The Common Assessment Instrument:
Residents are the Biggest Winners

Nestled in the small rural town of Mount Forest, Ontario, Saugeen Valley Nursing Centre houses 87 beds and provides 24-hour nursing care as well as short-term respite care.

The home's management team has always welcomed opportunities to improve the quality of resident care, which is why Administrator Andrea Parsons was excited at the opportunity to have Saugeen Valley join the Long-Term Care Homes Common Assessment Project (LTCH CAP) — in doing so, becoming one of the first homes to adopt the Resident Assessment Instrument Minimum Data Set (RAI-MDS 2.0).

For more than two years now, the LTCH CAP project has been facilitating the implementation of this common assessment instrument in Ontario's long term care homes. Homes are provided with free training and tools, guidance and support. This includes a dedicated educator, a comprehensive intranet site, which includes up-to-date information on all aspects of the initiative, and a Project Support Centre, where project team members answer inquiries by phone and e-mail.

Andrea was already familiar with the movement towards common assessment in the health care sector. As a post-graduate student in health studies at the University of Waterloo, Andrea had written a paper on the significance of RAI instruments. Therefore, the decision to join LTCH CAP was a no-brainer for her. In September 2005, Saugeen Valley became one of the first 20 homes in Ontario to begin the transition to RAI-MDS 2.0.

by David Abbou

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"I had researched and understood the RAI-MDS model, and I could see the many important benefits it would give to our residents," explains Andrea, who has worked in long term care since 1993.

All about the resident

RAI-MDS 2.0 is already being used in 20 countries, including the United States, United Kingdom, Germany, Italy, France, Japan and Australia, as well as several provinces and territories in Canada. Ontario is now among the leaders, using the full RAI-MDS 2.0 approach to create in-depth care plans. By incorporating each resident's strengths, preferences and needs into the assessment from all aspects of the care team involved, the results enable an in-depth care plan that is tailored to the resident.

Kim McCarthy was selected to be Saugeen Valley's RAI Coordinator. A RN and RPN in long term care for nearly 20 years, Kim was excited to learn how RAI-MDS differs from the present data collection process.

"With the other classification process, if you had a resident who was completely dependent on staff for day-to-day needs, you received optimal funding," explains the Ryerson University graduate. "With RAI-MDS, you are rewarded for using resources with interventions to rehabilitate and enable the resident. RAI-MDS focuses on making the resident the best he or she can be, with the emphasis on improving quality of life."

At its core, the RAI-MDS assessment is designed to give homes a holistic view of the needs, risks, strengths and preferences of each resident. Resident Assessment Protocols (RAPs) in the assessment alert the care team of actual or potential risks that may require further assessment or a referral to the appropriate health professional. This allows the care team to identify risks or problems earlier and to take action.

"The RAPs look at the resident from a holistic aspect. It is more thorough than any assessment that's been used in the past, and it encourages you to look at the resident from the top of the head to the tip of the toe," explains Kim.

Kim remembers when a new resident arrived at Saugeen Valley from a nearby hospital. The resident was not eating or sleeping well, and exhibited unhappiness with home staff on a daily basis. The resident was equally as negative when family visited. Often expressing discontent at being admitted to a long term care home, the resident even attempted to elope from the home.

However, coding within the RAI-MDS 2.0 revealed that this resident was suffering from depression, delirium and dementia. The care team acted promptly to treat these conditions and provided the appropriate medications. During the team's investigation, it was also discovered that the resident was a passionate piano player and missed not being able to play. Management contacted the family about moving the piano into the home. The results were dramatic, with improvements to scores in the resident's Cognitive Performance Scale (CPS) and Depression Rating Scale (DRS). Within 30 days, the resident became much more independent and was freely socializing with other residents, something the resident had never done before. Quality of life had sharply improved.

Kim believes the RAI-MDS has been instrumental in benefiting many other residents in the same way. "The RAI-MDS brings issues to your attention much faster and allows you to act earlier. In the past, the data gathering for such a resident could have taken much more time."

