MDS Alert

QUALITY OF CARE: Use The MDS To Make Sure Residents' Meds Are Helping

These 3 snags can lead to F329 tags.

The MDS can tell you if all is well with a resident's medication regimen. And tapping the instrument for that information will improve resident care and keep your facility from ending up with deficiencies under the tougher new survey guidance for F329 (unnecessary medications).

Make sure these common medication-related omissions don't occur on your MDS watch:

1. No one looks to see if a medication could be causing or contributing to a resident's change in condition. For example, as a part of doing a significant change in status assessment, the interdisciplinary team should evaluate whether that may be the case, advises **Carla Saxton McSpadden, RPh, CGP,** with the **American Society of Consultant Pharmacists.**

Timing is important: "If you add a medication or increase the dose -- and the resident has an unexplained symptom within a couple of days -- likely the medication has caused it," reports **Matthew Wayne, MD, CM,** chief medical director, **Eliza Jennings Senior Care Network** in Cleveland, OH.

Even when you're not doing an MDS, use certain items as triggers to look at a resident's medications as part of the care planning team process, suggests McSpadden. She notes that the team could ask the consultant pharmacist or physician to take a closer look when the team sees one of these triggers:

- A hospital stay (P5)
- An ER visit (P6)
- Physician visits (P7) and order changes (P8)
- Abnormal labs (P9)
- Delirium (B5)

"Delirium is often caused by a medication," says McSpadden. Thus, anytime a resident has an "acute change in cognition or mental status," evaluate whether a medication could be causing or contributing to it, she advises. Or the resident's delirium or mental status change could be due to a med error, McSpadden adds.

Example: Staff in one facility mistakenly gave a resident Zyprexa rather than Zyrtec (for allergies), which caused the resident to "appear as if she'd had a stroke" due to her altered mental status, says McSpadden.

2. There's a mismatch between the resident's meds and expected outcomes. To see if that's the case, compare the medication administration record to the MDS, suggests **Clare Hendrick, ANRP,** a geriatric nurse practitioner and consultant in San Clemente, CA.

For example, if you see that a resident is receiving pain medications, does he still have enough pain for you to code it in Section J2? Is that in keeping with the resident's comfort goals -- for example, to have daily mild pain? Ask the resident to use numbers on a Likert scale to quantify his comfort goal, says Hendrick.

"The Likert scale is more measurable and transferable from nurse to nurse to provide consistent treatment to the resident when evaluating pain and administering appropriate medication," says Hendrick.

If you code that a resident is receiving an antidepressant or antipsychotic in Section O4, does he have more or fewer indicators of depression, anxiety and sad mood in E1 or behavioral symptoms in E4 than previously?

When a medication hasn't resolved a problem completely, the documentation and care plan should show that the team is on the case. For example, if a resident's antidepressant medication hasn't worked in three weeks, the interdisciplinary team at **Gallatin Rest Home** refers a resident to a clinical psychologist who sees residents, reports **P.J. Bailey,** the social worker for the facility in Bozeman, MT.

Patient safety tip: The team might also compare the medication administration record to the physician's orders to catch any errors, such as drugs that should have been discontinued, adds Hendrick.

3. The MDS shows falls and other potential medication-related negative outcomes that the care plan team hasn't addressed. Medication side effects in elderly patients can be subtle, including weight loss, decline in late loss ADLs, cognitive decline and falls, cautions Wayne.

For example, if a resident has dizziness (J1f) or has fallen (J4), look to see if he's taking a med known to cause dizziness or orthostatic hypotension. If so, the physician might consider modifying the dose or switching to an alternative medication that doesn't cause that problem, suggests **William Simonson, PharmD,** in Suffolk, VA. Say the resident is receiving an alpha receptor blockerfor lower urinary tract symptoms caused by benign prostatic hyperplasia. "Switching to a different alpha blocker that is less likely to cause dizziness could be an appropriate intervention," he says.

Also use the MDS to detect any opioid side effects, advises **Karl Steinberg, MD,** associate medical director for skilled nursing care at **SHARP Mission Park Medical Group** in Oceanside, CA. Those include constipation and "worst case, fecal impaction," he says, as well as sedation and gait disturbance, which can lead to falls.