

Health Services Advisory Group

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MDS 3.0: CHANGE IS COMING

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Learning Objectives

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1. Describe the MDS 3.0 Physical Restraint and Pressure Ulcer items, including how to accurately code them
2. Identify and accurately code other items on the MDS 3.0 that provide information about or have an effect on Physical Restraints and Pressure Ulcers
3. Discuss the Care Area Assessments (CAAs) for Physical Restraints and Pressure Ulcers and the requirement for selection of tools for conducting CAAs
4. List proposed quality measures for Pressure Ulcers and Physical Restraints
5. Relate the timing and scheduling requirements for the OBRA-required clinical assessments with MDS 3.0
6. Discuss the role of leadership in successful MDS 3.0 implementation and in decreasing Pressure Ulcers and Physical Restraints

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Skin conditions and the MDS 3.0

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SECTION M

Intent

The items in this section document the risk, presence, appearance, and change of pressure ulcers. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program.

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Section M: Skin Conditions

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- Before any skin problem can be coded on the MDS, the underlying cause must be determined
- Only selected types of skin conditions are captured; skin tears, cuts, lacerations, and rashes are not
- Skin problems are coded if they were present during the 7-day observation period even if they were present and coded on a previous MDS assessment

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MO100: Determination of Pressure Ulcer Risk

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- Asks to describe how the risk for pressure ulcers (PUs) was determined (see answer options)
- Formal risk assessment tools generally look at sensory perception, moisture, level of activity, mobility, nutrition
 - Findings must act as roadmap to care plan
 - Be cautions of summary overall risk scores; even if score doesn't reach threshold, any line-item risk factors should map to the care plan

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MO100: Determination of Pressure Ulcer Risk

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- Certain factors are always a red flag for high risk
 - History of resolved PU
 - Newly admitted or readmitted. A significant number of PUs develop within 4 weeks
 - Health problems: Diabetes, edema, recent weight loss, dehydration, difficulty with ADLs, low pre-albumin level, use of steroids, urinary incontinence, decreased mobility
 - Use of restraints

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MO210: Unhealed Pressure Ulcer(s)

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- Pressure ulcer: Lesion caused by unrelieved pressure that results in damage to the underlying tissues
- If a skin ulcer arises from a combination of factors of which pressure is the primary cause, capture it as a PU for Section M

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MO210: Unhealed Pressure Ulcer(s)

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- PU repaired with a flap or graft is a surgical wound, not PU, even if graft fails
- Resident with DM has heel ulcer from pressure that is present during the 7-day look-back period, capture it as a PU
- Resident with DM has ulcer on bottom of foot that is closer to the metatarsal and present during the 7-day look-back period - do not capture it as PU. This is coded as diabetic ulcer

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MO300: Current Number of Unhealed Pressure Ulcers at Each Stage

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- Asks about the number of PUs at each stage during look-back
 - See staging definitions on form
 - PU is always referred to by its deepest anatomical stage – the highest stage it ever reached – even after healing has decreased its depth and/or size
 - It is advisable to develop a procedure for tracking pressure ulcers over time so this info is easy to find

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**MO300: Current Number of Unhealed Pressure
Ulcers at Each Stage**

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- Asks about the number of stage 2, 3, and 4 PUs that were present *at that stage* on admission/reentry
 - Present on admission/reentry means:
 - The PU was present on admission/reentry to this nursing home
 - The stage has not worsened at any time since admission
 - The PU was not acquired while the resident was in the care of this nursing home during any stay

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**MO300: Current Number of Unhealed
Pressure Ulcers at Each Stage**

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- When admission PU worsens, it becomes in-house-acquired rather than an admission ulcer
- If a PU was unstageable on admission and subsequently became stageable, it is captured as present on admission unless stage worsened while in the nursing home
- If PU that was in-house acquired in the nursing home worsens to a higher stage during hospitalization, it is coded at the higher stage upon reentry and as present on admission

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**MO300: Current Number of Unhealed
Pressure Ulcers at Each Stage**

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- Asks about the date of onset of the oldest stage 2 PU
 - If oldest stage 2 PU was present on admission and date of onset is unknown, enter a dashes (-)

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Mo300: Current Number of Unhealed Pressure Ulcers at Each Stage

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- Unstageable PUs
 - Mo300E - *Unstageable due to non-removable dressing or device*. PU diagnosed, but it cannot be assessed due to dressing that is not to be removed per physician orders, or it is covered by a non-removable orthopedic device or a cast

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Mo300: Current Number of Unhealed Pressure Ulcers at Each Stage

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- Unstageable PUs
 - Mo300F - *Unstageable due to slough and/or eschar*. PU diagnosed, but the wound bed cannot be seen, so it is not possible to stage the ulcer
 - ✦ When the PU is debrided and the wound bed can be seen and the depth can be determined, the ulcer should be staged and no longer captured as unstageable. The PU does not have to be completely debrided or free of all necrotic tissue in order to stage it

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Mo300: Current Number of Unhealed Pressure Ulcers at Each Stage

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- Unstageable PUs
 - Mo300G - *Unstageable due to suspected deep tissue injury (DTI)*. Suspected DTI is defined as “purple or maroon area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue. The adjacent or surrounding area may be painful, firm, mushy, boggy, warm, or cool.” After the suspected DTI opens, it should be staged and no longer classified as unstageable.

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MO610: Dimensions of Unhealed Stage 3 or 4 PU or Eschar

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- Measure each PU present during the 7-day look-back period that meets following description:
 - Unhealed stage 3 and 4 pressure ulcer
 - Pressure ulcer that is unstageable due to slough or eschar
- Measurement must be made in centimeters to one decimal point

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MO610: Dimensions of Unhealed Stage 3 or 4 PU or Eschar

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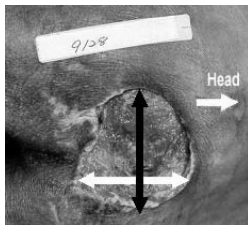
- Measurement for each applicable ulcer:
 - Length: Measure longest portion of the ulcer along the same line as an imaginary line running from the resident's head to his or her toes
 - Width: Measure widest portion of the ulcer along a line perpendicular (at right angles) to the head-to toe line
 - Multiply length x width (total surface area)
- MO610 = the one with the largest surface area
 - Also measure depth of the one with largest surface area

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Pressure Ulcers

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Pressure ulcer measurement to calculate surface area



Source: RAI User's Manual

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**Mo700: Most Severe Tissue Type
for Any Pressure Ulcer**

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- Considering each PU on the resident's body during look-back period, identify the one with the most severe tissue type
- Key is understanding the definitions for the answer options that are summarized on the form (see handout)

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**Mo800: Worsening in PU Status Since Prior
Assessment (OBRA, PPS, or Discharge)**

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- Number of PUs that were not present or were at lesser stage on prior assessment
- Enter 0 if resident did not have a PU at that stage during look-back period

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**Mo800: Worsening in PU Status Since Prior
Assessment (OBRA, PPS, or Discharge)**

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- If an ulcer was unstageable on admission, it is not considered to be worsened in the first assessment following debridement
- If a previously staged pressure ulcer becomes unstageable and then is debrided sufficiently to be staged, compare its stage before and after it was unstageable.
 - If its stage has worsened, include it in Mo800 when it is captured in the look-back period of an MDS assessment

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Mo800: Worsening in PU Status Since Prior Assessment (OBRA, PPS, or Discharge)

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- Pressure ulcers coded as present on admission in Mo300 are not considered to be new or worsened for Mo800
 - Any deterioration after admission would be counted in Mo800 when captured in the look-back period of an MDS assessment

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Mo900: Healed Pressure Ulcers

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- Number of PUs that healed since most recent prior MDS assessment of any kind
 - Healed: Completely closed, fully epithelialized, covered completely with epithelial tissue or resurfaced with new skin, even if the area continues to have some surface discoloration
- Always refer to PU by the highest stage it ever reached, even after it has healed

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**Other Skin Problems
M1030 and M1040**

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- Arterial, venous, and diabetic ulcers may be identified by their unique characteristics
- See handout *Definitions for Coding Skin Problems Other Than Pressure Ulcers*

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M1200: Skin and Ulcer Treatments

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- Avoid making assumptions about definitions for these items
- See handout *Definitions for Skin and Ulcer Treatments*

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Pressure Ulcer Prevention

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**RISK ASSESSMENT: FROM THE MOMENT OF
ADMISSION**

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Pressure Ulcer Prevention Risk Assessment

