MDS Alert

MDS Accuracy: Is 'Garbage In, Out' Syndrome Trashing Your MDSs?

5 ways to keep your assessments and coding from going astray.

Over time, inaccurate MDS assessments create cracks in your SNF's fiscal integrity and lead to a survey upheaval.

The solution: Implementing a handful of systematic strategies can keep your quality outcomes on the right track and your facility in the black.

Strategy No. 1: Do an operations assessment to identify mistaken coding beliefs and practices, suggests **Diane Brown**, CEO of **Brown LTC Consultants** in Peabody, MA.

Example: Brown recently trained CNAs on the night shift in a facility and figured out that they thought you were supposed to code what the previous caregiver recorded for ADLs.

But "it wasn't an example of purposeful copy-cat charting," she says. "They thought they weren't supposed to change the coding until an ADL activity happened three times." Brown notes that some of the myths can become so ingrained that it takes effort to convince staff that they are incorrect. "The antidote is to train, retrain and then train some more--every three months." And have someone quickly validate what the CNAs record for MDS items on each shift.

Strategy No. 2: Get and keep newbies up to speed. Require newly hired MDS team members to pass "some type of competency testing to make sure they can complete the MDS questions correctly," suggests **Rita Roedel, MS, RN**, national director of clinical reimbursement for **Extendicare Health Services** in Milwaukee.

"You could give a new social worker, for example, a practice scenario and say the assessment reference date is May 15, so how would you complete Section E1 and Section E4?" says Roedel.

Make it real: Provide ongoing ADL training for CNAs and other staff not only in the classroom, but also on the units with actual residents and staff providing care, advises **Sheryl Rosenfield, RN, BC,** director of clinical services for **Zimmet Healthcare Services Group** in Morganville, NJ. That way, "the clinical team can ensure that they are using the same language and parameters to identify resident function."

Strategy No 3: Simplify ADL assessment, documentation and coding. Implement approaches that help staff cut to the chase in coding ADLs accurately. ADL flow sheets should focus on the payment drivers and maybe ambulation status, suggests Rosenfield. She notes "it's unreasonable to expect staff to accurately report 11 ADLs plus other functional issues on every resident, every day on every shift. The accuracy of information declines as the requirements" for collecting it increase, she says.

Memory tool: To help staff code support provided, where a two-person assist is counterintuitively coded as a "3," teach staff to "count heads" present when helping the resident with an ADL, advises **Reta Underwood**, president, **Consultants for Long Term Care Inc.** in Buckner, KY. "If there were three heads (the resident and two staff members) involved in an ADL, then you code a '3.'" If there were two (the resident and one staff person), you'd code a "2." The formula helps staff remember how to code accurately, Underwood says.

Strategy No. 4: Don't let CNAs and the computer code ADLs. Many software vendors sell electronic products that allow the CNAs to enter ADL data on hand-held devices or computerized systems, observes Rosenfield. The newer software "populates the MDS with the information and calculates the ADL score."

Stay in charge: But the licensed nurse needs to maintain responsibility for actually completing the ADL assessment and not rely only on the automated computerized function, says Rosenfield. Keep in mind that "CNAs are not allowed to conduct formal assessments," she emphasizes. CNAs "are responsible to report their observations and level of care provided specific to the individual resident's ADL requirements."

Strategy No. 5: Revisit your assessment and coding for QIs/QMs, especially sentinel events, such as a low-risk pressure ulcer or dehydration. "Some facilities monitor for sentinel events as they complete the MDS, because they know which items trigger a sentinel event," says **Patricia Boyer, RN, LNHA**, principal of **Boyer and Associates** in Brookfield, WI.

Then they recheck the coding--for example, ADL scores for someone who flags as having a low-risk pressure ulcer, advises Boyer.

Reap the rewards of pristine data: "Cleaning up MDSs can have a huge ripple effect on risk management," says **Steven Littlehale, ARPN, MS**, chief clinical officer for **LTCQ Inc.** in Lexington, MA, which finds data integrity errors in about 80 percent of assessments performed by facilities.

"In working with one client using our real-time data integrity feedback, we found that the facilities over the course of a year had 245 fewer residents trigger QM/QIs, 14 of which were sentinel events," advises Littlehale.