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MDS Alert

Resident Assessment: Troubleshoot These 4 Common Causes Of Missing Mood And Anxiety Indicators

The cure for coding woes at E1 may be simpler than you think.

Failing to detect resident's depression can leave you with a very depressing survey--especially now that surveyors are targeting psychosocial outcomes.

To avoid missing indicators of a depressed, anxious or sad mood, target these four common MDS assessment and coding problems.

Problem No. 1: Staff don't recognize certain residents behaviors that should be coded in E1. For example, a resident who repeatedly requests health services, such as a daily laxative, may have unrecognized depression, says **Jan Zacny, RN**, a consultant with **BKD Southern Missouri** in Springfield, MO. One of the indicators (E1i) asks you to code the resident who "persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, and relationship issues."

Sometimes staff don't capture depression indicators because a resident has always acted a certain way--for example, a person with dementia may constantly call out or try to leave the unit and have a sad facial expression, adds Zacny. Staff will say that's "normal for him, but really the person may have had depression for a long time."

Remember: Code regardless of what you believe the cause of the person's behavior, instructs the RAI user's manual.

Problem No. 2: The facility's mood and behavior documentation sheets aren't specific enough to capture information for coding Section E. "Some facilities use behavioral monitoring sheets supplied by the pharmacy," notes **Marilyn Mines, RN, BC**, a consultant with **FR&R Healthcare Consulting** in Deerfield, IL. But not all residents with mood and behavioral symptoms receive medications, Mines notes. "And the forms aren't always specific enough to code the indicators described in E1," she says.

Problem No. 3: The person completing Section E1 doesn't review all of the disciplines' charting before coding the MDS. Surveyors will cite facilities that have documentation of signs of depression in the social worker's or nursing notes when it's not on the MDS--and thus not on the care plan, cautions Zacny.

"The **Centers for Medicare & Medicaid Services** wants facilities to treat people for depression," Zacny emphasizes. "It doesn't have to be antidepressant therapy but psychosocial interventions of some sort on the care plan."

Clinical gem: Baldomero Lopez State Veterans' Nursing Home in Land O' Lakes, FL, offers halogen light therapy for residents who have mood issues.

Problem No. 4: The interdisciplinary staff doesn't use a true 30-day lookback for E1. Since most of the MDS items have a seven-day lookback, including behaviors in E4, staff may not start soon enough to assess residents for mood and anxiety issues. To solve this problem, consultant **Leah Klusch, RN**, suggests disseminating tracking tools for Section E to nursing, therapy and activities at the beginning of the 30-day assessment reference period for a resident. The social worker uses her own assessment form. "At the end of the period, the social worker has the responsibility to gather" the forms, says Klusch, principal of the **Alliance Training Center** in Alliance, OH. "That strategy increases the amount of data that the social worker gets by about 300 percent."

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