MDS Alert

Documentation: Hone Documentation To Support ADL Coding

These simple real-world tips will work wonders.

Ambiguous charting is the enemy of accurate MDS coding. That's why you need to help staff to be as clear and specific as possible when they document residents' ADL needs and care.

For example, sometimes nursing staff writes "assisted with ADLs," which links all of the care for a shift as "one activity," notes **Clare Polatschek, RN, MA,** MDS coordinator for **Tallwoods Care Center** in Bayville, NJ. And that documentation doesn't describe the assistance staff provided to help a resident with each of his late-loss ADLs, which drive RUG placement.

Help the message stick: To remind staff to separate their documentation for the four late-loss ADLs, Polatschek and her team made a sticker that lists bed mobility, transfers, eating and toileting, says Polatschek. The sticker goes on the back of each nurse's ID badge so the nurse can flip it over and see what to assess and capture for charting. "We also have other stickers at the nurse's station with the same information -- and on the Medicare daily flow sheet," Polatschek adds.

Polatschek also audits residents' charts to select examples of unclear ADL documentation to help target inservicing. For example, "someone might write 'independent ambulator in wheelchair.'" But the documentation is misleading because the resident in question is actually "independent in self-propelling her wheelchair -- not in ambulation," says Polatschek. The documentation doesn't describe that ADL, she points out.

Tip: Nurses at Tallwoods Care Center use a Medicare documentation form that incorporates actual MDS ADL terminology for self-performance and support.