Codify
BY AAPC

MDS Alert

Care Planning: Don't Let Surveyors Accuse You Of Being Asleep At The Assessment Wheel

Evaluate the reason for a hypnotic coded at O4d.

Anytime you code a hypnotic at O4d, revisit the reason a resident needs a sleep aid. The answers may help residents get some zzz's and save your facility from a nightmare survey scenario filled with F tags for unnecessary drugs or hypnotic-induced falls.

Check for this MDS contradiction: If the physician orders a hypnotic or if the resident is taking one (coded in O4), look at sleep cycle issues in Section E, advises **Reta Underwood**, president of **Consultants for Long Term Care Inc**. in Buckner, KY. "See if the team has assessed and recorded the resident as having insomnia and/or an unpleasant mood in the morning," she advises. "If you don't do that and [the clinician] has ordered a hypnotic, you've taken the logic out of the MDS. Why introduce a hypnotic if the resident has no changes in sleep patterns, etc.?"

Do a Good Admission Assessment

Carefully completing Section AC1 (customary routine) can give you a lot of information about the person's usual sleep and other lifestyle habits, which may hold clues for creative care plan interventions to prevent the need for a sleep aid.

As you do your assessment, you may find the person has never required more than six hours of sleep and will awaken in the middle of the night if she goes to bed too early. "In such a case, the person could 'cure' his 'insomnia' by moving up the bedtime up a bit each night," says Underwood.

Find out what helped the resident sleep at home. Underwood recounts how one resident couldn't sleep without hearing the regular sounds of trains that came and went in the night in her neighborhood throughout her entire life. So the facility recorded the sound of a train to play as the resident went to bed, which helped the woman sleep soundly.

"If a resident with dementia is used to sleeping with his dog and gets confused about where his pet is, get him a little stuffed animal that looks like his former pet," suggests Underwood.

Tip: Look at how you assessed the resident for coding F3c (resident perceives daily routine is very different from prior pattern in the community). If you code yes, find out how the resident compares his lifestyle now to his previous one, including his nighttime activities and bedtime.

Look at Time Awake (N1)

Pay attention to how you code N1, because residents who sleep too much during the day won't be tired at night, says Underwood.

Assessment tip: Little Flower Manor attaches copies of assessment of resident's time awake during the lookback for every MDS they do, according to **Lisa Marcincavage, RNAC,** MDS nurse for the Wilkes-Barr, PA facility.

Dig deeper by looking at how the resident spends time awake, advises Underwood. "Is it time awake when the person isn't doing anything or is he involved in a mixture of activities, including some physical ones. If so, the person may have energy reserves that lead to night-time waking.

"If the resident gets in the bed after dinner at 7 or 7:30, you can't expect him to sleep until 7 in the morning," adds Underwood. Spending that much time in bed can also set the person up for developing pressure ulcers, aches and depression, she cautions.

Examine These Additional MDS Items

Doing a careful assessment of a resident's customary routine coded at AC1 or time awake (N1) may offer clues for care planning his insomnia. If not, connect the dots between the person's insomnia and the following MDS items to look for potential reasons he may not be sleeping well.

Urinary incontinence (H1b). For residents who wear absorbent products at night, consider using an electronic device that alerts staff to when a resident is wet, advises Underwood. That way you only disturb the resident to change his or her pad or pull-ups when necessary. Also identify residents' toileting patterns at night so you can be available to assist, if needed, when he awakens on his own to go.

Indicators of depression, anxiety, sad mood (E1). Insomnia can be a sign of depression or anxiety that might resolve with more psychosocial support and/or an antidepressant.

Medications with a stimulating effect, caffeine intake--and diuretics (O4e) taken near bedtime. Ask the consulting pharmacist to review the resident's medication list to identify meds known to cause insomnia.

You may be able to time the stimulating medication in a way to prevent night-time insomnia, says **David Jones, RPh, FASCP**, in Baltimore.

Pain at J2a and J2b. For example, a person with rheumatoid arthritis can become very stiff by nighttime, so he has trouble sleeping, cautions Underwood.

Resource: See "Check Out These Pain Scales For Residents With Dementia" in the June 2005 MDS Alert, p. 62. (If you haven't signed up for online access to past issues, call customer service at 800-508-2582 today to obtain user log-on instructions.)

Target new insomnia: When a resident who had been sleeping well suddenly develops insomnia, look for a recent loss, new pain, infection or depression, advises Underwood.