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- Identify risk on admission: the road map to prevention
 - Assessment tools
 - Braden, Norton scales
 - Resident Assessment Protocol: Pressure Ulcers
 - Use caution with cumulative scores
 - q shift charting on admission should include skin condition

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Pressure Ulcer Prevention
Risk Assessment

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- Identify risk **ON ADMISSION**
 - Regardless of score on assessment tools, certain factors always indicate high risk
 - History of resolved pressure ulcer
 - Newly admitted or readmitted - within 4 weeks
 - Health problems: Diabetes, edema, recent weight loss, dehydration, difficulty with activities of daily living, low pre-albumin level, use of steroids
 - Use of restraints

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Pressure Ulcer Prevention
Risk Assessment

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- Identify risk **WITH CHANGE OF CONDITION**
 - Change of condition = **red flag warning** of increased risk for skin breakdown
 - Facilities tend to be slow to respond to the effects a change of condition has on the patient's or resident's functional status
 - As soon as the change occurs, the care plan should be revised to include updated pressure ulcer prevention interventions
 - q shift charting should include skin condition from moment change of condition is identified

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Pressure Ulcer Prevention

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ACTION PLANNING

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Pressure Ulcer Prevention
Action planning

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- Intervene quickly
 - Interventions must be specific to the assessed risk factor
 - Example: Poor nutritional status, edema, ↓ mobility, incontinence
 - Identify and treat underlying causes
 - Example: Pain or shortness of breath causing decreased mobility
 - Individualize interventions
 - q2h turn schedule is not appropriate for everyone

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Pressure Ulcer Prevention
Action planning

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Effective effort to remove, modify, or stabilize the risk factors and underlying causal factors is *the* key to success

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Pressure Ulcer Prevention
General Strategies – Individualize to resident

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- Individualized positioning schedule
- Positioning that avoids pressure on an existing pressure ulcer(s)
- Measures to prevent or reduce potential for shearing or friction during transfers, elevation, and repositioning
- Pressure redistributing devices for the bed and/or chair that are working and used according to the manufacturer's recommendations

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Pressure Ulcer Prevention
General Strategies – Individualize to resident

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- In wheelchairs or reclining chairs, seat cushions adequate to prevent "bottoming out" for individuals unable to self-reposition
- Ensure that repositioning/weight shifts occur at consistent and frequent intervals for residents needing assistance with mobility and/or transfer
- Avoid massage over bony prominences, use mild cleansers, and moisturize the skin

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Pressure Ulcer Prevention
General Strategies – Individualize to resident

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- Do not place directly on greater trochanter
- HOB elevated $\geq 30^\circ$ is comparable to sitting – requires same positioning considerations
- No evidence that "microshifts" of 5° or 10° or 10-15 second lifts are beneficial

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Pressure Ulcer Prevention

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- The MDS 3.0 as a tool for monitoring risk
 - Decline in ADLs (G0110)
 - Decline in mood (PHQ-9 or PHQ-9-OV)
 - Urinary incontinence (H0300)
 - Bowel incontinence (H0400)
 - Pain effect on function (J0500)
 - Dehydration (J1550)
 - Weight loss (K0300)
 - Determination of risk (M0150)
 - Daily physical restraints (P0100)

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Pressure Ulcer Prevention
Clinical Strategies – When the best is not good enough

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- “Unavoidable”: pressure ulcer developed even though the facility:
 - Had evaluated the individual’s clinical condition and pressure ulcer risk factors
 - Defined and implemented interventions that are consistent with the individual’s needs, goals, and recognized standards of practice
 - Monitored and evaluated the impact of the interventions
 - Revised the approaches as appropriate

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Pressure Ulcer Treatment

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**MEETING THE STANDARD OF PRACTICE:
EVIDENCE-BASED PROTOCOLS**

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Evidence-Based Protocols

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- Set the standard for care
- Guide individual actions based on proven techniques and treatments
- Provide a systematic approach
 - Reproducible
 - Subject to evaluation

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Evidence-Based Protocols

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“Standardized assessments, screenings, and evaluations increase efficiency, aid data abstraction, and are crucial to developing an individualized plan of care for all patients.”

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Medicare Quality Improvement Community website
www.medqic.org

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Evidence-Based Protocols

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- Guidelines for care based on research
- The research identifies what works and what doesn't work – the protocols build on that

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Evidence-Based Protocols

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- Example of the evidence
 - Vyhldal, et al. (1998). Newly admitted patients who were at risk of the development of **pressure ulcers** had a lower incidence of **ulcers** when they used a specially designed foam mattress compared with a foam overlay and a standard mattress.

Source: *Evidence-Based Nursing*, 1(51).

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Evidence-Based Protocols

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**University of Iowa Gerontological Nursing
Interventions Research Center**

Evidence-based practice guidelines

www.nursing.uiowa.edu/consumers_patients/evidence_based.htm

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Evidence-Based Protocols

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American Medical Directors Association

Clinical Practice Guidelines

www.ama.com

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Evidence-Based Protocols

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- Pressure Ulcer Prevention
- Pressure Ulcer Treatment
- National Guideline Clearinghouse

Agency for Healthcare Research and Quality

www.ahrq.gov

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Resources

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- Regulatory requirements for nursing homes – also includes significant information about assessment, prevention, care, and treatment
 - Medicare State Operations Manual
 - Appendix PP
 - F314 Pressure Sores, page 152 at:

www.cms.hhs.gov/manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

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Physical Restraints and the MDS 3.0

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SECTION P

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PO100: Physical Restraints

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The key to coding this section is the definition of “restraints”

Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body

- It is the **effect the device has on the resident** that classifies it into this category, not a name or label given to the device, nor the purpose or intent of the device

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PO100: Physical Restraints

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- **Remove easily** - can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g., side rails are put down or not climbed over, buckles are intentionally unbuckled, ties or knots are intentionally untied), considering the resident's physical condition and ability to accomplish his or her objective (e.g., transfer to a chair, get to the bathroom in time)
- **Freedom of movement** - any change in place or position for the body or any part of the body that the person is physically able to control or access

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PO100: Physical Restraints

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- A device that meets definition of a restraint for the particular resident may be used only in the presence of *medical symptoms* that justify its use – and not for discipline or staff convenience
- If IDT determines that a physical restraint is appropriate for the resident, must be least restrictive
- Medical symptom must be documented, including ongoing assessments and care planning
- Physician order for the restraint must include the specific medical symptom being treated by its use

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PO100: Physical Restraints

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- **Bed rails** - Any combination of partial or full rails. Include in this category enclosed bed systems
- **Trunk restraints** - Any device or equipment or material that the resident cannot easily remove such as, but not limited to, vest or waist restraints or belts used in a wheelchair
- **Limb restraints** - Any device, equipment or material the resident cannot easily remove, that restricts movement of any part of an upper or lower extremity, including mittens

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PO100: Physical Restraints

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- **Chair prevents rising** - Any type of chair with a locked lap board or that places the resident in a recumbent position that restricts rising, or a chair that is soft and low to the floor. Included here are chairs that have a cushion placed in the seat that prohibit the resident from rising
- Any device that does not fit into the listed categories but that meets the definition of a restraint and has not been excluded from this section should be coded in items PO100D or PO100H, **Other**

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Physical Restraints – F222

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- **Physical restraints include, but are not limited to:**
 - Leg restraints
 - Arm restraints
 - Hand mitts
 - Soft ties or vests
 - Lap cushions
 - Lap trays the resident cannot remove easily.

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Physical Restraints – F222

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- **Practices that meet the definition of a restraint, such as:**
 - Using side rails to keep a resident from voluntarily getting out of bed
 - Tucking or using Velcro to hold a sheet, fabric, or clothing tightly so that a resident's movement is restricted

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Physical Restraints – F222

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• Practices that meet the definition of a restraint, such as:

- Using devices in conjunction with a chair, such as trays, tables, bars or belts, that the resident can not remove easily, that prevent the resident from rising
- Placing a resident in a chair that prevents a resident from rising
- Placing a chair or bed so close to a wall that the wall prevents the resident from rising out of the chair or voluntarily getting out of bed.

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Physical Restraints

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Key Point

- It is the effect the device has on the resident rather than its name or its intended use that determines whether or not it is classified as a restraint

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MDS Coding – P0100

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Two-step process for coding

1. Determine if the resident uses a device that could be a restraint
2. Evaluate as part of the assessment process whether or not a device meets the definition of a physical restraint

For P0100, code only devices that have the effect of restraining the resident

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Physical Restraints

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Example

- A resident who is unable to get out of a chair without assistance has a lap tray attached to his wheelchair. The lap tray does not restrict his access to his body. He is unable to remove the lap tray.
 - PO100G, Chair Prevents Rising, would not be checked, since the device does not prevent the resident from doing something he could do if the device were not present.

