MDS Alert

In The Spotlight: Follow This Facility's Lead To Keep Your Resident Assessment Data Moving Through The Care Plan Loop

With the RAI process, silence isn't golden, but you can bank on the right communication system to improve your QI and fiscal profile.

Think of your facility's safety and payment track record as a continual relay race in which everyone on the team must hand off the information baton smoothly - or risk getting tagged with survey citations or flagged for medical review.

Bortz Health Care of Traverse City has put this concept into action, with positive results. The Michigan nursing facility has created a "seamless communication system" to prevent information about residents - including MDS assessment data - from falling through the cracks," says its DON **Debra Hagerty, RN, MSN, NHA.**

Back-to-back meetings on Wednesdays provide the system's linchpin. Staff starts that day with an interdisciplinary rehab meeting to determine the following:

1. The accuracy of MDS assessments, RUGs placement and therapy/restorative minutes. **The payoff:** "We have very accurate MDS coding of therapy minutes in Section T and P because of the rehab meeting," says Hagerty.

2. The success of accident and safety techniques. During the rehab meeting, the interdisciplinary team discusses what therapy and restorative nursing is doing to promote each resident's safety - and whether it's working.

3. Which residents will be coming off therapy and when. In fact, the team nails down the exact day when a resident will be stopping all therapy, which assists the MDS coordinator in knowing when to do an Other Medicare Required Assessment (OMRA).

In addition, the team identifies residents who can transition from high or medium rehab to low rehab with restorative for about a week - and then to level-2 (maintenance) restorative with nurse supervision and restorative-trained certified nursing assistants, says Hagerty.

"The skilled restorative program with licensed nursing supervision provides another transition to maintenance restorative to make sure the resident is ready for that next 'step down' in level of care," Hagerty explains. If someone in maintenance restorative shows a decline in function, the interdisciplinary team bumps him/her into Part B-covered rehab therapy or the skilled restorative program, Hagerty adds.

The benefits: "From a payment perspective, putting a resident in rehab low keeps therapy involved for a bit longer to make sure the resident doesn't lose functional status," Hagerty explains. "Michigan is moving to a Medicaid program with different doors that open for various areas of care, but unfortunately, it doesn't pay additionally for restorative nursing."

Give the Falls Committee the Lowdown

The rehab meeting dovetails with the falls committee where managers analyze residents' falls. The interdisciplinary team identifies residents at risk for falls through a fall-risk assessment performed at admission and quarterly thereafter - and when the resident has a significant change. They also target specific MDS sections and items to determine fall risk (see Article 7).

Staff flag residents at risk for falls by placing a falling star by their names on the doors and on the equipment they use,

says Hagerty. The care team also individualizes fall prevention interventions, i.e., bed and chair alarms, based on the MDS process and fall assessment.

Evaluate Care Plans Weekly

Nurse managers also conduct care plan meetings on Wednesday afternoons using information gleaned in the rehab and fall committee meeting. After meeting with residents and families, the team formulates and implements the care plan immediately. The team then re-evaluates the care plan during the next Wednesday's slate of meetings.

"Of course, if a resident has a change in status before then, we respond immediately," Hagerty adds, "but we give fall-prevention and other interventions a week to document their effectiveness."

Safeguard Residents With Cognitive Impairment

The facility also flows resident information from the Wednesday rehab, fall committee and care plan meetings into its evening safety program for cognitively impaired residents at risk for falls and accidents.

The evening program convenes from 6:30 to 8:30 each evening, which is the time when the nursing staff is busy toileting residents and providing p.m. care. One nursing assistant typically handles the group, which can include up to 10 residents.

The program gears activities to the resident's cognitive abilities and interests. "For example, a resident with mild or minimal cognitive impairment might participate in a discussion group or watch a movie," says Hagerty. The goal is twofold: to keep the resident safe and help him successfully participate in an activity.

To ensure the program's effectiveness, the nursing assistants who run it receive training on what residents with various levels of dementia can do. "Activities personnel also help devise the individualized activities for residents and provide materials for the evening program," Hagerty adds.

Some residents participate in activities during the program designed to strengthen their mobility or functional status. "Thus, information from the rehab meeting follows the resident into the activities program and vice versa," says Hagerty.

The nursing facility's quality indicators on falls and accidents show the communication systems and evening safety programs are paying off for the residents - and the facility, according to Hagerty.