MDS Alert

Care Planning: Revamp Risk Management for These 4 MDS 3.0 Areas

On the list: anticoagulant therapy and another med now coded in Section N.

The MDS 3.0 captures more information than the 2.0 version did in a number of areas. And while that's great for care planning, it can also open the door to survey and other liability woes if you don't use the information to address identified risks.

Case in point: Section N0400 of the MDS 3.0 identifies residents taking anticoagulants (warfarin, heparin, low molecular weight heparin).

Proactive strategy: Review your standing protocols for managing residents receiving these medications and work closely with the medical director to develop and update them, advises **Joy Cornelius, ADC/MC/EDU, RMC**, a risk management consultant with Robinson Adams, a liability insurer in Birmingham, Ala. "At a minimum, the policy and procedures should say what to do when you get lab results of a certain number. When do you call the physician, etc.?" Cornelius asks.

Problem combo: You also code antibiotics in N0400. "Antibiotics are probably the most notorious" for affecting warfarin levels, says **Albert Barber, PharmD,** director of pharmacy for Golden Living and president of the American Society of Consultant Pharmacists. Thus, "any time you put someone on an antibiotic, you should probably check their INR within a couple of days to make sure there's not an interaction," he says.

"Drug-drug interactions are much less of a concern with the low molecular weight heparins," Barber adds.

Resource: The RAI User's Manual notes that information on common medication-medication interactions associated with anticoagulants can be found in Appendix PP **(**www.cms.gov/Manuals/IOM/list.asp). The interactions can significantly increase or decrease PT/INR levels, the manual cautions.

Safety tip: Check with the physician and/or consultant pharmacist to see if the resident still has a reason for being on an anticoagulant.

Example: Look to see if warfarin was intended for shortterm use for deep vein thrombosis or chronic use for atrial fibrillation, advised **Thomas Lynch, PharmD,** at the last American Medical Directors Association's annual meeting.

2. Suicidality. "The question in Section D about suicide is another area rife with liability," cautions Cornelius. The mood interview directs the interviewer to ask if the resident has "thoughts that you would be better off dead, or of hurting yourself in some way."

In doing online research, Cornelius found that people with the highest suicide risk are males over the age of 65 who have seen a healthcare professional in the last 30 days. "So maybe we should have been asking questions about whether a resident wants to hurt himself or feels like he/she would be better off dead more than we have," she says. But now facilities have to ask that question as part of the mood interview. "And the facility has to have a process in place for safety notification."

Cornelius cautions facilities to review their policies to see whom the person on staff should notify immediately when they determine a resident is at risk of suicide. "If someone indicates they are a suicide risk on Friday, you can't wait until Monday to notify someone. To me, this is along the lines of a resident saying he has been abused. The process to investigate that kicks into place immediately."

Also look at the facility's processes for managing a person identified as being at risk of committing suicide. "Do you send the resident out to an inpatient psychiatric facility to do an evaluation?" Cornelius asks. "Is the facility equipped to

handle a person who says, 'I want to kill myself'? Most of the time, we may have to go to a higher level and get some help," she says.

Using more comprehensive strategies to help prevent and address depression can also help. For example, "does the facility have a strong social services department, external resources, and activities that focus on a person's special interests?" Cornelius asks. "Does the facility get people out of their rooms and involved in life again?"

Resource: For more information on how to assess and manage suicide risk in the nursing home, see MDS Alert, Vol. 6, No. 10, page 112. The article is available in the Online Subscription System, a free service for subscribers. If you haven't signed up, call 1-800-508-2582.

3. Behavioral symptoms. "The MDS 3.0 does a better job than the MDS 2.0 in identifying which residents have behaviors that put them or others at risk of harm," observes **Lynda Mathis, RN,** lead consultant for LTC Systems in Conway, Ark.

Specifically, MDS 3.0 Section E0500 asks you to code whether a resident's identified behaviors put him or her "at significant risk for physical injury or illness." Code at E0600 whether the resident's identified behaviors put others (staff, visitors, residents) at "significant risk for physical injury."

"The liability issue," says former Ohio survey agency chief **Kurt Haas, RN,** comes down to "the predictability of a resident having a maladaptive behavior in an environment that you can manipulate to avoid that behavior."

Step ahead: Take a look at what you're doing to address behaviors, advises Cornelius. For example, "is your facility doing behavioral management and looking for and using external mental health resources?" (See "Hone Your Behavioral Care Plan With a 'Scatter Plot'" on page 21 of this issue.)

4. Comprehensive pain management. Section J now asks you to code whether the pain management plan includes non-pharmacological remedies. And Cornelius can foresee CMS looking at whether facilities are providing such remedies -- for example, ice, heat, diversional activities, positioning with pillows, and counseling to help people understand pain.

Coding tip: You can't count herbal remedies for pain when coding non-medication pain management at J0100C.