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Physical Restraints

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Example

- A resident has half-rails up on both sides of the bed to assist with bed mobility. When the side rails are down, the resident is able to move into a sitting position on the side of the bed by elevating the head of the bed and swinging her legs over the side. She is unable to do this with the side rail up.
 - The side rails have the effect of restraining this resident and would be checked at PO100A.

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Physical Restraints

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Example

- A resident is able to transfer himself from a wheelchair to his bed, even though he often loses his balance once he's on his feet. He has been placed in a geriatric chair because of his impulsivity.
 - The geriatric chair would be marked at PO100G, Chair Prevents Rising, because it prevents him from completing an activity he is capable of completing.

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Physical Restraints

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Example

- A resident has no voluntary movement. Full side rails are elevated on both sides of her bed.
 - P0100A, Bed Rail, would not be marked on the MDS, since the side rails do not restrict the resident's activity.

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Physical Restraints

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Example

- A resident uses an enclosed framed wheeled walker that has an integral seat. The resident is able to open the gate and exit the device at will.
 - This device does not have the effect of restraining this resident and would not be coded at P0100G, Chair Prevents Rising.

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Physical Restraints

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Example

- A resident wears a trunk restraint to improve trunk stability to enable him to remain in a wheelchair rather than a geriatric chair. This resident is unable to stand up from any type of chair without assistance. He has a slight rash on his back, and occasionally tries to scratch the itch.
 - This device would be coded at P0100E, Trunk Restraint Used in Chair or Out of Bed, because it limits the resident's access to his body.

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When Restraints are Indicated

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PHYSICAL RESTRAINTS

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Appropriate Use of Restraints

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- **Residents have the right “to be free from any physical or chemical restraint imposed for purposes of discipline or convenience...”**

- **Convenience:** Any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest.

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Appropriate Use of Restraints

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- **“...and not required to treat the resident's medical symptoms.”**

- **Medical Symptom:** An indication or characteristic of a physical or psychological condition.
 - ✕ Resident's subjective symptoms may not be the sole basis for using a restraint
 - ✕ Falls do not constitute self-injurious or a medical symptom that warrants use of physical restraints

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Appropriate Use of Restraints

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• **Factors that can result in consideration of use of restraints:**

- Health or medical problems
- Psychosocial issues
- Functional decline

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Appropriate Use of Restraints

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• **Before restraint is used, facility must identify how the use of restraints would:**

- Treat the medical symptom
- Protect the resident's safety
- Assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being.

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The Role of Assessment
and Care Planning

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APPROPRIATE USE OF RESTRAINTS

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Appropriate Use of Restraints
Assessment and Care Planning

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- **Adequacy of fall risk assessment is tightly linked to decision to consider restraint use.**
- **Identify and treat reversible problems**
 - Behavioral problems that might be reversible (delirium)
 - Pain
 - Polypharmacy or specific type of med
 - Sleep disturbance
 - Electrolyte imbalance
 - Environmental hazards

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Appropriate Use of Restraints
Assessment and Care Planning

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- **Adequacy of fall risk assessment (continued)**
- **Identify and care plan for chronic problems**
 - Behavioral issues that increase risk
 - Neuromuscular, cardiovascular, orthopedic problems
 - Impulsivity
 - Diabetes, dizziness, vertigo, postural hypotension
 - Incontinence
 - Unavoidable functional decline

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Appropriate Use of Restraints
Assessment and Care Planning

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- **Avoid use of cumulative scores from safety and fall risk assessments**
 - Focus on line items that point to important risk factors regardless of total score

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Appropriate Use of Restraints
Assessment and Care Planning

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- **The medical symptoms or the need for restraints to manage them may be resolved by:**
 - Meeting individual needs in accordance with Daily and Activity Preferences (F0400-F0500)
 - Providing restorative care
 - Providing meaningful activities
 - Manipulating environment to enhance safety
 - Use of less intrusive methods of administering meds and nourishment

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Appropriate Use of Restraints
Assessment and Care Planning

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- **Eliminate or minimize the specific problems and risk factors through individualized, interdisciplinary care planning**
 - Trapeze instead of side rails for mobility
 - ID side effects of medications that contribute to balance or behavior problems
 - Provide ↑ toileting for climbing out of bed
 - Frequent ambulation for restlessness

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Appropriate Use of Restraints
Assessment and Care Planning

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- **When restraint elimination presents higher risk than using a restraining device, use least restrictive device for the least amount of time that will achieve the goal**
 - Example: If pressure alarm and frequent standing and ambulation are not sufficient, try wedge cushion instead of belt restraint in wheelchair

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Appropriate Use of Restraints
Assessment and Care Planning

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- **Adopt policies that mandate avoiding use of restraints and that require use of least restrictive device if avoidance is not possible**

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Appropriate Use of Restraints
Assessment and Care Planning

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- **If restraints are used:**
 - Continually try to find and use less restrictive alternatives
 - Ensure that the resident or legal surrogate makes an informed choice about the use of restraints, explaining the risks, benefits, and alternatives explained
 - Use the Physical Restraints CAA to evaluate the appropriateness of restraint use
 - Periodically re-evaluate the need for the restraint, make efforts to eliminate its use, and maintain residents' strength and mobility
 - Address all possible safety issues

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Appropriate Use of Restraints
Assessment and Care Planning

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- **If restraints are used, systematically and periodically monitor for adverse effects, such as**
 - Functional decline (G0110: ADLs, G0300: Balance)
 - Agitation (Section E)
 - Preferences (F0400-F0500)
 - Diminished sense of dignity
 - Depression (PHQ-9 or PHQ-9-OV)
 - Decreased appetite, weight loss (K0300)
 - Pressure ulcers (Section M)
 - Incontinence (H0300, H0400)

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Summary

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PHYSICAL RESTRAINTS

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Physical Restraints
Summary

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- Use fall risk assessment as foundation for identifying risk factors
- Use restraints only when all other avenues have been ruled out
 - Use restraint assessment to periodically review appropriateness of restraint use
 - Care plan aggressively to prevent functional decline
 - Care plan aggressively to avoid injury related to the restraints
- Be clear about the definition of “physical restraints” for MDS coding and care planning

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Conclusion

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Although the requirements describe the narrow instances when physical restraints may be used, growing evidence supports that physical restraints have a limited role in medical care. Restraints limit mobility and increase the risk for a number of adverse outcomes. Physical restraints certainly do not eliminate falls. In fact in some instance reducing the use of physical restraints may actually decrease the risk of falling.

Source: CMS S&C Memorandum June 12, 2007

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MDS 3.0 Care Area Assessments

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MDS 3.0 and CAAs
Summary

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- ✓The Resident Assessment Instrument (RAI) process has not changed
- ✓Some of the language of the process is different
- ✓Requirements related to tools for assessments have changed

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CAA Requirement

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- Comprehensive assessments only
 - Admission assessment (MDS item A0310A=01)
 - Annual assessment (MDS item A0310A=03)
 - Significant Change in Status Assessment (MDS item A0310A=04)
 - Significant Correction to prior Comprehensive Assessment (MDS item A0310A=05)

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What's Changed?

