ASSESSMENT AND DIAGNOSIS

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Impacted F-tags: F641 Accuracy of Assessments, F658 Services Provided Meet Professional Standards, F841 Responsibilities of Medical Director, F642 Coordination/Certification of Assessment (REMOVED)

Critical Element Pathway: Resident Assessment

MAIN POINTS

- Surveyors are not evaluating the clinician's judgment in assigning diagnoses but rather the existence of appropriate documentation to support assignment of the specific diagnosis.
- Diagnoses must be made in accordance with professional standards of care / accepted standards of practice.
- Diagnoses, or maintenance of a given diagnosis, must be supported by a comprehensive assessment that evaluates the resident's physical, behavioral, mental, and psychosocial status and comorbid conditions.
- Existing diagnoses must be evaluated on admission to confirm that the diagnosis is accurate and applicable.
- Comprehensive assessments and diagnoses must be documented by the practitioner. Nurses notes alone are not sufficient. Diagnoses on a diagnosis list or medication order are not sufficient. Notes from previous practitioners or notes in a transfer summary of a diagnosis or "history of" diagnosis are not sufficient. A completed Pre-Admission Screening and Resident Review (PASARR) is not sufficient.
- The Medical Director holds ultimate responsibility for ensuring that clinicians follow clinical standards of care when evaluating and assigning diagnoses.

WHAT TO DO

- Focus your efforts: begin by identifying residents with schizophrenia diagnoses.
- Run your audits: comprehensive assessments, practitioners' documentation, historical documentation, PASARRs.

FREQUENTLY ASKED QUESTIONS

We admitted a resident with a long history of mental illness. The transfer record included documentation from the previous practitioner. Would this be considered sufficient documentation?

No. The resident must be re-evaluated at the time of admission to confirm that the diagnosis assigned prior to admission remains accurate. While pre-admission documentation is important for confirming the resident's history of functioning, the resident's current functioning, including symptoms, behaviors, and complaints, must be documented. Likewise, the resident must be evaluated to rule out other causes for the observed/reported symptoms, behaviors, and complaints.

The resident's behavior is well-documented in nurses' notes, social services' notes, and recreational therapy notes. The resident has a completed PASARR on file, and the diagnosis is included on the MDS assessment, diagnosis lists, and medication lists. Would this be considered sufficient documentation?

No. The medical record must also contain evidence of a comprehensive assessment, documented by a *practitioner* according to professional standards of care. Documentation must be provided by the practitioner.