# MDS Alert

## Quality of Care: Use the MDS as a Safety Net to Catch Actual or Potential Decline in Time

Flag residents who may need rehab or restorative.

The best patient safety and quality-of-care systems have built-in redundancies to detect the need to move to a new plan of care. And, in that regard, the MDS can provide a heads up that a resident is heading in the wrong direction in time to turn things around.

Key point: "Rehab therapy is reliant on nursing to compare the two MDS assessments to identify a decline," says **Michael Sciacca**, a physical therapist and director of rehabilitation for consulting firm **Zimmet Healthcare Services Group** in Morganville, N.J.

Real-world example: Working in a nursing facility with 158 beds, occupational therapist **Jody Neimann** looks to the MDS nurse to let her know her when the assessment indicates that someone's ADL ability has declined. For example, "the MDS three months ago may have shown that the person required only supervision with dressing but is now [requiring] extensive assistance," says Neimann.

Keep in mind: The QM identifying residents whose need for ADL help has increased only picks up decline in late-loss ADLs. The QIs/QMs will also identify someone with a worsening ability to move in and around her room -- or a decline in range of motion. The ADL Functional Rehabilitation Potential RAP key items can help you consider a resident's risk of decline and chance of rehabilitation, according to the RAI instructions. But you can also eyeball the MDS and compare it to the previous assessment to identify a resident who may be on a downward trajectory or poised for one.

Dig Deeper in Section G

Start with a look in Section G. For example, anyone coded as having a self-performance score greater than "0" for any of the ADLs is a candidate for restorative nursing, says **Marilyn Mines, RN, RAC-CT, BC**, manager of clinical services for **FR&R Healthcare Consulting** in Deerfield, Ill.

You can also look for a deterioration in ADLs coded at G9 (for more information on G9, see the Coding Quizzer, p. 136).

In addition, ask these key questions to detect decline that may have escaped the interdisciplinary team's radar screen:

• **How have you coded Section G8 (ADL functional rehabilitation potential)?** If a resident or staff believes the resident can increase his independence in some ADLs, that should be a trigger for rehab or restorative, says **Pauline Franko**, a physical therapist and principal of **Encompass Consulting & Education** in Tamarac, Fla.

• Is the person newly checked at G5 as using an assistive device or now using a wheelchair as his primary means of locomotion? If a resident is now using an assistive device or using it more, such as a wheelchair or walker or cane, he needs a therapy evaluation, says **Katy O'Connor**, a physical therapist and consultant at **Zimmet Healthcare Services Group**.

• Could a resident with dementia benefit from task segmentation (G7)? "Occupational therapy might help in terms of determining the level at which a dementia patient can function if you divide ADLs into subtasks," says Franko. "OT might provide some sessions to help with this and restorative could pick it up."

Target These Additional Sections

A decline in mental status could warrant an OT evaluation if the change purely involves cognition, says Franko. "For speech to be involved, the person would have to have a linguistic component to the cognitive problem, such as receptive aphasia," she adds.

Also look for a change in coding indicating a worsening status for Section C (communication/hearing patterns), Section H (continence), Section K (oral/nutritional status) and Section T2 (walking when most self-sufficient), suggests **Elisa Bovee**, an occupational therapist and consultant with **Harmony Healthcare International** in Topsfield, Mass.

Restorative to the rescue: The resident with declining mental status or communication abilities who doesn't qualify for rehab might be a candidate for a cognitive or communication group. "These groups are well under-used" in nursing facilities, says **Robert W. Serianni**, a speech language pathologist and VP of clinical services for **Nyman Associates Inc.** in Fort Washington, Pa.

Beware hearing impairment: In the MDS 3.0 pilot, nurses used external amplifiers when doing the MDS assessments and found that when they interviewed a supposedly cognitively impaired resident -- or even one with actual dementia -- they got valid answers, noted **Joy Morrow, RN, PhD**, in a presentation on the MDS at the October 2008 **American Health Care Association** annual meeting.

Important question: Has the resident developed signs of a swallowing problem since the last assessment -- for example, coughing during or after meals or refusing to eat? If so, you may need to get the speech language pathologist to do a screening (for an inside look at how to best assess for and manage dysphagia, see Long-Term Care Survey Alert, Vol. 10, No. 12, or if you are not yet a subscriber, request a free copy of the article by e-mailing the editor at KarenL@Eliresearch.com).

Keep Your Eye on Sections J and I

If the resident has had a fall (J4), you'd expect therapy to screen the person to identify any potential causative factors, such as a balance problem, a wheelchair-related issue, or a cognitive problem, etc., says Sciacca.

In assessing actual decline or residents at risk for it, look at stability of conditions in Section J5 -- and also Section I (diagnoses), advises **Cheryl Field, RN, MSN, CRRN**, a consultant with **PointRight Inc**. in Lexington, Mass.

Section I can flag residents with the potential for change due to a chronic, progressive condition, such as chronic renal failure or Parkinson's disease, Field notes.

"You'd expect a person with the disease to experience a slow, steady decline where restorative could help the person maintain function for a longer period of time and improve quality of life," Field adds.

**Head Off Trouble at the Pass Even Faster**

Of course, your best approach is to identify resident decline in real-time. And one way to do that is to meet with CNAs routinely to discuss any subtle changes they have noted in long-term care patients, suggests physical therapist **Shehla Rooney**, principal of **Premier Therapy Solutions** in Cookeville, Tenn.

Another suggestion: Meet with restorative aides to discuss patients who may have had a decline in status potentially warranting skilled therapy intervention, advises Rooney.

Editor's note: See part 2 of this article, "Should The Resident Receive Restorative, Rehab Or Both? This Decision-Making Tree Helps Keep You Worry Free," in the next MDS Alert.