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MDS 2.0

- MDS screens for possible problems in **18** care areas
- Triggers alert to possible issues in the care areas
- Care area must be thoroughly assessed
- Tool for conducting the assessment **must be the RAP**
- Documentation must meet criteria

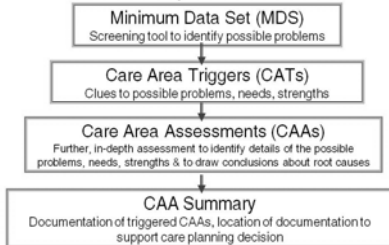
MDS 3.0

- MDS screens for possible problems in **20** care areas
- Care Area Triggers (CATs) alert to possible issues in the care areas
- Care area must be thoroughly assessed
- Specific tool for assessment **not mandated***
- Documentation must meet criteria*

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MDS 3.0

Anatomy of the RAI



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KEY POINT

The purpose is development of a resident-specific care plan based on identified problems, needs, strengths

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The Triggers

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CARE AREA ASSESSMENTS

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The Triggers

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- A Care Area **Trigger** (CAT) - MDS response indicating that clinical factors exist that may or may not represent a condition that should be care planned
- When a resident's status on a particular MDS item matches one of the CATs → the care area is **triggered** for further assessment
- Triggers flag conditions that warrant further investigation
- Trigger Legend in Chapter 4 lists the triggers

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Pressure Ulcer Triggers

TRIGGERS:			
Item	Item Description	Code	Other C.A.s Triggered
G0110A1	ADL: bed mobility: self-performance	1, 2, 3, 4, 7, 8	ADL Functional/Rehabilitation
H0300	Urinary continence	1, 2, 3	Urinary Incontinence/Catheter
H0400	Bowel continence	2, 3	
K0300	Weight loss	1, 2	Nutritional Status
M0150	Is resident at risk of developing pressure ulcer	1	
M0300A	Number of Stage 1 pressure ulcers	0-9	
M0300B1	Number of Stage 2 pressure ulcers	0-9	Nutritional Status
M0300C1	Number of Stage 3 pressure ulcers	0-9	Nutritional Status
M0300D1	Number of Stage 4	0-9	Nutritional Status
M0300E1	Number of un-staged pressure ulcers due to dressing	0-9	Nutritional Status
M0300F1	Number of pressure ulcers un-staged due to slough/eschar	0-9	Nutritional Status

Pressure Ulcer Triggers			
TRIGGERS:			
<i>Item</i>	<i>Item Description</i>	<i>Code</i>	<i>Other CAAs Triggered</i>
M0300G1	Number of pressure ulcers un-staged – deep tissue	0-9	Nutritional Status
M0800A	Worsened since prior assessment: Stage 2 pressure ulcers	0-9	
M0800B	Worsened since prior assessment: Stage 3 pressure ulcers	0-9	
M0800C	Worsened since prior assessment: Stage 4 pressure ulcers	0-9	
P0100B	Restraints used in bed: trunk restraint	1, 2	Falls Physical Restraints
P0100E	Restraints in chair/out of bed trunk restraint	1, 2	Falls Physical Restraints

Restraint Triggers			
TRIGGERS:			
<i>Item</i>	<i>Item Description</i>	<i>Code</i>	<i>Other CAAs Triggered</i>
P0100A	Restraints used in bed: bed rail any type	1, 2	
P0100B	Restraints used in bed: trunk restraint	1, 2	Falls Pressure Ulcer
P0100C	Restraints used in bed: limb restraint	1, 2	
P0100D	Restraints used in bed: other	1, 2	
P0100E	Restraints in chair/out of bed: trunk restraint	1, 2	Falls Pressure Ulcer
P0100F	Restraints in chair/out of bed: limb restraint	1, 2	
P0100G	Restraints in chair/out of bed: chair stops rising	1, 2	
P0100H	Restraint in chair/out of bed: other	1, 2	

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KEY POINT

The trigger is a small piece and only the beginning of the assessment process

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The Care Areas

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CARE AREA ASSESSMENTS

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The 20 Care Areas

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<ol style="list-style-type: none"> 1. Delirium 2. Cognitive Loss 3. Visual Function 4. Communication 5. ADLs-Functional Status 6. Urinary Incontinence and Indwelling Catheter 7. Psychosocial Well-Being 8. Mood State 9. Behavioral Symptoms 10. Activities 	<ol style="list-style-type: none"> 11. Falls 12. Nutrition Status 13. Feeding Tube(s) 14. Dehydration/Fluid Maintenance 15. Dental Care 16. Pressure Ulcer(s) 17. Psychotropic Medication Use 18. Physical Restraints 19. Pain 20. Return to Community Referral
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Conducting the Assessment

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CARE AREA ASSESSMENTS

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Conducting the Assessment

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Step 1: Identify the trigger

- Usually a sign, symptom, or other indicator

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Conducting the Assessment

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Step 2 : Identify the triggered Care Area

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Conducting the Assessment

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Step 3 : Conduct thorough assessment of the entire Care Area

- Include factors that could cause or contribute to the symptom
- Include factors for which the symptom places the resident at risk
- Some factors will be on the MDS, some will not

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Conducting the Assessment
Tools Requirement

100

- “Current, evidence-based or expert-endorsed research and clinical practice guidelines/resources”
- “The facility should be able to identify the resources they use upon request”

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Conducting the Assessment
Tools Option 1

101

- *Review of Indicators* for each care area provided in Appendix C
- Each provides a checklist of indicators that guides the assessment for the particular care area
- Also provides space and guidelines for documentation

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Conducting the Assessment
Tools Option 2

102

- Appendix C also offers a list of resources that may be used for this purpose
 - May be accessed online or through professional associations or other organizations
 - Not an exhaustive list – providers are free to use others that meet regulatory requirement

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Conducting the Assessment

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Step 4 : Draw conclusions based on the information collected

- What is causing or contributing to the problem for this resident?
- What is this resident at risk for related to the problem?
- What other health professionals should be involved?

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Documentation

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CARE AREA ASSESSMENTS

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CAA Documentation

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- The nature of the issue or condition - what is the problem for this resident?
- Causes and contributing factors
- Complications affecting or caused by the care area for this resident
- Risk factors that arise because of the presence of the condition
- Factors that must be considered in developing individualized care plan interventions
- Need for referrals to other health professionals

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KEY POINT

Regardless of tool or format, documentation should walk the surveyor through the evidence of the root causes, contributing factors, risk factors, referrals to other health professionals

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Endgame

107

- When the information is located
 - Anyone reading it should be able to understand how the assessor came to the decisions made about the nature of the problem, causes and contributing factors, risk factors, referrals to other disciplines, and whether to care plan the issue or not
 - Those factors should have direct connections to the care plan to eliminate or mitigate problems and risks

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Food for Thought

High quality assessments lead to improved quality of care and better quality of life

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Continuous Quality Improvement

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Continuous Quality Improvement

110

- **Strong programs of Continuous Quality Improvement (CQI)**
 - Track and trend in-house pressure ulcer development, healing of existing ulcers; correlate related and causative factors
 - Continuous monitoring of key aspects of key systems
 - Identify and correct problems before they become trends
 - Individual accountability for key systems – put someone in charge of the system

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Continuous Quality Improvement

111

- **Conduct systematic, ongoing monitoring of Pressure Ulcer Prevention systems**

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Continuous Quality Improvement

112

- Systematic monitoring of care systems related to risk for falls, restraint avoidance and reduction

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Continuous Quality Improvement

113

- Can't be done without consistent and effective leadership

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Proposed Quality Measures

114

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Pressure Ulcers (Short Stay)

115

- Percent of residents with pressure ulcers that are new or have not improved
 - Percent of all short-stay residents with a discharge assessment during the quarter who were identified as having one or more stage 2-4 pressure ulcers that were new or had not improved since their OBRA admission or 5-day PPS assessment

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Pressure Ulcers (Long Stay)

116

- Percent of high-risk residents with pressure ulcers
 - Residents with non-Admission clinical assessments during the quarter who were comatose, impaired in bed mobility or transfer, or suffering from malnutrition AND who have one or more stage 2-4 pressure ulcers

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Physical Restraints (Long Stay)

117

- Percent of residents who were physically restrained
 - Percentage of long-stay residents with non-Admission clinical assessments during the quarter who were physically restrained daily during the seven days prior to the assessment

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OBRA Assessment Requirements

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MDS 3.0: SUMMARY OF CHANGES

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OBRA Requirements

119

- OBRA '87 requirements for assessments are unchanged with MDS 3.0
 - Within 14 days of admission
 - Quarterly
 - Annually
 - When a significant change in status occurs
 - When a significant error is identified in a previously completed MDS

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OBRA Requirements

120

- What **HAS** changed is how to determine when the next assessment is due
 - Comprehensive assessments: 366 days after ARD of most recent comprehensive assessment (ARD + 366 days)
 - Quarterly: 92 days after the ARD of the most recent comprehensive or Quarterly assessment (ARD + 92 days)

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OBRA Requirements

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- Also changed
 - Assessments must be accepted into the national repository (the QIES ASAP system) within 14 days after completion
 - ✦ CAA completion (V0200B2) for comprehensive assessments
 - ✦ MDS completion (Z0500B) for Quarterlies

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Admission Assessment

122

- Required under 3 circumstances
 - Resident is admitted for the first time
 - Resident is readmitted after discharge **return not anticipated**
 - Resident is discharged **return anticipated and returns more than 30 days later**

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Completion Sequence

123

- Item completion/Z0400 attestations
 - After ARD
- MDS completion – Z0500B
- CAA completion – V0200B2
- Care plan completion – V0200C2

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A0310F. Entry/Discharge Reporting

124

- Tracks a resident's admissions/ readmissions and discharges from the facility
 - 01: Entry record
 - 10: Discharge assessment—return not anticipated
 - 11: Discharge assessment—return anticipated
 - 12: Death in facility record

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A0310F. Entry/Discharge Reporting

125

- These are the federal requirements
- Some states require more frequent discharge-and/or entry-tracking

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Discharge Assessments

126

• Discharge

When a resident leaves the facility for more than 24 hours for other than a temporary home visit or therapeutic leave or is admitted to the hospital. Can be to home or another community setting

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Discharge/Entry Records Not Required
with Leave of Absence

127

- Temporary home visit
- Temporary therapeutic leave
- Hospital observational stay of less than 24 hours when the hospital does not admit the resident to an inpatient stay

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Discharge Assessments

128

- Two Discharge Assessments:
 - Return Not Anticipated: **AO310F=10**
 - Return Anticipated: **AO310F=11**
- Must be completed within 14 days of discharge and transmitted within 14 days of completion.

