The RCS and Associated Processes From Start To Finish

When a new resident is admitted to a facility, the RCS is the last thing that should come to mind.

When a new resident arrives in a facility, the Director of Care should make a diary entry for one month ahead with a reminder to carry out an RCS appraisal and then forget about the RCS for the rest of the month.

The RCS should have no bearing on the assessment of care needs which is carried out for a new resident.

The RCS should have no bearing on the care plan which is designed for that resident.

The RCS should have no bearing on the documentation of the care plan which is decided on for that resident.

The RCS just does not enter into this process.

Once the assessment process is complete, and that normally takes a minimum of 21 days after the 7 days settling in period, then the RCS appraisal is carried out using the documentation which has been used to determine the care plan. This will normally comprise the observation notes, progress notes, a care plan and exception reports for the assessment period.

The RCS, like the RCI and PCAI before it, is blamed for all documentation requirements. In fact, documentation requirements are dictated by the nursing process, best practice, duty of care, and good management practices. The assessment of needs and the documentation of these needs, the development of a plan of care and the documentation of that plan, as well as the documentation of exception reports and changes to the plan are all required whether or not there is an RCS. They are required sp that a resident's needs can be determined and the staff of the facility will be able to refer to the plan to ensure that appropriate care is given.

The RCS, does not, in itself, require any documentation to be carried out for the appraisal. It relies completely on documentation existing at the time of the appraisal.

Admittedly, in order to make an accurate RCS appraisal it is necessary for a facility to **have carried out** a comprehensive assessment of the resident's care needs and if the care planning documentation does not reflect the current needs of the resident and interventions required for the resident's care, then that documentation will not support the appraisal on review.

it is not unreasonable to expect that professional practice associated with care planning will normally ensure that documentation does reflect a resident's current care needs.

Why do we document? Simply, we carry out a process which leads from observation to care plan.

We **observe, record** our observations, make **assessments,** detail a **plan** to provide **care** and then we constantly **confirm** that what is given is what is needed and that what is needed is what is given.

Record keeping and documentation are methods by which we can ensure that we are considering the full picture when we come to plan care. Without keeping records and without using these records, we cannot ensure that we are making assessments based upon full 24 hour a day information.

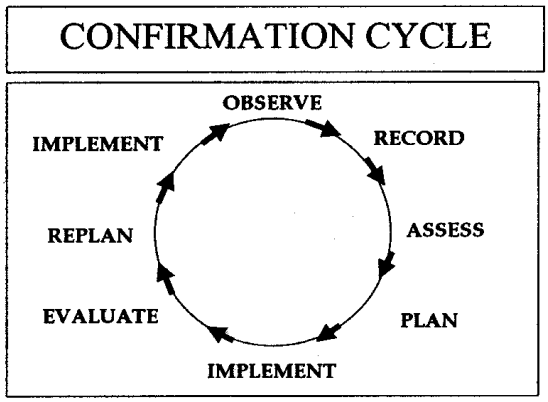
We must document all observations otherwise we risk omitting or forgetting some of the evidence when we come to decide on a care plan. We must document the care plan because it must be available for new staff members or temporary staff members to refer to in our absence.

Example of forgetting - keeping a journal, not working 24 hours a day - if we don't document we will not take account of the full range of data when we make assessments and plan for care

Similarly, we need to ensure that the records are kept over a sufficiently long period of time that they are normative and not episodic. If we make assessments over too short a period the care needs identified may be directed to satisfy care needs which are not truly representative of the care needs of the resident, but directed toward his or her temporary needs dictated by a short term occurrence.

We may be able to breath a sigh of relief when we finish a care plan for a new resident, but that does not mean that we stop the process of observing recording and planning. By continuously reviewing and evaluating the

outcomes of our care, which are the effect on the resident, we can make small or large adjustments to continually make sure that the care plan which we are following is the most appropriate one for the resident now.



So we have observed our resident and we have recorded our observations and we use these documented records to make an assessment of the care needs of the individual. The Care Plan.

