Long-Term Care Survey Alert

MDS CORNER: Keep Your Post-Acute Delirium QM on Track as a QA Tool

Keeping an eye on this measure can help prevent rehospitalizations.

The delirium post-acute quality measure provides a warning that all may not be well with your assessment, care -- or MDS coding. If the facility scores higher on the delirium QM than the national average, analyze what's going on, suggests **Sue LaBelle, MSN, RN,** senior healthcare specialist with PointRight Inc. in Lexington, Mass.

Good idea: Give your MDS coding a check-up. Short-stay residents with any sign of delirium that represents a departure from their usual functioning on the 14-day PPS assessment will trigger the post-acute delirium measure, unless they have one of the exclusions.

As for specific coding, the resident will trigger on the measure if any one indicator of delirium (B5a through B5f) is coded as a "2" (new onset or worsening).

Remember: The lookback for B5 is seven days.

Make sure to assess for and code items that exclude the resident from the delirium quality measure. These are end-stage disease (J5c is checked) or hospice (P1ao) is checked -- or the resident is comatose (B1=1).

Also: "The delirium QM has a covariate identifying whether the resident has ever been in a facility before," says LaBelle. The covariate is 1 if the person has no prior residential history indicated by: a recent admission assessment (AA8a = 01);

AB5a through AB5e are not checked (value 0). AB5f is checked (value 1).

Perform These QA Checks

If your facility is high on the measure (and coding isn't the culprit), consider asking these questions, included in a fact sheet on delirium published by the American Medical Directors Association:

How many of the residents who have delirium were admitted into the facility with delirium?

Tip: "Identify that someone was admitted with signs and symptoms of delirium," advises **Nathan Lake, RN, BSN, MHSA,** a long-term care expert in Seattle. "That way, if surveyors ask you about it later, you can show documentation that the delirium was assessed to be present at admission," he points out.

How does the facility identify and assess delirium in a timely fashion, especially in those residents coming from the hospital?

How does the facility ensure that a doctor or other healthcare professional such as a nurse practitioner is involved in diagnosing and managing delirium?

How does the facility investigate factors that may contribute to delirium in its residents?

For example, how does the nursing facility monitor fluid balance and side effects of medications?

Editor's note: For a suite of articles in MDS Alert on assessing and preventing delirium, including medication- induced delirium, e-mail the editor at KarenL@Eliresearch.com.

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