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Discharge Assessments

129

- Cannot replace or be replaced by any other assessment type,
- Includes tracking information as well as data used for quality monitoring.
 - Not a comprehensive assessment: No CAA or care planning requirement.
 - Can be combined with other assessment types as long as all requirements of both are met.

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Discharge Assessment–Return Anticipated

130

- When resident is discharged to the hospital and
 - Is admitted to an inpatient bed or
 - Is in a hospital observation stay of more than 24 hours and is expected to return to the nursing home.
- Must be completed at Z0500B within 14 days after the date of discharge (A2000)
- Must be accepted into QIES ASAP within 14 days after completion date (Z0500B)

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Discharge Assessment–Return Anticipated

131

- If SCSA criteria are not met, OBRA schedule picks up where it left off.
 - If OBRA assessment was due while resident in hospital, must be completed within 14 days of readmission
 - If SCSA indicated, must be completed within 14 days of readmission

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Discharge Assessment–Return Not Anticipated

132

- When resident is discharged to lower level of care, home, or another nursing home

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Entry and Reentry Tracking

133

- Required anytime a resident is:
 - Admitted for the first time or
 - Returns to the facility after a discharge assessment of either type.
- Use Nursing Home and Swing Bed Tracking (NT/ST) Item Set

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Entry and Reentry Tracking

134

- Current Entry Date is entered at A1600
- 2 Types of Entry:
 - Admission: A1700 = 1
 - Reentry: A1700 = 2
- *Entry record required in addition to any other assessments that might be required.*
- Must be completed within 7 days after entry/reentry date & transmitted within 14 days after the Entry Date.
 - May not be combined with any assessment, but it may be submitted with or without an assessment.

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Death in Facility Records

135

- A0310F = 12
- Used when resident dies in the facility or while on LOA
- Must be completed within 7 days of the event and transmitted within 14 days of completion.

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PPS Assessments

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SUMMARY OF CHANGES

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Scheduled Assessments

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Medicare MDS Scheduled Assessment Type	Reason for Assessment (A0310B code)	Assessment Reference Date	Assessment Reference Date Grace Days ⁺	Applicable Standard Medicare Payment Days ⁺
5-day Readmission/Return	01 06	Days 1-5	6-8	1 through 14
14-day	02	Days 11-14	15-19	15 through 30
30-day	03	Days 21-29	30-34	31 through 60
60-day	04	Days 50-59	60-64	61 through 90
90-day	05	Days 80-89	90-94	91 through 100

Part A resident **discharged return anticipated** to inpatient hospital stay and returns on Part A → PPS schedule restarts with Readmission/Return assessment

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Unscheduled Assessments

138

- To recalculate the RUG-IV level between scheduled assessments
 - Start of Therapy Other Medicare-Required Assessment (SOT OMRA, A0310B=07 and A0310C=1)
 - End of Therapy OMRA (EOT OMRA, A0310B=07 and A0310C=2)
 - Start and End of Therapy OMRA (A0310B=07 and A0310C=3)

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**End of Therapy OMRA
(EOT OMRA)**

139

- To establish a non-therapy payment rate when
 1. Resident is in a Rehabilitation RUG-IV category
 2. All therapies are discontinued, and
 3. Resident continues to be covered on Part A for skilled nursing services

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**End of Therapy OMRA
(EOT OMRA)**

140

- ARD must be on day 1, 2, or 3 after the last day of therapy services
 - Day 1 is first day that therapy would *normally be provided* after the last therapy treatment
- EOT OMRA sets payment starting the day after the last therapy treatment is provided (latest therapy end date)

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**Start of Therapy OMRA
(SOT OMRA)**

141

- **Optional** assessment to calculate a Rehab RUG when
 - Rehab services start between scheduled assessments

OR

 - Rehab services start within regular assessment window when not enough therapy was delivered for a rehabilitation RUG to be calculated

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**Start of Therapy OMRA
(SOT) OMRA**

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- ARD day 5, 6, or 7, with the first day of therapy counting as day 1
 - First day of therapy = Date of 1st therapy evaluation
- SOT OMRA sets payment rate starting on the earliest start of therapy date

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Start-of-Therapy OMRA

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- Example
 - For a 5-day assessment, therapy began on day 5. ARD set for day 7. Only three days of therapy captured.
 - Facility would have the option of doing a start-of-therapy OMRA with an ARD of day 5, 6, or 7 after the start of therapy (day 9, 10, or 11 of the Part A stay in this example) to capture more days of therapy

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**Start of Therapy OMRA
(SOT) OMRA**

144

- Some non-rehabilitation RUGs pay at higher rates than some rehabilitation RUGs
 - Providers may opt not to complete the SOT OMRA if the non-rehabilitation RUG calculated by the most recent assessment has a **higher rate** than a SOT OMRA would provide

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Short Stay Designation

145

- To calculate a RUG-IV category for residents with Part A stay \leq **8 days** who received therapy **< 5 days** and therefore would not otherwise classify into a rehabilitation RUG
- With RUG-III and MDS 2.0, the section T projection was utilized for this kind of situation
- Software determines if criteria are met – you cannot select this as an option

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Short Stay Designation

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- Assessment Requirements
 1. Must be SOT OMRA
 2. 5-day or Readmission/Return must be completed (may be combined with the SOT OMRA)
- ARD Requirements
 3. Must be day 8 or earlier of Part A stay
 4. Must be last day of Part A stay
 5. Must be no more than 3 days after the start of therapy

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Short Stay Designation

147

- Rehabilitation Requirements
 6. Must have started in last 4 days of Part A stay
 7. Must continue through last day of Part A stay
 - RUG Requirements
 8. Must classify resident into Rehabilitation Plus Extensive Services or Rehabilitation group
- NOTE: When the earliest start of therapy is 1st day of stay, then the Part A stay must be 4 days or less

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Short Stay Designation

148

- Software will add up all minutes of therapy and divide by the number of days therapy **could have been provided**
 - If continuous days of therapy, divisor is actual number of days of therapy
 - If non-therapy day is within the therapy timeframe, divisor will be number of days of therapy + the non-therapy days

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Short Stay Designation

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RUG-IV categories for Short Stay assessments

Average Daily Minutes	Rehabilitation Category
15-29 minutes	Rehabilitation Low (RLx)
30-64 minutes	Rehabilitation Medium (RMx)
65-99 minutes	Rehabilitation High (RHx)
100-143 minutes	Rehabilitation Very High (RVx)
144 or more minutes	Rehabilitation Ultra High (Rux)

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Short Stay Assessment Example 1

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- Day 1 – Part A admission
 - Day 6 – 1st therapy eval + 30-minutes PT
 - Day 7 – 60 minutes PT
 - 30 minutes OT
 - Day 8 – 60-minutes PT
 - 30 minutes OT
 - Discharge from Part A
 - ARD (SOT OMRA + 5-day)
- Are Short Stay Criteria Met?**

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Short Stay Assessment Example

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- All 8 criteria are met
- $30+90+90=210$
- $210/3= 70$ minutes per day

RHx

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MDS 3.0 Implementation Planning

152

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MDS 3.0 – Major Change

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- How facility implements it will determine:
 - How accurate the data the surveyors see will be
 - How representative of the quality of care in the facility the Quality Indicators and Quality Measures will be
 - Whether Part A reimbursement will be consistent with the intensity of care the facility provides

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MDS 3.0 – Major Change

154

Leadership is key to success

- See the vision – share the vision
- Make the commitment to change
- Model the attitude and commitment needed for success

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MDS 3.0 – Major Change

155

Leadership is not magnetic personality – that can just as well be a glib tongue. It is not ‘making friends and influencing people’ – that is flattery. Leadership is lifting a person’s vision to higher sights, the raising of a person’s performance to a higher standard, the building of a personality beyond its normal limitations.

