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MDS Alert

Quality Improvement: The MDS Can Give Your End-Of-Life Care A Quality Reality Check

Research analysis flags gaps--make sure your facility isn't falling into them.

Your MDS assessments have a tale to tell about how well your facility meets the needs of residents in the dying process. That's according to **LTCQ Inc.'s** analysis of 630 facilities caring for residents at end of life.

LTCQ performed the study with a goal of beginning to identify improvement opportunities in end-of-life care, according to **Steven Littlehale, MSN, RN**, chief clinical officer for the consulting and research firm in Lexington, MA. Facilities might look at the following key MDS sections and outcomes to see how they stack up against LTCQ's findings:

• **Section M5 (pressure-relieving devices).** "While residents at the end of life have a great likelihood of skin breakdown," says Littlehale, "balancing their wishes with the standards of pressure ulcer prevention can be a challenge." Providing pressure-relieving devices for the person's bed is one valuable strategy for pulling off that juggling act. But LTCQ's analysis found pressure-relieving devices incorporated into care plans for residents at end of life only 73 percent of the time.

• **Section P4 (devices and restraints).** Littlehale says one would hope not to find use of restraints at the end of life, including siderails. "Restraints contribute to mood decline and can be humiliating for the resident's loved ones who see the person restrained," he says. To look at use of restraints at end of life, LTCQ researchers created a process indicator far more specific than siderails, e.g., use of trunk restraints and use of chair that prevents rising for residents who were totally dependent in bed mobility and transferring. They reasoned that a facility would have few good reasons to use restraints in such an instance--"not for safety reasons, certainly, as the person can't move without assistance," says Littlehale.

When LTCQ looked at the MDSs for residents at the end of life, it found that facilities specializing in end-of-life care "triggered" this outcome or used unnecessary restraints 44 percent of the time compared to 68 percent of facilities that didn't specialize in palliative care, according to Littlehale.

Lesson learned: If a resident at the end of life has a restraint, do a careful analysis of the reason and find ways to meet the resident's safety and other needs without restraints.

• **Section K (artificial nutrition/hydration).** The literature shows that tube feedings not only don't necessarily lengthen the life of someone actively dying ...quot; but often lessen the quality of the person's life, Littlehale says. "Some empirical findings speak to hydration as increasing pain in residents who are actively dying," he adds. Yet LTCQ found that 40.6 percent of residents at the end of life had a new feeding tube inserted. (But only 5.2 percent of residents not at the end of life had a new tube feeding inserted, Littlehale says.)

What might explain the high use of tube feedings for dying patients? Some nursing homes may still be using a medical model at the end of life, complying with family's wishes for their loved ones--or not soliciting resident wishes prior to a crisis, Littlehale postulates.

• **Section A10 (DNR orders).** LTCQ's analysis found that 42 percent of dying residents had DNR orders in place, "so the likelihood is that at end of life, many residents are going to be resuscitated," cautions Littlehale. "Residents not at end of life had DNR orders 31 percent of the time."

Tip: Code DNR orders in Section A10 and develop a consistent strategy for alerting all providers to a resident's DNR status.