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MDS Alert

Quality Improvement: Practice These ABCs Of Analyzing ADL Decline

Figure out what's driving a downward spiral before it's too late.

You know that residents who trigger the late-loss ADL quality indicator flag a potential problem - the challenge lies in figuring out whether to blame the care, the MDS or the resident's disease and aging.

To navigate your way out of this quagmire, ask these questions:

1. Is Section G1 miscoding the culprit? Most often, you'll find that's the case. "And that's good news in a way because you can easily fix your coding," says consultant **B.J. Collard, RN, BSN, GNP, ANP, CPHQ, RAC-C**, the founder of **CTS Inc.** in Denver, CO. Double-check the coding and look for supportive documentation for late-loss ADLs.

Tip: "Compare the transfer score to toileting," advises **Rita Roedel, RN, MS**, a consultant with **BDO/Heritage Healthcare Group** in Milwaukee. "If the resident's toileting scores are less than the ones for transfer, take a closer look. Usually a resident will need more help with toileting than transferring."

2. Did nursing support the rehab plan of care? If the resident received rehab therapy, did nursing consult with therapy to bring their perspective to the plan of care?

3. Did the resident fail to receive needed restorative services or did he receive restorative care that didn't achieve expected outcomes? If the resident did receive restorative services, review the assessment, goals, interventions, follow-through and evaluation of the plan of care. "You have to figure out which part of the restorative care plan needs fixing," says Collard.

4. Does the resident have specific diagnoses in Section I associated with a deteriorating ADL status over time? Examples include Parkinson's disease, multiple sclerosis (MS) or Alzheimer's disease. "Some residents will have a decline in late-loss ADLs due to the disease process or aging," comments **Patricia Boyer, RN, MSN**, also with BDO/Heritage Healthcare Group.

But to see if the facility is really off the hook for the ADL decline, ask these two key questions: (1) What are we doing to help the person preserve his function? (2) Have we done everything we can possibly do?

Use the nursing process to answer those questions. "Start by reassessing the resident to identify the causes of the ADL decline," advises Boyer. See if the treatment team can rectify some of those causes. "If so, include those interventions in the plan of care," she adds. If not, then still develop realistic goals and interventions - and evaluate the care plan on a regular basis and when the resident has a change in status.

Example: If a resident with progressive MS requires a walker (and was ambulating with a one-person assist three months ago), the goal might be to delay use of a wheelchair for X amount of time, says **Robin Bleier, RN, CLC, LHRM**, president of **RB Health Partners** in Crystal Beach, FL.

If the facility did everything possible - and the MDS coding is on target - then the interdisciplinary team can build a case for the resident's decline being unavoidable, and thereby avoid an F309 tag. That's especially true if one could anticipate the decline.

Documentation tip: Have the physician or physician extender document realistic negative expected outcomes for a patient or resident with a progressive disease, advises Bleier.

Do an Audit

To detect trends in ADL decline, pull your QI reports and identify residents who triggered on the ADL QI. Analyze a sample from that group to see why they triggered.

If six out of 18 residents in the sample had Section G errors, for example, then you know the facility probably has a systemic coding problem, advises Collard. If several residents receiving restorative nursing declined unexpectedly, your restorative program may be in need of a care plan.