--Peter F. Drucker, Management Consultant

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Much to Learn

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Much to Learn – MDS 3.0

157

- **Centerpiece: shift in assessment philosophy**
 - New emphasis on resident's own voice as primary source of information
 - Brief Interview for Mental Status (BIMS)
 - Resident Mood Interview (PHQ-9)
 - Interview for Daily Preferences
 - Interview for Activity Preferences
 - Pain Interview

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Much to Learn – MDS 3.0

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- Many other changes – many we've discussed today

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Making it Happen

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A FACILITY-WIDE EFFORT

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Making It Happen

160

☆ *Make a plan* – well in advance

- Involve entire team
- A leader who believes in the process should be the facilitator throughout the process
- Leave no doubt that this project has the full support of the facility's administrative team

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Making It Happen

161

☆ *Provide formal training* by recognized experts for all staff members who will participate in the assessment

- Remove obstacles that might prevent them from receiving the training and support they will need
- Ensure they have the most up-to-date instruction manual at all times
- Affiliate with AANAC

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Making It Happen

162

☆ *Provide training to all staff regarding their role in providing input into the resident's status*

- Incorporate this into orientation program on ongoing basis
- Repeat this training at least annually

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Making It Happen

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☆ Find out about *your software vendor's transition plan*

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Making It Happen

164

☆ Have the team *analyze current processes, develop new processes*

- Study current MDS-related processes
- Brainstorm what will be needed in terms of process for the team to be able to do their work efficiently and effectively
- Flowchart proposed process step by step
 - Identify and remove barriers
 - Change process when necessary

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Making It Happen

165

☆ Study reimbursement impact

- Analyze effect of redistribution of RUG levels, changes in look-back periods, concurrent therapy, OMRA requirements
- Identify potential new revenue streams
- Discover missed opportunities

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Making It Happen

166

☆ *Start using the interviews now*

- Not for completing MDS 2.0 but to start to improve quality of assessment and care planning now

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Making It Happen

167

☆ *Incorporate staff practice time into the transition plan*

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Making It Happen

168

☆ *Develop a quality improvement plan for MDS 3.0 activities*

- Include practice audits
- Implement routine monitoring of accuracy

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Making It Happen

169

☆ *Resistance to change is inevitable*

- Prepare for it
- Learn from it
- Harness the energy and use it toward change

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Making It Happen

170

☆ *Be a cheerleader for change*

- Emphasize the positive change for the residents
 - MDS 3.0 meets standard of clinical practice
 - Improvement in quality of life
- Stress the positives for the facility
 - Results will shine through at survey time and in resident and family satisfaction

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Resources

- **American Association of Nurse Assessment Coordinators (AANAC)**
www.aanac.org
- **MDS 3.0 Website**
www.cms.hhs.gov/NursingHomeQualityInits/25_NHQMDS30.asp
- **AANAC Assessment University Webinars**
www.aanac.org/learn/

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Resources
Clinical Practice

- Medicare Quality Improvement Community
www.medic.org
- University of Iowa Gerontological Nursing
Research Center Evidence-Based Practice
Guidelines
www.nursing.uiowa.edu/consumers_patients/evidence_based.htm
- American Medical Directors Association Clinical
Practice Guidelines
www.ama.com/tools/guidelines.cfm

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Thank You!!

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M0700: Most Severe Tissue Type for Any Pressure Ulcer (cont.)

Planning for Care

- Identify tissue type.
- Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices.
- Changes in tissue characteristics over time are indicative of wound healing or degeneration.

Steps for Assessment

1. Examine the wound bed or base of each pressure ulcer. Good lighting is important.
2. Determine the type(s) of tissue in the wound bed (e.g., epithelial, granulation, slough, eschar).
3. Code for the most severe type of tissue present in the pressure ulcer wound bed.
4. If the wound bed is covered with a mix of different types of tissue, code for the most severe type. If a mixture of necrotic tissue (eschar) and slough is present, code for necrotic tissue (eschar).

Coding Instructions for M0700

- Code 1, epithelial tissue: if the wound is superficial and is re-epithelializing.
- Code 2, granulation tissue: if the wound is clean (e.g., free of slough and necrotic tissue) and contains granulation tissue.
- Code 3, slough: if there is any amount of slough present and necrotic tissue is absent.
- Code 4, necrotic tissue (eschar): if there is any necrotic tissue present.

Coding Tips and Special Populations

- All Stage 2 pressure ulcers should be **coded as 1** for this item.
- Stage 2 pressure ulcers should **not** be coded with granulation, slough, or necrotic tissue.
- If the wound bed is covered with a mix of different types of tissue, code for the most severe type. For example, if a mixture of necrotic tissue (eschar) and slough is present, code for necrotic tissue (eschar).

DEFINITIONS

EPITHELIAL TISSUE
New skin that is light pink and shiny (even in person's with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.

GRANULATION TISSUE
Red tissue with "cobblestone" or bumpy appearance, bleeds easily when injured.

SLOUGH TISSUE
Yellow or white tissue that is soft, stringy, or mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

NECROTIC TISSUE (ESCHAR)
Hard or soft in texture; usually black, brown, or tan in color. Eschar is usually firm or hard with brown or black color and may appear scab-like. Necrotic tissue can also present as soft, soggy black or brown tissue. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.

M0700: Most Severe Tissue Type for Any Pressure Ulcer (cont.)

Examples

- A resident has a Stage 2 pressure ulcer on the right ischial tuberosity that is healing and a Stage 3 pressure ulcer on the sacrum that is also healing with red granulation tissue that has filled 75% of the ulcer and epithelial tissue that has resurfaced 25% of the ulcer.

Coding: Code M0700 is based on the sacral ulcer and would be coded as 2, granulation tissue.

Rationale: Coding is based on M0700, the sacral ulcer, because it is the pressure ulcer with the most severe tissue type. Granulation tissue, code 2, is selected because this is the most severe tissue present in the wound.
- A resident has a Stage 2 pressure ulcer on the right heel and no other pressure ulcers.

Coding: M0700 would be coded as 1, epithelial tissue.

Rationale: Coding the item for epithelial tissue is consistent with identification of this pressure ulcer as a Stage 2 pressure ulcer.
- A resident has a pressure ulcer on the left trochanter that has 25% black necrotic tissue present, 75% granulation tissue present, and some epithelialization at the edges of the wound.

Coding: M0700 would be coded as 4, necrotic tissue.

Rationale: Coding is for the most severe tissue type present, which is not always the majority of type of tissue.

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)	
Complete only if A0130E = 0	
Indicate the number of current pressure ulcers that were not present or were at a lesser stage on prior assessment (OBRA, PPS, or Discharge). If no current pressure ulcer at a given stage, enter 0	
Enter Number <input type="text"/>	A. Stage 2
Enter Number <input type="text"/>	B. Stage 3
Enter Number <input type="text"/>	C. Stage 4

Item Rationale

Health-related Quality of Life

- This item documents whether skin status, overall, has worsened since last assessment. To track increasing skin damage, this item documents the number of new pressure ulcers and whether any pressure ulcers have worsened to a higher (deeper) stage since the last assessment. Such tracking of pressure ulcers is consistent with good clinical care.

Handout 3

Definitions for Coding Skin Problems Other Than Pressure Ulcers M1030 and M1040

Venous Ulcers Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.

- Most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg
- May or may not be painful
- Typically shallow with irregular wound edges, a red granular (e.g., bumpy) wound bed, minimal to moderate amounts of yellow fibrinous material, and moderate to large amounts of exudate. The surrounding tissues may be erythematous or reddened or appear brown-tinged due to hemosiderin staining.
- Leg edema may be present
- May start with some kind of minor trauma, such as hitting the leg on the wheelchair.
- Does not typically occur over a body prominence, and pressure forces play virtually no rule in the development of the ulcer

Arterial Ulcers Ulcers caused by peripheral arterial disease which commonly occur on the tips of toes, top of the foot, or distal to the medial malleolus.