It needs to be noticed that, so far, we have not mentioned the RCS. We have assessed, documented, planned care and documented because that is what we are paid to do. We cannot provide do our primary job without having done these things.

We have not done any documentation for the RCS. The RCS is not an assessment instrument, it is an appraisal instrument. It is used to appraise pre-existing assessments and plans, based upon pre-existing documentation which has been done to comply with professional requirements.

We have, however, all that is required for the RCS appraisal.

Care Domain	Settling In				Minimum 21 day assessment period																							
	Day																											
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
Communication												■	■	■	■	DCP					EN							CP	RCS
ADLs		ON									■	■	■	DCP									EN			CP			RCS
Continence	ON			ON								DCP						EN							EN		CP		RCS
Behaviour			ON										■	■	■	DCP						EN					CP	CP	RCS
Social & Human Needs		ON							■	■	■	■	DCP													CP			RCS
Medication	ON	ON												■	■	■	DCP								EN		CP		RCS
Technical Procedures	ON				ON											■	■	■	■							CP	CP		RCS
Therapy		ON								■	■	■	■	■	DCP									EN			CP		RCS

ON = Observation note

■ = Assessment

DCP = Draft Care Plan

EN = Evaluation note (Exception Report)

CP = Care Plan

RCS = RCS Appraisal

How is the RCS reviewed?

In the same way that the RCS, in itself, does not require documentation, the verification or review process, in itself, requires no documentation. The review process only examines the documentation which was used in the facilities own appraisal process.

The review officer's task is a difficult one. Officers are dispersed across the country and have limited time to work together to resolve issues. They are, like you, operating in an environment of significant change, of which the introduction of a single classification instrument is only one.

The role of review officers is complicated by the fact that they are largely in the hands of the claiming service provider for material on which to base their validation.

It could be said that important ingredients for provider success at validation are good skills at writing care plans and progress notes.

There appears to be confusion around whether there is a need to have a running record as evidence that tasks have been done and are done regularly. This contrasts with the level of documentation that would be involved in specifying a resident's needs and a care plan and then only recording exceptions.

It seems to me that relying on written but largely unverifiable progress notes is likely to encourage active and imaginative recording directed at the RCS, and not at the resident. There is little benefit and possibly considerable waste in insisting on reporting that cannot be verified.

When reviewing an **initial** RCS classification appraisal, a reviewing officer restricts his/her review to documentation that pertains to the period from the entry of the care recipient to the facility to the end of the assessment period. This will normally comprise the seven day settling in period and a further 21 days (minimum) for assessment. This documentation will normally take the form of observation or progress notes, a care plan and exception reports.

Observation or progress notes and exception reports, and changes to the care plan which refer to a period after the RCS appraisal has been completed, should not be included in the review process.

However, documentation that confirms care needs that were pre-existing at the time of entry into the facility may be included in the review. An example of this documentation might be an ACAT assessment report that indicated the care recipient suffered from intractable incontinence. Allowing the inclusion of this documentation precludes the need for further establishing the incontinence level of the care recipient.

Reviewing re-appraisals is more difficult for the reviewing officers as, often, regrettably it is less clear which documentation has been used for the reappraisal and therefore which documentation should be should be reviewed.

When reviewing an RCS classification **re-appraisal,** a reviewing officer should restrict his/her review to the materials on which the facility based its re-appraisal. This documentation will normally take the form of documented information in the current care plan together with observation or progress notes and exception reports that pertain to care provided at the time of the re-appraisal.

While a review officer may observe and interview a resident and interview facility staff in order to clarify supporting documentation, verbal information alone would not be regarded as evidence either to support or to invalidate a claim.

To ensure that an accurate re-appraisal is made, it may be necessary for facilities to undertake a comprehensive reassessment of the resident immediately before completing the application for reclassification form. However this would only be necessary if care planning documentation at the time of re-appraisal does not accurately reflect the current needs and interventions required for the resident's care. It is expected that professional practice associated with care planning would normally ensure that a resident's care needs are reflected in current documentation.