MDS Alert

QUALITY OF CARE: Assess, Document 'The Rest Of The Story' For Residents' Behavioral Symptoms

Recognize the limits of Section E4 as the be-all and end-all.

When evaluating residents' behaviors, Section E4 provides a good starting place, but if you stop there, your care plan may be off track -- and your facility on a collision course for a negative survey.

"E4 only includes certain behavioral categories," which can be a "big bucket to throw a lot of behaviors into," says **Jennifer Gross, RN, BSN,** a consultant with **LTCQ Inc.** in Lexington, MA. Thus, "her instinct" tells her that "some specific behaviors fall through the cracks."

Example: Withdrawal can be a behavioral symptom, says Gross. But it's not really specified as such in E4. A resident who suddenly stops a behavior, such as resisting care or pacing, may have a short-term acute illness, says Gross. Or the person may not be wandering anymore "because he's having more trouble getting out of bed."

Do a Crosswalk

To connect the dots between various MDS items in a particular case, use the "MDS as an interdisciplinary as opposed to a multidisciplinary tool," advises **Steven Littlehale, APRN, BC,** chief clinical officer for LTCQ. Using the latter approach, the social worker does Section E, and nursing gets G and H, etc. As a result, "the MDS isn't really woven together to make sense across categories," says Littlehale. When "approaching the MDS from an interdisciplinary viewpoint, everyone on the team looks at section E and signs off on it, which helps clinicians put all the puzzle pieces together to provide holistic care," explains Littlehale.

Example: You may detect the resident has problems that staff haven't noticed or put together before, says Gross. Examples include falls, pain or instability of condition (Section J) or sensory deficits.

"The person may have been able to compensate for visual or hearing deficits but is losing his ability to do," which staff figure out when they do their assessments for Sections C and D, says Gross. Visual and hearing deficits not only show up in potential behavioral issues but put the resident at risk for several problems, including falls, a change in participation in activities, ADL decline, and depression.

Target Incontinence Patterns

In looking at the potential cause of a behavior, especially a behavioral change, always assess the resident for constipation (coded in Section H), suggests Littlehale. Constipation "has a huge impact on a person's whole being and many times is expressed in behaviors," he says. Thus, "the staff should immediately assess if a behavioral change is caused by constipation -- or worse, fecal impaction."

Gross notes that "incontinence patterns can also reflect urinary tract infection or a change in resident's nutritional status, which can result in a change in his usual behavioral patterns."

Check Oral Health

Oral health problems can impact a resident's behavior, says Littlehale. "Studies have made the link between oral hygiene and psychosocial and medical health," he points out. The problem could be a cavity, ill-fitting dentures, gum disease or a mouth sore, "which are the problems people most often" consider, says Littlehale. "But poor oral hygiene can be

distressing to someone in and of itself."

Be Careful in Coding 'Resists Care'

A resident's "conscious choice" to forego a bath or medication does not equate to resisting care coded at E4, says Littlehale. "The person can have some cognitive impairment, but if he is able to make a conscious choice, staff should not count" the resistance in E4, he advises. Coding it in such cases "classifies resisting care as a behavior that staff try to change versus an opportunity to explore with the person why he or she doesn't engage" in care.

Look for a Correlation Between Behaviors, Falls

You can definitely correlate behavioral issues with falls (Section J), says Littlehale. He knows of one resident who would come to the nurses station at a certain time of day "and swoon, throwing herself on the floor," as an "ultimate cry for attention." The facility still counted that as a fall on the MDS but looked at the underlying need, he says.

For example, the care plan included a directive for the staff to pay extra attention to the resident at the time of day when the "falls" tended to occur.

Physical aggression coded in E4 can increase a resident's fall risk and also the risk of others for falling when they become frightened by the behavior or try to get away from the person, notes Gross.

Work the Behavior RAP, Care Plan Risks

To ensure the care plan addresses behavioral symptoms, work the behavior RAP triggers even for off-cycle assessments, suggests Gross. "The MDS only tells you a behavior is present -- it doesn't tell you what shift, what circumstances, what could be causing the behavior."

"The RAPs were set up as a quality assurance tool to help you walk through the various steps to identify the potential causes of a behavior or other issue you are seeing," observes **Karen Merk, RN,** a senior care consultant with **Briggs Corporation** in Des Moines, IA.

Think outside the RAP triggers: You can use the behavior RAP to walk through potential causes of behaviors that don't fit neatly in E4, such as withdrawal.

Also, given that only wandering coded in E4 triggers the fall RAP, you should assess and care plan behaviors that increase fall risk for the resident and others, such as physical aggression or attention-seeking behaviors.