- Commonly occur on the tips of toes, top of the foot, or distal to the medial malleolus
- Often painful
- Have a pale pink wound bed, minimal exudate, minimal bleeding, and necrotic tissue
- Trophic changes, such as dry skin, loss of hair growth, muscle atrophy, or brittle nails, may be present
- Lower extremity and foot pulses may be diminished or absent
- May start with some kind of minor trauma, such as hitting the leg on the wheelchair
- Does not typically occur over a body prominence, and pressure forces play virtually no rule in the development of the ulcer

Diabetic Foot Ulcers Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful.

- Diabetic neuropathy affects the lower extremities of individuals with diabetes. Individuals with diabetic neuropathy can have decreased awareness of pain in their feet. This means they are at high risk for foot injury, such as burns from hot water or heating pads, cuts or scrapes from stepping on foreign objects, and blisters from inappropriate or tight-fitting shoes. Because of decreased circulation

Handout 4

and sensation, the resident may not be aware of the wound.

- Neuropathy can also cause changes in the structure of the bones and tissue in the foot. This means the individual with diabetes experiences pressure on the foot in areas not meant to bear pressure. Neuropathy can also cause changes in normal sweating, which means the individual with diabetes can have dry, cracked skin on his/her feet.
- Do NOT include pressure ulcers that occur on residents with diabetes mellitus here. For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer.

Surgical Wounds Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body.

- This category does not include healed surgical sites and stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.
- Do not code pressure ulcers that have been surgically debrided as surgical wounds. They continue to be coded as pressure ulcers.
- This coding is appropriate for pressure ulcers that are surgically repaired with grafts and flap procedures.

Open Lesion Other Than Ulcers, Rashes, Cuts Most typically skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer.

- Do NOT code skin tears, cuts, or abrasions here. Although not recorded on the MDS assessment, these open lesions need to be addressed in the care plan.

Burns (Second Or Third Degree) Skin and tissue injury caused by heat or chemicals and may be in any stage of healing.

- Do NOT include first degree burns (changes in skin color only).

Handout 5

Definitions for Skin and Ulcer Treatments

M1200

Avoid assumptions about the definitions assigned to the treatments listed, as some of them might not be consistent with exactly what an assessor might think.

- M1200A and M1200B, pressure reducing device for chair and for bed
 - Definitions encompass pressure relieving, pressure reducing, and pressure redistributing devices.
 - Exclusions: Egg crate cushions of all kinds and doughnut or ring devices in chairs, which can decrease circulation to the tissues within the ring, potentially resulting in harm to the resident.

- M1200C, Turning/repositioning program
 - For MDS coding, blanket facility policies for turning and repositioning residents should not be coded in M1200C
 - To capture turning and positioning on the MDS, the facility must develop a resident-specific program that includes interventions that were developed for that resident based on resident-specific problems and needs. Some residents, for example, can tolerate lying in one position for two hours; others cannot. Some residents can be positioned on both sides and back, some cannot. Some residents require special positioning devices; others do well with standard pillows. Program should specify intervention and frequency.
 - Also, the program must be organized, planned, document, monitored, and evaluated. As the manual instructions state, “Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the interventions” (p. M-32).

- M1200D, Nutrition or hydration intervention to manage skin problems should be checked when dietary measures are implemented to prevent or treat specific skin conditions.

- M1200E, Ulcer care, includes any intervention for treating the pressure ulcers coded in M0300, Current Number of Unhealed Pressure Ulcers at Each Stage.

- M1200F, Surgical wound care includes “any intervention for treating or protecting any type of surgical wound.” It does not, however, include post-operative care following eye or oral surgery or surgical debridement of a pressure ulcer (CMS, 2009, p. M-32).

- Items M1200G, Application of nonsurgical dressings (with or without topical medications), and M1200H, Application of ointments/medications, specify that when these treatments are applied to the feet, it is captured in M1200I, Application of dressings to the feet, and not in M1200G and M1200H.

- M1200H, Application of ointments/medications other than to the feet. This captures ointments and medications used to treat or prevent a skin condition.

- M1200I, Application of dressings to the feet (with or without topical medications) does NOT include treatments to pressure ulcers of the foot.

16. PRESSURE ULCER(S)

Review of Indicators of Pressure Ulcer(s)

		<p align="center">Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)</p>
<p align="center">✓</p>	<p>Existing pressure ulcer(s) (M0100)</p>	
<p align="center">☐</p>	<ul style="list-style-type: none"> • Assess location, size, stage, presence and type of drainage, presence of odors, condition of surrounding skin <ul style="list-style-type: none"> — Note if eschar or slough is present — Assess for signs of infection, such as the presence of a foul odor, increasing pain, surrounding skin is reddened (erythema) or warm, or there is a presence of purulent drainage — Note whether granulation tissue (required for healing) is present and the wound is healing as expected 	
<p align="center">☐</p>	<ul style="list-style-type: none"> • If the ulcer does not show signs of healing despite treatment, consider complicating factors <ul style="list-style-type: none"> — Elevated bacterial level in the absence of clinical infection — Presence of exudate, necrotic debris or slough in the wound, too much granulation tissue, or odor in the wound bed — Underlying osteomyelitis (bone infection) 	
<p align="center">✓</p>	<p>Extrinsic risk factors</p>	
<p align="center">☐</p>	<ul style="list-style-type: none"> • Pressure <ul style="list-style-type: none"> — Requires staff assistance to move sufficiently to relieve pressure over any one site — Confined to a bed or chair all or most of the time — Needs special mattress or seat cushion to reduce or relieve pressure — Requires regular schedule of turning 	
<p align="center">☐</p>	<ul style="list-style-type: none"> • Friction and shear <ul style="list-style-type: none"> — Slides down in the bed — Moved by sliding rather than lifting 	
<p align="center">☐</p>	<ul style="list-style-type: none"> • Maceration <ul style="list-style-type: none"> — Persistently wet, especially from fecal incontinence, wound drainage, or perspiration 	

Handout 7

		Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input checked="" type="checkbox"/>	Intrinsic risk factors	
<input type="checkbox"/>	• Immobility (G0100)	
<input type="checkbox"/>	• Altered mental status — Delirium limits mobility (see Delirium CAT/CAA) — Cognitive loss (C0500, C0700-C1100) limits mobility (see Cognitive Loss CAT)	
<input type="checkbox"/>	• Incontinence (H0300, H0400) (see Incontinence CAT/CAA)	
<input type="checkbox"/>	• Poor nutrition (see Nutrition CAT/CAA)	

<input checked="" type="checkbox"/>	Medications that increase risk for pressure ulcer development	
<input type="checkbox"/>	• Antipsychotics (N0400A)	
<input type="checkbox"/>	• Antianxiety agents (N0400B)	
<input type="checkbox"/>	• Antidepressants (N0400C)	
<input type="checkbox"/>	• Hypnotics (N0400D)	
<input type="checkbox"/>	• Steroids	
<input type="checkbox"/>	• Narcotics	

<input checked="" type="checkbox"/>	Diagnoses and conditions that present complications or increase risk for pressure ulcers	
<input type="checkbox"/>	• Delirium (C1600)	
<input type="checkbox"/>	• Comatose (B0100)	
<input type="checkbox"/>	• Cancer (I0100)	
<input type="checkbox"/>	• Peripheral Vascular Disease (I0900)	
<input type="checkbox"/>	• Diabetes (I2900)	
<input type="checkbox"/>	• Alzheimer's disease (I4200)	
<input type="checkbox"/>	• Cerebrovascular Accident (I4500)	
<input type="checkbox"/>	• Other dementia (I4800)	
<input type="checkbox"/>	• Hemiplegia/hemiparesis (I4900)	
<input type="checkbox"/>	• Paraplegia (I5000), Quadriplegia (I5100)	
<input type="checkbox"/>	• Multiple sclerosis (I5200)	
<input type="checkbox"/>	• Depression (D0300, D0600, I5800)	
<input type="checkbox"/>	• Edema	
<input type="checkbox"/>	• Severe pulmonary disease (I6200)	
<input type="checkbox"/>	• Sepsis (I2100)	
<input type="checkbox"/>	• Terminal illness (O0100K)	

(continued)

Handout 8

✓	Diagnoses and conditions that present complications or increase risk for pressure ulcers (continued)	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	<ul style="list-style-type: none"> Chronic or end-stage renal (I1500) , liver, or heart disease (I0400, I0600) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Pain (J0300) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Dehydration (J1500D, I8000) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Shortness of breath (J1100) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Recent weight loss (K0300) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Malnutrition (I5600) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Decreased sensory perception 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Recent decline in activities of daily living (G0110-G0600) 	

