**The Salvation Army – William Booth Special Care Home**

**Diagnostic Tests Policies and Procedures**

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# Minimum Data Set (MDS)

**POLICY:**

This policy is written to provide direction on the Resident Assessment Instrument (RAI) - Minimum Data Set (MDS).

The Minimum Data Set (MDS) is a standardized assessment tool of health status that forms the foundation of the comprehensive assessment for all residents in long-term care facilities. The MDS contains items that measure physical, psychological and psychosocial functioning. The items in the MDS give a multidimensional view of the resident’s functional capacities and help to identify health problems.

All Residents admitted to WBSCH Long Term Care will be assessed using the RAI-MDS. The RAI-MDS is the standardized assessment tool approved by the Ministry of Health.

RAI-MDS forms the foundation of the comprehensive assessment for all residents admitted to WBSCH Long Term Care. The RAI-MDS contains items that measure physical, psychological and psychosocial functioning, give a multidimensional view of the resident’s functional capacities, and help to identify health problems.

At WBSCH, the completion of RAI-MDS is a component of LTC licensed staff **primary care assignment**. The assigned licensed staff is responsible for the accurate completion of the RAI-MDS and Care Plan within the timelines for completion.

**EQUIPMENT:**

* MDS accessed through PointClickCare / clinical / MDS tab
* Progress notes (type – behavior, dressings / wounds, falls, hospitalization, incident, infection, pain, physician orders)
* Completed MDS skin / nail condition form (purple form)

**PROCEDURE:**

**CRITERIA for completing MDS 2.0 Canadian Version FULL ASSESSMENT**:

* A MDS FULL ASSESSMENT shall be completed by **day 14** after admission. Admission day is considered **day zero**.
* Only the MDS 2.0 Canadian Version FULL ASSESSMENT is used at WBSCH. The FULL ASSESSSMENT is used on **admission**, **quarterly review**, **annual review**, and when there is a “**significant change**”.
* A **quarterly review** shall be initiated no later than **3 months** following the Assessment Reference Date of the preceding assessment (**Section A3** – last day of MDS observation period).
* **14 calendar days** following a “**significant change**” in Resident status, a MDS FULL ASSESSMENT shall be completed. A “significant change” should be considered when there has been a consistent decline or improvement in two or more areas of Resident functioning.

**TIMELINE standards for completion of MDS Assessment:**

* **Day 0**  Admission Day
* **Day 1 – 7** 7 Day Assessment Period (tick sheet)
* **Day 7** Assessment Reference Date - last day of MDS observation period (Section A3)
* **Day 8 – 14** MDS data entry complete
* **Day 15 – 21** CAPS MDS care plan development
* **Day 21** MDS assessment completed, verified and locked
* **Day 21** Care Plan completed

**Resident, Facility and Assessor NUMBERS**:

* Resident Number – **Medical Record Number** (MRN) shall be used as the Resident identifier on all MDS assessments (Section A6a)
* Facility Number – Saskatchewan Health Facility numbers shall be sued as the facility identifier on all MDS assessments (Section AA6) **WBSCH 73558**
* Assessor Number – there will be no assessor numbers for the employees at WBSCH (Section R2 leave blank)

**Certification of Accuracy / Legality**:

* All MDS assessments must be signed authenticating the assessment data in order for them to be considered a legal document. An electronic signature is equivalent to a written signature. Each assessor must sign for the section or items completed.
* The MDS assessment shall be signed by Day 21

**Locking and Unlocking Electronic MDS Assessment:**

* The DOC / designate will have the authority to Lock and Unlock Electronic MDS assessment. No other staff will be permitted to Unlock electronic MDS assessments.
* Once MDS assessment data has been entered, the MDS assessment data is to be locked by Day 21.

**MDS Documentation:**

* A paper copy of the MDS assessment(s) and CAPS shall be kept on the Resident chart for one full year.

**Ministry of Health Requirements**:

* Quarterly, MDS scores shall be electronically submitted to the Ministry of Health

Sources:

Program Guidelines for SCH (2015), Section 9

Canadian Institute for Health information RAI-MDS 2.0 USER MANUAL (2012)

**Approval/Implementation/Evaluation Process**

Date Approved / Revised: November 28/02; January 30/06: September 29/15

Review date: August 22/16

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Master Signature Sheet

**POLICY:**

All care staff who documents on the Resident’s health record will sign the Master Signature Sheet.

WBSCH recognizes as valid the use of care staff initials on the Resident’s health record, provided the Master Signature Sheet has been signed according to the Procedure. The Master Signature Sheet ensures identification of the writer by his/her initials.

**PROCEDURE:**

All care staff are required to sign the Master Signature Sheet:

* Annually (in January)
* During orientation to WBSCH

The Master Signature List will include the individual’s printed name, signature, initials, and date. The Master Signature List is grouped according to position / status.

The Master Signature Sheet will be retained in the Administrative area.

Annually (January), notification will be given to all care staff of the requirement to sign the annual Master Signature Sheet.

**Approval/Implementation/Evaluation Process**

Date Approved / Revised: January 17/11

Review date:

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Thinning Of Resident Records / Charts

**POLICY:**

Staff may thin charts according to the following procedure. All items which are thinned from the current chart are to be sent to the “Receptionist” for permanent retention (according to Salvation Army guidelines) in the locked file room downstairs.

**PROCEDURE:**

**Physician’s Order sheet and Quarterly Medication Review**

* To remain on chart for one year, then sent to the secure file room.
* The signed QMR is considered to be a Physician order and therefore is to be filed in chronological order (starting with most recent order/date) in the resident’s chart, in the Physician’s Orders section.

**Physician’s Progress Notes**

* Physician Progress Notes to remain on the chart for one year then sent to the secure file room.

**MAR**

* MAR remain on chart for 6 months, and then sent to the secure file room.

**MDS**

* Quarterly MDS (paper copy) are to remain on chart for one year.
* As the MDS is stored electronically, the MDS (paper copy) in excess of one year can be sent for shredding (confidential document).

**Flow Sheets** –

* Any type of paper flow sheet will remain on the current chart for 6 months, then sent to the secure file room (i.e.: behavior monitoring; DOS charting; in and out sheets; etc)

**Lab and Special Reports**

* All routine lab reports to remain on chart for one year, then sent to the secure file room.
* Radiology, ultrasound and ECG reports remain on the current chart.

**Immunization**

* Remain on the current chart

**Consults**

* All Consults are to remain in chart
* Examples (i.e.: Mental Health / Psychiatrist consultation reports; Specialist consultation report; Swallowing assessment report; operative record; approval for oxygen; approval for exceptional drug status).

**History and Px**

* Completed Care Conference forms – are to remain on chart.
* Referral information sheets – remain on chart for one year, then sent to the secure file room
* MMS / MOCA – are to remain on chart.

**Misc. Records**

* remain on chart for one year, then sent to secure file room (i.e.: change in doctor form, interagency referral form, etc)

**Approval/Implementation/Evaluation Process**

Date Approved / Revised: January 17/11

Review date: September 2016

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_