MDS Alert

Care Planning: Tune In A Clear Picture Of Residents With Cancer

Use the MDS to avoid gaps in your care plan.

When developing a care plan for a resident with cancer, you need an MDS-based scheme to beat avoidable negative outcomes that can befall a frail elder with the disease.

The goal: Use the RAI process and some old-fashioned detective work to identify the effects of cancer and its treatment -- and potential signs of metastatic disease.

Start With Section G

Start by looking at the person's baseline functional status in Section G before he receives chemotherapy. If chemo makes the resident so sick that he doesn't get out of bed, he is at risk for functional decline, cautions **Louise Walter, MD**, a geriatric cancer expert at **University of California at San Francisco.**

"That's a huge problem" that caregivers don't "focus on in some cases," she says. The healthcare providers will say, "we have cured the cancer, but the resident can't ambulate or meet his own needs as well as he did" before the treatment, she says.

The answer to that problem lies in Section P: "The facility should get physical therapy (P1b) and restorative nursing (P3) involved with patients receiving cancer chemotherapy to make sure they ... hold onto their functional status," emphasizes Walter.

4 More Best-Practice Strategies

Follow these additional steps to develop a care plan that optimizes outcomes and earns flying colors from surveyors.

• **Tap and augment the RAPs.** Various resident assessment protocols or RAPs may trigger for a resident with cancer, including nutritional status, psychosocial well-being, dehydration and fluid maintenance, falls and delirium.

But you also want to preempt clinical issues that trigger RAPs and quality indicators/measures.

Stop this downward spiral: Check food intake and appetite before the person starts shedding weight. "Once a frail elderly person becomes anorexic from chemotherapy or radiation, a lot of potentially serious consequences follow suit," warns **Matthew Wayne, MD, CMD**, chief medical officer at **Eliza Jennings Senior Care Network**. The list of consequences includes poor immune functioning, weakness, falls and pressure ulcers, he says.

• **Update advance directives.** Nurse consultant **Cheryl Field, RN, MSN**, notes that "an advance directive at admission might say the person is full code." But that "picture changes 18 months later" when the person has a terminal diagnosis, says Field, a consultant with LTCQ Inc. in Lexington, MA.

Know the score: LTCQ uses an MDS-based tool called the Personal Severity Index, which indicates the risk of death in the next six months, says Field. Many of the facilities LTCQ works with advise the social worker to talk to residents about advance directives and end-of-life care when their PSI scores move from moderate to high, Field says (to review the MDS items in the PSI, see p. 53).

• **Target psychosocial issues and pain.** Facilities should address psychosocial issues and pain management for

people with cancer, emphasizes **Nancy Shellhorse**, an attorney in Austin, TX. "Surveyors are going to really look at those issues -- particularly if the resident is receiving chemotherapy or radiation."

Staff can easily overlook unsettled relationships coded in Section F2, says **Jennifer Gross, RN, BSN**, with **LTCQ**. And that's "unfortunate because F2 triggers the psychosocial RAP, which would lead the facility to care plan the issue. A resident with a cancer diagnosis could have lost contact with family members for various reasons," says Gross. "The resident could be pulling back or the family members might be having problems with the person's diagnosis. The person may be having pain or psychological and/or cognitive changes that affect his personal relationships."

Target this RAP gap: "There's currently no pain RAP," says Field. And pain is "a large part of the care" for some residents with cancer. So make sure the care plan focuses on pain management, if the resident needs that service.

• **Look for MDS items that signal undetected cancer metastasis.** "A non-healing wound can be cancerous, especially in someone with a previous history of cancer," says Field. Even if the person doesn't have cancer, a non-healing wound may signal a primary or metastatic cancer. **Michael Miller, DO**, knows of one case where a resident who fell down the stairs had a non-healing wound on his sacrum for months.

"Everyone assumed the wound was due to the accident. But when a surgeon excised the wound, the pathology report showed it was a basosquamous cell carcinoma," says Miller, a wound care expert in Terre Haute, IN.

"Pathological fracture is another diagnosis you'll see on the MDS that could be related to cancer," says Field. For example, "a person may have a metastatic lesion in the hip, leading to a fracture," she adds. Instead of assuming osteoporosis caused a pathological fracture, take a closer look.

"You want to detect metastatic disease to the bone not only to treat the pain but because there are treatments for the cancer," says **Sara Wright**, a geriatric nurse practitioner with the Pennsylvania **Restraint Reduction Initiative/Kendal Outreach LLC**.

Resource: For information on treatment of bone metastasis, go to www.bonetumor.org.