✓	Treatments and other factors that cause complications or increase risk	
<input type="checkbox"/>	<ul style="list-style-type: none"> Newly admitted or readmitted 	
<input type="checkbox"/>	<ul style="list-style-type: none"> History of healed pressure ulcer(s) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Chemotherapy (A0100A) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Radiation therapy (A0100B) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Ventilator or respirator (A0100F) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Renal dialysis (A0100J) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Functional limitation in range of motion (G0400) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Head of bed elevated most or all of the time 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Physical restraints (P0100) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Bedfast (G0800) or wheelchair bound 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Devices that can cause pressure, such as oxygen (A0100C) or indwelling catheter (H0100A) tubing, TED hose, casts, or splints 	

Handout 9

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		Care Plan Considerations
Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. 	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
 Yes No

18. PHYSICAL RESTRAINTS

Review of Indicators of Physical Restraints

✓	Evaluation of current restraint use (based on chart documentation, including care plan)	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	<ul style="list-style-type: none"> Does not meet regulatory definition of restraint (stop here and check accuracy of MDS item that triggered this CAT) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Evidence of informed consent not evident on chart 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Medical symptom not identified for treatment via restraints 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Used for staff convenience 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Used for discipline purposes 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Multiple restraints in use 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Non-restraint interventions not attempted prior to restraining 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Less restrictive devices not attempted 	
<input type="checkbox"/>	<ul style="list-style-type: none"> No regular schedule for removing restraints 	
<input type="checkbox"/>	<ul style="list-style-type: none"> No schedule for frequency by hour of the day for checking on resident's well-being 	
<input type="checkbox"/>	<ul style="list-style-type: none"> No plan for reducing/eliminating restraints 	

✓	Medical conditions/treatments that may lead to restraint use	
<input type="checkbox"/>	<ul style="list-style-type: none"> Indwelling catheter (H0100A), external catheter (H0100B), or ostomy (H0100C) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Parenteral/IV feeding (K0500A) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Feeding tube (K0500B) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Pressure ulcer (M0210) or pressure ulcer care (M1200E) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Other skin ulcers, wounds, skin problems (M1040) or wound care (M1200F-M1200I) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Oxygen therapy (O0100C) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Tracheostomy (O0100E and from record) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Ventilator or respirator (O0100F) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> IV medications (O0100H) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Transfusions (O0100I) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Functional decline, decreased mobility (from record) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Other medical problem or equipment associated with restraint use (from record) 	

Handout 11

✓	Cognitive impairment/behavioral symptoms that may lead to restraint use (also see Cognitive Loss and Behavior CATs/CAAs)	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	• Inattention, easily distracted (C1300A)	
<input type="checkbox"/>	• Disorganized thinking (C1300B)	
<input type="checkbox"/>	• Fidgety, restless	
<input type="checkbox"/>	• Agitation	
<input type="checkbox"/>	• Confusion (C0100, C0600)	
<input type="checkbox"/>	• Psychosis (E0100A-E0100C)	
<input type="checkbox"/>	• Physical symptoms directed toward others (E0200A)	
<input type="checkbox"/>	• Verbal behavioral symptoms directed toward others (E0200B)	
<input type="checkbox"/>	• Rejection of care (E0800)	
<input type="checkbox"/>	• Wandering (E0900)	
<input type="checkbox"/>	• Delirium (C1600), including side effects of medications (from record)	
<input type="checkbox"/>	• Alzheimer's disease (I4200) or other dementia (I4800)	
<input type="checkbox"/>	• Traumatic brain injury (I5500)	
<input type="checkbox"/>	• Psychiatric disorder (I5700-I6100)	

✓	Risk for falls (also see Falls CAT/CAA) that may lead to restraint use	
<input type="checkbox"/>	• Poor safety awareness, impulsivity (from record)	
<input type="checkbox"/>	• Urinary urgency (from record)	
<input type="checkbox"/>	• Incontinence of bowel and/or bladder (H0300, H0400)	
<input type="checkbox"/>	• Side effect of medication, such as dizziness, postural hypotension, sedation, etc. (from record)	
<input type="checkbox"/>	• Insomnia, fatigue (D0200D, D0500D)	
<input type="checkbox"/>	• Need for assistance with mobility (G0110)	
<input type="checkbox"/>	• Balance problem (G0300)	
<input type="checkbox"/>	• Postural hypotension (from record)	
<input type="checkbox"/>	• Hip or other fracture (I3900, I4000)	
<input type="checkbox"/>	• Hemiplegia/hemiparesis (I4900), paraplegia (I5000), quadriplegia (I5100)	
<input type="checkbox"/>	• Other neurological disorder (for example, Cerebral Palsy (I4400), Multiple Sclerosis (I5200), Parkinson's Disease (I5300))	
<input type="checkbox"/>	• Respiratory problems (J1100 and from record)	
	• History of falls (J1700 – J1900)	

Handout 12

		Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
✓	Adverse reaction to restraint use	
<input type="checkbox"/>	<ul style="list-style-type: none"> • Skin breakdown (Section M) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> • Incontinence or increased incontinence (H0300, H0400, record) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> • Constipation (H0600) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> • Increased agitation (from record) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> • Depression, withdrawal, diminished dignity, social isolation (I5800, I5900, and from record) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> • Loss of muscle mass, contractures, lessened mobility and stamina (from record) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> • Infections, such as UTI or pneumonia (I1700 – I2500) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> • Frequent attempts to get out of the restraints, falls (J1700 – J1900 and from record) 	

Handout 13

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)

Analysis of Findings		Care Plan Considerations
Review indicators and supporting documentation, and draw conclusions. Document: <ul style="list-style-type: none"> • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area. 	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.

Referral(s) to another discipline(s) is warranted (to whom and why): _____

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):
 Yes No

CARE AREA GENERAL RESOURCES

The general resources contained on this page are not specific to any particular care area. Instead, they provide a general listing of known clinical practice guidelines and tools that may be used in completing the RAI CAA process.

NOTE: This list of resources is neither prescriptive nor all-inclusive. References to non-U.S. Department of Health and Human Services (HHS) sources or sites on the Internet are provided as a service and do not constitute or imply endorsement of these organizations or their programs by CMS or HHS. CMS is not responsible for the content of pages found at these sites. URL addresses were current as of the date of this publication.

- Advancing Excellence in America's Nursing Homes Resources: http://www.nhqualitycampaign.org/star_index.aspx?controls=nhTechAssist;
- Agency for Health Care Research and Quality: <http://www.ahrq.gov/clinic/>;
- Alzheimer's Association Resources: http://www.alz.org/professionals_and_researchers_14899.asp#professional;
- American Geriatrics Society Clinical Practice Guidelines and Tools: <http://www.americangeriatrics.org>;
- American Medical Directors Association (AMDA) Clinical Practice Guidelines and Tools: <http://www.amda.com/tools>;
- American Pain Society: http://www.ampainsoc.org/pub/cp_guidelines.htm;
- American Society of Consultant Pharmacists Practice Resources: <http://www.ascp.com/resources>;
- Association for Professionals in Infection Control and Epidemiology Practice Resources: <http://www.apic.org/AM/Template.cfm?Section=Practice>;
- Centers for Disease Control and Prevention: Infection Control in Long-Term Care Facilities Guidelines: http://www.cdc.gov/ncidod/dhqp/gl_longterm_care.html;
- CMS Pub. 100-07 State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities (federal regulations noted throughout; resources provided in endnotes): <http://www.cms.gov/Manuals/IOM/list.asp>;
- Emerging Solutions in Pain Tools: <http://www.emergingsolutionsinpain.com/>;
- GeriatricWeb Resources and Practice Guidelines: <http://geriatricweb.sc.edu/>;
- Hartford Institute for Geriatric Nursing Geriatric Protocols and Assessment Series: <http://www.hartfordign.org/resources>;
- Hartford Institute for Geriatric Nursing Geriatric Clinical Nursing Resources: <http://consultgerirn.org/resources>;
- Institute for Safe Medication Practices: <http://www.ismp.org/>;
- Medicare Quality Improvement Community (MedQIC): <http://www.qualitynet.org/dcs/ContentServer?c=MQParents&pagename=Medqic%2FCContent%2FParentShellTemplateandcid=1089815966986andparentName=Setting>.
- Quality Improvement Organizations: www.medqic.org;
- Research in Gerontological Nursing: <http://www.geronurseresearch.com/>;
- University of Missouri's Geriatric Examination Tool Kit: <http://web.missouri.edu/~proste/tool/>; and
- U.S. Department of Health and Human Services Agency for Healthcare Research and Quality's National Guideline Clearinghouse: <http://www.guideline.gov/>;