MDS Alert

Best Practices ~ Include Family Input At Admission To Meet These 3 Key Goals

Improve your care, risk management and payment.

Families can give you invaluable information at admission that will improve MDS accuracy, care planning and payment.

If the resident has dementia or can't relay needed information, communicating with the family at admission becomes especially important to accomplish three essential tasks.

Goal No. 1: Develop an interim plan of care, including information for Section AC (customary routine), suggests **Marilyn Mines, RN, RAC-C, BC,** director of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL. You also want to obtain information from the family about the person's baseline cognitive, behavioral and functional status, advises **Susan Scanland, MSN, RN,** principal of **GeriScan Geriatric Consulting** in Clarks Summit, PA. For example, did the person have behavioral symptoms at home or are problem behaviors something new?

Knowing about the resident's prior level of function will help in establishing achievable goals for the resident care plan and the rehab therapy plan of care, says **Bet Ellis, RN,** a consultant with **LarsonAllen** in Charlotte, NC.

The family can also give you information for risk management. For example, a "family member may know that a resident with Parkinson's tends to freeze and fall at certain times of the day when his current anti-Parkinson's medication is in an off cycle," says Mines.

The family may also be able to tell you what medications the resident was taking at home, which may not be the ones he's on coming from the hospital, says **William Simonson, PharmD,** a consultant in Suffolk, VA. "All of us have seen cases where Mrs. Jones is on digoxin, and no one knows exactly why. The family member may be able to tell you that a doctor prescribed the medication for Mrs. Jones 15 years ago when she lived in Kansas."

Goal No. 2: Obtain ADL information to complete Section G1, if needed, which can improve the resident's ADL score.

If you set the assessment reference date on or around the day of admission for someone who goes back to the hospital or dies, you may have to use the family's input to score ADLs, says Mines.

In such cases, staff will have to rely on the resident and family -- and records from transfer facilities -- to document the resident's ADL status in the seven-day lookback, says Mines.

Don't short-change the ADL score: "Assistance provided by the family could potentially bump the resident into extensive assistance" if they provided weight-bearing assistance a third time in the seven-day lookback, Mines points out.

Documentation tip: Document that you observed the ADL self-performance or support -- or how the family described the help provided, adds Mines.

Goal No. 3: Fill in the gaps in coding treatments in Section P1a. Families can give you a heads up about services, such as chemotherapy or radiation, which a resident may have received in the 14-day lookback for P1a, notes **Diane Brown,** CEO of **Brown LTC Consultants** in Boston. That input affects RUG placement and care planning, she notes.

For example, a patient may have received his last dose of chemo for cancer seven days before a SNF admission for an unrelated medical problem. Without family input in some cases, the facility has to rely on physician notes that may not include the resident's outpatient services, Brown notes.