MDS Alert

Quality Improvement Trends: Follow These Facilities' Lead to Take the MDS 3.0 and Care to a New Level

Including mood items on the daily CNA documentation form helped this care team assist a resident in crisis.

A group of facilities has found smart but simple ways to make the most of the MDS 3.0 -- and stay on the same page in meeting residents' needs.

Good News: "The Pioneer Network has been working with a few nursing homes that are piloting a very residentcentered, staff-engaged process for the MDS 3.0," says **Barbara Frank,** a consultant in Rhode Island who is working with the effort. "And they are finding the sections meant to drive more resident-centered approaches really work beautifully."

How it works: Facilities in the collaborative use consistent caregiver assignments and incorporate MDS 3.0 items in the CNAs' daily charting templates, Frank reports. "With this in place, CNAs on every shift look at and document mood and psychosocial [information] and customary routines, as well as physical functioning and ADLs." As an additional step, CNAs and nurses share what they are observing about the resident with the oncoming shift caregivers where they focus on "differences, risks, and opportunities," she adds.

Example: One facility in the collaborative designed a check-off chart that includes elements from the MDS mood section, reports Frank. A CNA using the form noted that a resident's mood had changed and asked her what was going on. The resident explained that she'd just found out that her daughter had cancer. That's not the kind of psychosocial stressor that you want to wait until the quarterly MDS to find out about, Frank points out.

Instead: The CNA shared what she'd found out at the end-of-shift meeting, which was attended by a social worker. The team implemented a plan immediately to provide psychosocial support for the resident. This included having the resident spend more time with another resident whom she was close to, Frank relays.

Participant Highlights Facility's Process

One of the participants in the collaborative, MaineGeneral Rehabilitation & Nursing Care, views its change of shift handoff as being "critical to resident-centered care," says **Connie McDonald,** administrative director for the facility in Augusta, Maine. The facility, in fact, has always had a change-of-shift process, but the MDS 3.0 "gave us another opportunity to talk about" what information the team needs to collect and whether "we are getting a good picture," McDonald says. "And do people understand what we are looking for and why it's important?"

CNAs participate on committees where they provide input about what they view as residents' needs -- and what information the team needs to collect in addition to what's on the MDS 3.0, McDonald explains.

Each shift has a "half-hour overlap" where care staff from the ending and beginning shifts perform physical rounds, she adds. In addition, CNAs, all of whom have primary assignments, give reports to the licensed nurses coming on and going off the shift.

To quickly home in on what's important, the CNAs "report by exception," says McDonald. That means they don't share things that the resident typically does, such as sleeping well, she adds.

Instead: CNAs report if a resident has any risks, such as pressure ulcers or falls. The CNAs also discuss anything that may indicate a decline, such as a resident refusing meals. And they share "psychosocial well-being topics"-- for example, how a resident became tearful during a family visit or enjoyed a musical program, McDonald relays (see the facility's change-

of-shift tool on page 70).

The CNAs also identify any behavior that's not usual for their residents. This "may lead to a group discussion andbrainstorming for interventions."

Interdisciplinary Sharing Provides 'Rest of the Story' in Some Cases

Once or twice a week, the social worker, dietary techs, and activities staff also participate in the change-of-shift meeting, McDonald reports. These staff members provide information that the nursing staff may not have, which can change how nursing views the resident.

Example: The CNAs may be reporting how certain residents are isolating themselves because they choose not to attend activities. But the activity professional may point out that those residents have expressed preferences to do certain activities in their rooms, such as listening to books on tapes or watching soap operas, McDonald notes. "The social worker may also be able to give some added insight into a resident's behaviors based on the psychosocial history or family information," she adds. In addition, "the diet tech may be able to offer suggestions to improve the intake of a resident at risk for weight loss."

The team also focuses on tracking and understanding residents' behaviors. When a resident moves into the facility, staff initially "maintain a concentrated mood and behavior log [that's] much more comprehensive than the mood and behavior questions on the MDS." The team starts to keep the log again when a resident shows significant changes in his behavior or mood.

Bottom line: The meetings provide "a check and double check" about whether the team has accurate information about the residents, McDonald says. The interdisciplinary exchange produces "so many teaching moments and 'Ahas!'"

Focusing on the MDS: Each week the staff members also "spotlight those residents entering the ARD lookback period for the MDS" -- and they make sure the care plan is on the mark and that everyone knows the care plan expectations, McDonald says. "The nurse manager shares the pertinent interview questions from the MDS and Quality Indicator Surveys to help staff understand the importance of resident choice and satisfaction."