCY OF CONDUCTING COMPREHENSIVE RESIDENT ASSESSMENT**

Comprehensive Client Assessments shall be conducted no later than fourteen days after admission to the Craig Center (CC) and at least annually thereafter. New assessments shall be completed when there is a significant change in the client's condition. All clients must be reviewed at least quarterly and documentation of this quarterly review should be reflected in the progress notes with a summary of all aspects of progress or decline in accordance with the individual Client Care Plan.

V. **ASSIGNED STAFF**

Each Comprehensive Client Assessment must be coordinated by a registered nurse. Individual staff members completing portions of the assessment must also sign in the signature section.

These disciplines shall complete the following sections:

- A. MDS Nursing Facility Client Assessment and Care Screening - Background Information at Admission - Social Work
- B. MDS Nursing Facility Client Assessment and Care Screening

Section	A.	Social Work
	B.	Nursing/Psychology
	C.	Nursing
	D.	Nursing
	E.	Nursing
	F.	Nursing
	G.	Social Work/Nursing/Psychology
	H.	Nursing
	I.	Nursing
	J.	Nursing
	K.	Dietitian
	L.	Nursing
	M.	Nursing
	N.	Nursing
	O.	Nursing
	P.	Nursing

VI. **CLIENT CARE PLANS**

Client Care Plans (IP/IAP) must be completed within seven (7) days of the assessment and must be prepared by an interdisciplinary team that includes:

- A. Physician
- B. Registered Nurse

- C. Social work representative
- D. other appropriate staff
- E. the client and, to the extent possible and appropriate, the client's family and/or legal representative

Approved:

This policy has been approved by the CEO and CMO on 4/20/09.