I. SCREENING - Best Practice

Screening Purpose: The purpose of a screen is to identify residents that have had a change in condition. If a change is identified, an evaluation needs to be completed to determine the need for therapy. A screen cannot determine the need for therapy

Timing of Screens:

1. Screen all new admits in skilled beds that have no orders within 24 hours of admit.
2. Screen all new admits in nonskilled bed within 1 week of admit
3. Screen long term residents quarterly & as needed / referred

Screen Methods:

1. Review pt's 1:1 with Rehab Coordinator or in CMI meeting with Facility Team.
   Timing is based on quarterly MDS/care plan calendar - initiate ~ 2-3 weeks prior to care plan date.
   Bring screen form to meeting so can complete as much as possible during the meeting
   Pt's with deficits, falls, or declines are discussed / identified.
   Supportive documentation is then verified in chart.
   If appropriate, recommend evaluation
2. Interview RN/C.N.A./Other Team members (Reported decline must be documented)
   If a change or unaddressed issue is identified, Supportive documentation is then verified in chart
   If appropriate, recommend evaluation
3. Interview pt and or family for any new concerns.
   If a change or unaddressed issue is identified, Supportive documentation is then verified in chart
   If appropriate, recommend evaluation
4. Visually assess patient (ie. performing functional skills with C.N.A., poor positioning in w/c, etc)
   No physical contact allowed
   If a change or unaddressed issue is identified, Supportive documentation is then verified in chart
   If appropriate, recommend evaluation on form
5. Review Documentation comparing current status in PCC to last therapy DC.
   If a change is identified, recommend evaluation on form

Supportive Documentation:

Preview Chart for documented change in condition

a) MDS - compare last 2 completed MDS's
b) RN notes: Progress notes or Assessments
c) Restorative notes
d) Fall/Incident Reports
e) ADL tracking per Task Tab / Significant Change Analysis Report
f) Physician notes
g) Hospital transfer records
h) Previous therapy notes

If when reviewing documentation, a need is identified, evaluation should be recommended

Discipline Recommendation:

Based on Long Term Care Discipline Recommendation form and Scope of Practice

Finalize Screen:

1. Complete Screen Form.
   a. If nothing triggered eval, recommend any restorative services or no services. If pt is skilled in facility, notify administration that eval is not indicated.
   b. If therapy services are recommended, follow Insurance Verification & Evaluation Processes
2. File/Scan Screen into chart/EMR and issue a copy to Restorative Nurse / Coordinator
3. Supervisor add pt to screen tracking tool.