MDS Alert

Documentation: Up the Ante On Admission Evaluation Notes

Think of nursing notes as an effort that can illuminate care delivery and make staff's lives easier.

Doing some comprehensive groundwork at the very beginning can better your delivery of care and simplify life for team members down the line.

While the MDS, care plans, and the clinical record are all living documents, establishing baseline versions of each that cover all of the body systems, goals, and general responsibilities and care is good practice.

Look to these areas when evaluating a resident upon admission or readmission, says **Kathy Monahan**, specialist at **Harmony Healthcare International** in Topsfield, Massachusetts.

Think about compiling each of these documents, and any nursing notes, not just as medical records but as a narrative of the resident's care, both thus far and as a trajectory.

Establish a Template - And Use It

If you don't already have a template to utilize during admissions, you're missing a big opportunity to make your care planning as comprehensive as possible. A template allows your team members to assess and evaluate each resident with an eye toward consistency. Even if a less experienced team member is checking in a resident, a template allows that team member to look for all of the things your most experienced staff member would look for, which builds staff confidence and competency as well.

Beware: According to the Centers for Medicare and Medicaid Medicare Learning Network, lack of documentation causes the majority of "improper payments."

Craft your template so it's easy to understand and use. You can organize it so it roughly - or specifically - corresponds to the information necessary to complete the MDS.

Or you can organize so that the details correspond with whatever is most important for your staff. For example, if your facility doesn't have an area that is lockable and safe for wandering or delirious residents, your staff will need to prioritize keeping an eye anyone experiencing wandering or signs of delirium.

Include These Key Areas

Besides organizing your admission template around key areas, include space for special staff instructions as well as resident goals. For example, when observing and documenting behavior and cognitive patterns, include goals for making sure the resident remains alert and comfortable - and note their hearing and vision as well, as they impact both.

Write Notes as a Narrative

Encouraging staff to write their admission notes in narrative form may make the information easier to digest quickly and comprehensively. Instead of team members needing to page through pages of the clinical record (even from a different facility, etc.) or scattered observations, they can utilize a single paragraph that includes all of the most important information.

Monahan recommends including these key points in your admission narrative:

- "Time and date of admission"

- "Mode of transportation, assist level and number of assist with transfers and bed mobility”
- Activity of daily living (ADL) "care provided (bed mobility, eating, transfer, toilet).”
- "Location prior to admission”
- "Age, primary diagnosis, other pertinent medical history”
- "Prior level of functioning and if possible, discharge diagnoses”
- "List daily skilled needs.”

Consider which staff would be responsible for which aspects of care and consider further organizing your notes so other team members can easily see what they - and others in that role - are responsible for handling. Check out this example Monahan provides, with some minor adjustments for relevancy:

"Resident was admitted on 6/21/18 at 5:30 p.m. from hospital, via ambulance requiring 2-person staff assist with transfer from the stretcher and for positioning on the bed. Primary diagnosis is s/p left TKR performed on 6/18/18. Medical history includes IDDM, HTN, and CAD. He lives with his wife and he ambulated with a cane, and he plans to return home. Resident self -administered his medication daily. **Resident will require daily skilled nursing assessments for complications related to knee replacement and multiple medical complications**. He currently requires assist of 2 for toileting using bedside commode. Three-inch surgical incision on left knee is clean, dry, staples in place. He eats independently with set-up. **Daily observation and assessment of vital signs, monitoring for pain and response to medication, daily assessment of wound, drainage and treatment, effects of immobility, pulmonary assessment, observation for signs and symptoms of infection, hypo- or hyperglycemia, embolism and thrombophlebitis.**”

Notice how the bolded statements are particular to different roles within a facility's organization and staff. Registered/licensed nurses must be responsible for the skilled assessments and care of the wound site and the monitoring and distribution of medication. Certified nursing assistants and other staff are needed to complete the assists for various activities of daily living (ADLs). Consider using similar differentiation in type to make the various roles and responsibilities even more immediately visible and digestible for staff.

Tip: Get ready for the coming Phase 3 changes to Requirements of Participation (RoPs) by assessing and incorporating anything that causes the resident to struggle and would affect how staff can best interact with each resident, including whether she's experienced trauma or addiction.

Go even further in making your notes count for multiple uses by incorporating these considerations that Monahan offers, which build on how you organize the narrative and which information to include:

- **Inherent Complexity**:
  "Direct skilled nursing services that due to their inherent complexity may only be performed by a licensed nurse.”
- **"Skilled observation and Assessment:**
  Indicated when there is a reasonable probability or possibility for complication or the potential for further acute episodes.”
- **Management and Evaluation of a Care Plan:**
  "Based on the physician's orders, these services require the involvement of skilled nursing to meet the resident's medical needs, promote recovery and ensure medical safety. This area may include the sum of unskilled services.”
- **Teaching and Training:**
  "Activities which require skilled nursing or skilled rehabilitation personnel to teach a resident and/or family member how to manage the patient's treatment regimen.”

Bottom line: Every resident's admission assessment and notes are a chance to lay the groundwork for delivering more comprehensive and person-centered care, while saving staff time and energy.