MDS Alert

QUALITY ASSURANCE: Tap the MDS 3.0's Heightened Risk Prediction Powers

Coding for falls and behaviors can give you an edge in heading off problems.

The MDS 3.0 allows you to distill a more accurate resident risk profile to head off problems from admission on. Check out these five key assessment areas to take your care planning and trouble shooting to a new level.

1. Fall-related injuries. The MDS 3.0 captures the level of fallrelated injury (see page 42), so CMS will have more information about the facility's fall outcomes, says **Christine Twombly, RNC, RACCT,** a consultant with Reingruber & Co. in St. Petersburg, Fla. She's not certain facilities always track the types of injuries and their severity as part of their quality assurance efforts. The MDS 3.0, however, "will encourage them to do so in order to code that section accurately,"Twombly points out.

Analyzing fall-related injuries may help you review not only compliance with certain fall-related interventions, but also their effectiveness, Twombly notes. Examples include use of hip pads, fall mats by the bed, and rehab therapy aimed at improving balance and teaching people how to fall in a way that helps prevent injuries.

Injuries may be more common or worse in people with certain conditions. "For example," says consultant **Jane Belt, MS, RN, RAC-MT,** "a diagnosis of osteoporosis certainly makes a resident more vulnerable to fracture with any kind of fall." The resident on anti-coagulation therapy has a heightened risk of serious injury due to bleeding.

Key point: "Risk management involves looking at the whole picture -- trends, patterns -- and then getting down to the nitty gritty analysis to determine" what's intensifying that risk, says Belt, consulting manager for Plante & Moran in Columbus, Ohio.

Example: Belt worked with one facility where staff looked at the bathroom area to see if there was a pattern to the falls occurring there. And they found the culprit: a sloped floor near the shower area.

2. Pain management. "The pain section has a lot more information [than the MDS 2.0], including whether the person is on scheduled meds, PRNs, and whether non-medication interventions are being used," says Twombly. Also, there is a pain Care Area Assessment for the MDS 3.0. "Since there is no pain RAP, staff may not always remember to address pain on the care plan when it's coded on the MDS" 2.0.

3. Assessing mood, cognition, delirium. The MDS 3.0 includes the PHQ-9© for assessing mood, the Confusion Assessment Method© or CAM for delirium -- and the Brief Interview for Mental Status (BIMS) for cognition. And "you can interrelate the results of the scale scores with other care areas for particular residents," says **Sue LaBelle, RN, MSN,** senior health specialist with PointRight Inc. in Lexington, Mass.

The idea, she says, "is to look at the complete MDS picture in assessing the resident." For example, "looking at falls, you can use information from the BIMS in assessing a person's fall risk" related to his cognition, LaBelle points out. "Care planning for the resident who is severely cognitively impaired is a world away from someone who might be mildly impaired," she adds.

"The BIMS score can help the team decide whether a resident with incontinence might benefit from bladder retraining or a scheduled toileting program, which is less demanding cognitively."

In addition, "the facility could use the CAM to assess delirium at admission and then apply the MDS items more frequently, as delirium can manifest quickly," says LaBelle.

Resource: For a data collection tool for delirium, see page 44.

"The PHQ-9© provides even more risk management information," says LaBelle. "It asks questions that can give you a clearer picture as to whether or not the resident may be depressed or to what extent depression may affect his ability to progress in therapy or restorative nursing or want to participate in activities." However, "it's not just [about] what the person scores on the BIMS or PHQ-9." You look at "everythingthat has the potential to affect the resident's life in the facility" and care plan to reduce a potential negative impact, LaBelle adds.

4. Impact of behavioral symptoms. Facilities could do some risk management with the behavior items in Section E of the MDS 3.0, advises Belt. "The MDS 3.0 asks you to look more at how that behavior, whatever it might be, puts a person at risk for illness or injury or interferes with care -- and also if it [poses a risk] to other people."

5. The origin of pressure ulcers. Using the MDS 2.0, facilities simply transmit to CMS that a resident has pressure ulcers, although facilities may track on their own whether a person was admitted with pressure ulcers or acquired them in house, says Twombly. But the MDS 3.0 will be asking facilities to identify pressure ulcers present at admission, she notes.