RAI-MDS for Residential Care

1. Introduction

Description

The use of the Resident Assessment Instrument (RAI) is mandated by the B.C. Ministry of Health and is an internationally researched tool. It promotes evidence-informed clinical decisions to improve care provision and quality of life for the residents living in a residential care facility.

The RAI includes the Minimum Data Set (MDS), a functional clinical assessment, and four RAI outputs: Clinical Assessment Protocols (CAPs), Outcome Scales, Quality Indicators (QIs), and Resource Utilization Groups (RUGs). The RAI outputs provide information about an individual or groups of residents and are a source of data that may be used at the clinical, management, regional, provincial, and national levels to support decisions concerning care for the resident, quality improvement, accreditation, resource allocation, and health care policy.

Scope

This policy applies regionally to Vancouver Coastal Health (VCH) residential complex care facilities as defined by the Home and Community Care Policy Manual. Included are all sites owned and operated by VCH and affiliate sites funded by VCH.

RAI-MDS use for Short Term Stay Residents is not required. Use of RAI-MDS for residents in a private pay bed within a VCH residential care facility is encouraged but is optional.

2. Policy

2.1. RAI Assessments

The RAI-MDS must be completed for all permanent residents on admission, quarterly, annually, with significant change, and on discharge. The full application of RAI-MDS includes both assessment and use of RAI CAPs and Outcome Scales to inform a resident-centered care plan.

RAI completion must follow the rules and conventions set by interRAI and the Canadian Institute for Health Information (CIHI). These rules and conventions include:

- Admission: the Admission/Re-entry Form and Full Assessment are to be completed by Day 14 following admission (Admission day is Day 0).
- Quarterly: the Quarterly Assessment is to be completed at a minimum of every 92 days between Full Assessments.
- Annually: the Full Assessment is to be completed at a minimum of every 366 days.

- Significant Change: the Full Assessment is to be completed within 14 days following the determination that the resident meets the RAI definition for a 'Significant Change in Status'.
- Discharge: the Discharge Form will be completed upon discharge from the facility.

2.2. Care Plans

Following a RAI assessment, the resulting CAPs and Outcome Scales must be used to inform a resident-centered care plan and/or evaluate a previous care plan. RAI informed care plans must be completed by Day 21 following admission. Care plans must be reviewed and updated within 7 days following the RAI quarterly, annual, and significant change assessments.

2.3. Data Submission

All residential care facilities will submit RAI data through VCH Decision Support to the CIHI Continuing Care Reporting System (CCRS). Facilities are to follow VCH and CIHI data submission and correction processes and timelines. The licensing agreement with InterRAI for use of the RAI tools includes a requirement to share assessment data with InterRAI for research purposes.

2.4. Responsibilities

2.4.1. Professional Staff (RAI Assessors)

Designated professional staff whose scope of practice includes assessment and care planning will complete the RAI-MDS, as described in 2.1 RAI Assessments. Professional staff may include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Interdisciplinary Professional staff such as Physiotherapists, Occupational and Speech Therapists, Social Workers, Dieticians, Recreational and Music Therapists, and are referred to as 'RAI Assessors' for the remainder of this document.

RAI assessors will:

i) Complete the RAI-MDS only after receiving the VCH standardized RAI education or after demonstration of RAI coding competency if previously trained, for example by another health region. RAI-MDS is to be completed using the MDS forms, intent, definitions, and coding criteria outlined by interRAI and CIHI in the most current RAI User's Manual and CIHI communications.

ii) Demonstrate coding accuracy on a yearly basis according to a process set by the facility.

iii) Use CAPs and Outcome Scales to help form the resident care plan.

2.4.2. Residential Care Facilities

Residential Care Facilities are required to:

i) Designate which professional staff will complete the RAI for each resident and outline how RAI is integrated into workflow.

ii) Assign each resident to a RAI Assessor, preferably someone who knows the resident well.

iii) Ensure each RAI Assessor receives VCH standardized RAI education or demonstrates RAI coding competency if they were trained in another health region prior to completing RAI-MDS.

iv) Monitor completion of RAI assessments according to timelines specified by interRAI and CIHI, as outlined in 2.1 RAI Assessments and 2.2 Care Plans.

v) Ensure each RAI Assessor receives appropriate software training.

vi) Have processes in place to support care planning using CAPs and Outcome Scales.

vii) Have data submission processes in place.

viii) Assign responsibility and have a process for data corrections.

ix) Keeps a record for each RAI Assessor's completion of an annual AIS (Assessment & Intelligence Systems) coding accuracy evaluation. If not using AIS, facilities must have a VCH approved tool or process in place to show that coding accuracy is demonstrated for each RAI Assessor.

x) Use CIHI approved software with up-to-date CIHI specifications.