The RAI-MDS also prompted Saugeen Valley's care team to meet regularly and share information on specific residents. These brainstorming sessions would often include a clinical resource nurse, dietary advisor, therapeutic program aid and frontline support workers, as well as other disciplines.

"The RAI-MDS process encourages communication among the different disciplines," says Kim. "It also gives nurses the opportunity to think critically and take a leadership role. Ultimately, it makes us more responsive to the needs of the resident."

While the benefits of the assessment became clear for the care team at Saugeen Valley, some staff members were initially concerned that they would be spending more time behind a computer and not enough time tending to the needs of residents. The management team wanted staff to realize the long-term benefits of this transition. "It's important for staff to see that they can make a difference to our residents. With RAI-MDS, we can see and feel the impact," says Andrea.

Outcome measures pinpoint problems

The outcome measures within the RAI-MDS give the care team a clear indication of the progress they are making with a resident. Measures such as the Depression Rating Scale (DRS) indicate the severity of a resident's depression. A score of 3 or higher tells the nurse that the resident is clinically depressed. This allows nurses to quantitatively measure a resident's condition and strive to improve the DRS score. "The RAI-MDS allows nurses to see the evidence-based care in practice," explains Kim.

Kim remembers the difference that the DRS scale made for a particular resident, who exhibited a generally gloomy outlook on life that concerned the care team. He would venture out of his bed only to eat his meals and he never interacted with his fellow residents. After being assessed using the RAI-MDS, it was clear that he was suffering from a form of depression not revealed earlier. The need to change both the amount and type of medication was identified. The staff made the necessary changes until the DRS score indicated the treatment was effective. The resident felt like himself again. He began taking walks outdoors and would visit and socialize with other residents. His surprising improvement put a smile on the faces of residents, family members and caregivers alike.

With all of the success that has been achieved through RAI-MDS 2.0 implementation, the impact of the instrument on residents could not be realized without the leadership and support of Kim and the staff at Saugeen Valley.

Although Saugeen Valley completed the implementation of RAI-MDS 2.0 in October 2006, the home continues to work with the project to continually improve the new RAI-MDS world. At the moment, they are participating in a valuable streamlining initiative intended to reduce workload duplication and make administrative processes more efficient, as well as in a Best Practice Coordinator Working Group and the development of the RAI-MDS 2.0 resource guide for nutritional care. All of these initiatives will help improve resident care even further.

"It's a great opportunity to avoid some of the redundancies during admissions, quarterly reviews and other processes," says Kim about the streamlining initiative. "In the past, each department would collect the same information for three to five different assessments for an admission or quarterly review. The RAI-MDS assessment tool brings a standardized assessment to the interdisciplinary team and empowers team members to critically decide which further assessments are needed for each resident."

Other important processes that are affected by the RAI-MDS are the home's Continuous Quality Improvement program, which monitors the following quality indicators: restraints, urinary tract infections, ulcers and falls. The RAI-MDS data inform the care team on these specific areas and flag residents who are at risk. The information enables the care team to mobilize resources and implement best practice guidelines to improve resident care outcomes.

The Saugeen Valley Care Team
From left to right: Therapeutic Program Aid Carla Bonnema, Personal Support Worker (PSW) Lea-Ann Neulitz, PSW Paula Murray, PSW Peggy O'Neil, PSW Kim Nickel, RAI Coordinator Kim McCarthy, PSW Kathy Bryant, Nurse Clerk Laurie Mahar, PSW Donna Morris and Administrator Andrea Parsons.

The road ahead

After an additional 58 homes joined the Project's phase five in January, 35 per cent of the province's long term care homes have now taken the road towards RAI-MDS 2.0, making it a matter of time before the benefits of common assessment will be realized by all residents in Ontario.

"The RAI-MDS is so resident-focused; residents are at the centre of virtually all of the initiatives being worked on in our home," explains Kim. "It makes a huge impact on long term care — and the main person who benefits is the resident, which is the way it should be." **LTC**