MDS Alert

In The Spotlight: Harness The MDS To Move Into Best -Practices Territory

Use this step-by-step plan to improve care one area at a time.

To develop a reputation as a best practice facility, you need a plan, a thorough understanding of how to use the MDS as a QA tool--and a strong dose of commitment and patience.

A little help from your state quality improvement organization can also jumpstart efforts in the right direction.

A case in point: Baldomero Lopez State Veterans' Nursing Home dramatically improved its pain management program when it worked with its Florida quality improvement organization (QIO) as part of a pilot project in 2001. The facility's publicly reported pain QMs plunged from 17 percent to 0 percent. Now the facility has about 1 percent of residents with pain significant enough to trigger the pain QM, which is now part of the QIs/QMs that drive the survey.

"To reduce the prevalence of pain, the facility examined its pain management process from A to Z in terms of the program's structure, e.g., policies and procedures, assessment tools and staff education," says **Rebecca Yackel**, a former surveyor and currently the administrator for the facility in Land O' Lakes, FL.

The nursing staff documents the resident's pain on a shift-by-shift basis on the medication administration record, which includes a single question: Does the resident have pain? If the answer is yes, the nurse uses the back of the MAR to document the pain's location, severity, the type of pain or descriptors--and any interventions used to relieve the pain, says **Maureen Woods, RN**, an MDS coordinator at the facility. The MDS team then uses the MAR documentation to capture the resident's true pain levels in coding Section J2a and J2b (frequency and intensity of pain) and J3 (pain sites).

The interdisciplinary staff also individualizes the resident's pain medication regimen. "In some cases, round-the-clock medication doesn't fit" a resident's needs, says **Nancy Miranda, PharmD**, consulting pharmacist for the facility. "For example, if the resident gets [sleepy] on the medication, we may omit the six p.m. or midnight dose," she says. "The medication regimen is very much individualized to each person based on his/her goals and comfort needs, and desire to be alert, etc.," she says.

Pull Down the QIs, One by One

Once the pain management system was in effect, the facility systematically targeted other QIs:

• **Restraints.** At the outset of its quality improvement effort, the facility's prevalence of restraints ran about 22 percent. Now the facility has only two residents in restraints ...quot; and one of them has a full lap table by request. In the other case, the resident's spouse wanted the care team to use a belt restraint on the resident, which the team agreed met with the care plan goals.

To help residents stay on the go safely, the facility has applied for a grant to pay for a low-rider seating system (Broda Seating) that allows residents with functional deficits to maneuver without belt restraints. The residents who use the chairs will also wear hipsters in case they do roll out of the chair. "But if they do fall, it's a safe fall because the chair is so close to the ground," says Yackel.

Residents with behavioral symptoms can be a fall or other accident waiting to happen in a restraint-free environment. So the interdisciplinary team uses the MDS to identify the resident's behavioral symptoms and looks to see if the staff has

implemented safety measures, says Woods. "We also look at the resident's ability to communicate his or her needs (in Section C) and do a restraint reduction assessment," she says.

• **Urinary incontinence**. In tackling this common problem, the facility took into account its unique resident population, which includes primarily chronic care residents and few Part A-stay patients. "We are an old soldiers' home" where people come to live, says Yackel. "And while you can lower incontinence with bladder retraining, a facility's programs for long-term residents should also focus on maintaining the residents' attained or existing level of continence."

In addition, the facility has a dementia unit with a lot of residents who are incontinent because they don't have an awareness of the need to void, says Woods.

So the team uses the MDS to home in on key assessment factors that affect those residents' ability to toilet or benefit from bladder retraining, including independent ambulation, cognitive levels and behavioral symptoms.

Look at these additional parameters: The team also performs a bladder and bowel assessment on residents up front to determine their normal pattern and to identify potentially correctable medical or physical problems causing incontinence. The pharmacist reviews the resident's medications to see if a drug might be contributing to the problem. Next the team develops a toileting retraining program for residents who appear able to participate based on their MDS and other assessments. The remaining residents go on an individualized toileting maintenance program, which has proven very successful in keeping a lot of them dry, says Woods.

Editor's Note: To find out how Baldomero Lopez is reining in depression and behavioral symptoms with leading-edge nonpharmacological strategies, read the October 2005 Long-Term Care Survey Alert. For subscribing information, call 1-800-508-2582.