2.4.3. VCH Decision Support

Decision Support receives, maintains, and submits RAI data on behalf of facility sites to CIHI CCRS in accordance with interRAI and CIHI guidelines. In addition, Decision Support facilitates VCH reporting requirements using RAI data. They also provide data analysis and RAI data reports upon request.

2.4.4. RAI Clinical Educators

RAI Clinical Educators are CIHI educated and provide VCH standardized RAI education that aligns with the most current standards set by interRAI and CIHI.

2.5. Compliance

The VCH Regional Complex Care Working Group (RCCWG) will monitor compliance of this policy and determine subsequent appropriate actions.

A Quarterly VCH RAI Quality Report/Dashboard produced by VCH Decision Support will show completion and submission rates.

Quarterly reports from Community Care Facilities Licensing will list any residential care facilities that have not used CAPs and Outcome Scales for care planning.

Annual AIS reports will show completion rates for the annual coding accuracy evaluation. Facilities using a VCH approved tool or process must provide an annual record with 90% staff completion.

3. References

Tools, Forms and Guidelines

- Resident Assessment Instrument (RAI) RAI-MDS 2.0 User's Manual, Canadian Version
- interRAI Clinical Assessment Protocols (CAPs) Manual

Related Policies

None

Keywords

RAI, RAI-MDS, MDS, RAI 2.0, RAI-MDS 2.0, RAI-RC, residential care, assessment, interRAI, CIHI, CAPs, Clinical Assessment Protocols, Outcome Scales, RUGs, Resource Utilization Groups, QIs, Quality Indicators, AIS

Definitions

"AIS (Assessment & Intelligence Systems)"is a web-based system that provides self-directed RAI education modules and coding accuracy evaluations.

"CIHI (Canadian Institute for Health Information)"is an independent, not-for-profit organization that provides information on Canada's health care system. CIHI's vision is "Better data. Better decisions. Healthier Canadians". The CIHI Continuing Care Reporting System (CCRS) is the Canadian central repository for the RAI-MDS assessment data. CIHI partners with interRAI in releasing the latest interRAI guidelines and specifications.

"interRAI"is a collaborative international consortium of researchers from over 30 countries who have developed the RAI-MDS 2.0 and other RAI tools aimed at improving health care for persons across the continuum of care, who are elderly, frail, and/or impaired physically or mentally. Their goal is to promote evidence-based clinical practice and evidence-informed policy decisions which can result when high quality data about the characteristics and outcomes of persons served across a variety of health and social services settings is collected and interpreted.

"RAI (Resident Assessment Instrument)" encompasses the Minimum Data Set (MDS) assessment and RAI Outputs including Clinical Assessment Protocols (CAPS), Outcome Scales,

Resource Utilization Groups (RUGs) and Quality Indicators (QIs). Embedded algorithms within the RAI-MDS assessment software are used to calculate these RAI Outputs:

i) **CAPs (Clinical Assessment Protocols)"** are a RAI Output which identify problems, risk factors and areas of potential benefit. The CAP guidelines inform the clinical process by leading the RAI Assessor through a systematic review of relevant underlying issues towards developing a plan of care.

ii) **Outcome Scales** are a RAI Output which offer a numeric description of the resident's current clinical status in the following areas: cognitive performance, activities of daily living, pain, depression, behaviours, risk for pressure ulcers, social engagement, and medical frailty. The scales have been researched by the interRAI group and some scales have been validated against well known and used scales.

iii) **"Resource Utilization Groups (RUGs)**" are based on a case mix methodology which categorizes resident assessments by their clinical characteristics and resource use. The RUGs provide an indication of what resources were used during the assessment observation period, not the resources required.

iv) **"Quality Indicators (QIs)"** are summary measures that indicate potential poor practices, strengths, and trends over time. Risk adjusted QIs can be used for comparative analysis.

"**RAI Assessors**" are Professional staff and may include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Interdisciplinary Professional staff such as Physiotherapists, Occupational, and Speech Therapists, Social Workers, Dieticians, Recreational and Music Therapists.

"Significant Change in Status" means "a major change (improvement or decline) in the resident's status that: is not self-limiting; impacts on more than one area of the resident's health status; and requires interdisciplinary review and/or revision of the care plan" (*RAI-MDS 2.0 User's Manual, Canadian Version, February 2012, p. 13-17).*

"Short Term Stay Residents" include, but are not limited to, residents admitted (usually for less than 3 months) for respite, convalescent, or hospice palliative care. (Ministry of Health Home and Community Care Policy Manual, 6.A).

Questions

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