



Oklahoma State
Department of Health
Creating a State of Health

NEWS YOU CAN USE

Oklahoma State Department of Health
Quality Improvement & Evaluation Service (405) 271 5278
Nancy Atkinson, Chief

MDS

Special points of interest:

- Cognitive Skills for Daily Decision Making—Section B4-The Assessment Process
- MDS Accuracy Quick Section B4
- The MDS Connection
- Automation Tips, Reminders & Updates

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Cognitive Skills for Daily Decision-Making Section B4

The Assessment Process

Gail Livengood, RN, BSN—Director MDS/OASIS

Many residents in nursing facilities exhibit signs and symptoms of decline in intellectual functioning. Recovery will be possible for few of these residents, for example, those with a reversible condition such as an acute confusional state (delirium). However, for most residents the syndrome of cognitive loss or dementia is chronic and progressive. The appropriate care focuses on enhancing the quality of life, sustaining functional capacities, minimizing decline, and preserving dignity.

Confusion and/or behavioral disturbances present the primary complicating

care factors. Identifying and treating acute confusion and behavior problems can facilitate assessment of how chronic deficits affect the life of the resident. The intent of this item is to record the resident's actual performance in terms of daily decision making and will be



GOAL
Highest Practicable Level of
Functioning

the focus of this newsletter. Cognitive skills for Daily Decision Making, Section B4 of the MDS has a 7-day look back period.

Questions about cognitive function and thought processes can be sensitive issues for residents who may become agitated or very emotional during the assessment.

Clinicians have an obligation to ensure that capable residents have the opportunity to make treatment decisions that will be implemented and that incapacitated residents will be protected by having decisions made for them by others who act in their best interests.

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MDS Accuracy Quick Check—Section B4



If these MDS Items are:

B4 = 1,2, or 3

Cognitive Loss/Dementia

Has your staff reviewed the following MDS items to investigate possible links between these factors and the resident's cognitive loss in decision making?

Neurological:

Fluctuating Cognitive Signs and Symptoms/Neurological Status:

Only when acute confusion and behavioral disturbances are treated, or when the treatment effort is judged to be as effective

as possible, can a true measure of chronic cognitive deficits be obtained.

Recent Changes in the Signs/Symptoms of the Dementia Process:

Identifying these changes can heighten staff awareness of the nature of the resident's cognitive and functional limitations. This knowledge can assist staff in developing reasonable expectations of the resident's capabilities and in designing programs to enhance the resident's quality of life.

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Consult with family and nursing assistants regarding the resident's ability to make daily decisions.



QIES
HELP DESK
405 271 5278

Gail Livengood
Clinical

Bob Bischoff
Automation

Michael Jordan
Technical

Cognitive Skills for Daily Decision-Making Section—B4

The Assessment Process *(continued from page 1)*

The assessment process will begin by reviewing the clinical record. Consult with family and nurse assistants regarding the resident's ability to make decisions about daily living. Observe the resident. The inquiry should focus on whether or not the resident is actively making these decisions, and not whether the staff believes the resident might be capable of making them. Where a staff member takes decision-making responsibility away from the resident regarding tasks of everyday living, or the resident does not participate in decision-making, whatever his or her level of capability may be, the resident should be considered to have impaired performance in decision-making.

This item is especially important for further assessment and care planning in that it can

alert staff to a mismatch between a resident's abilities and his or her current level of performance, or that staff may be inadvertently fostering the resident's dependence.

When assessing your resident, you will have the following four coding choices:

0) INDEPENDENT—decisions consistent/reasonable.

1) MODIFIED INDEPENDENT—some difficulty in new situations only. If the resident experiences difficulty in decision-making when making choices in new situations only, code "1", Modified Independence.

2) MODERATELY IMPAIRED—decisions poor; cues/supervision required. If the resident attempts to make decisions, although poorly, code "2" for Moderately Impaired.

3) SEVERELY IMPAIRED—Never/rarely made decisions.

If the resident "rarely or never" made decisions, despite being provided with opportunities and appropriate cues, Item B4 would be coded as "3" for Severely Impaired.

It can often be difficult to accurately assess how someone is able to think, remember, and make decisions about their daily lives if they are verbally unable to communicate with you. This can be particularly difficult when the areas of cognitive function you want to assess require some kind of verbal response from the resident (e.g., memory recall). It is certainly easier to perform an evaluation when you can

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The MDS Connection Section B4—Participation Opportunities

Involvement Considerations

Opportunities for Independent Activity

Staff can encourage residents to participate in the many available activities, and staff can guard against assuming an overly protective attitude toward residents. **Decline in one functional area does not indicate the need for staff to assume full responsibility in that area nor should it be interpreted as an indication of inevitable decline in other areas.**

Review information in the MDS when considering the following issues:

- Are there factors that suggest that the resident can be more involved in his/her care (e.g., instances of greater self-performance; desire to do more independently; retained ability to learn; retained control over trunk, limbs, and/or hands)?
- Can resident participate more extensively in decisions about daily life?
- Does resident retain any cognitive ability that permits some decision-making?
- Does resident resist care?
- Are activities broken into manageable subtasks?

Functional Limitations

Extent and Rate of Change of Resident Functional Abilities

Functional changes are often the first concrete indicators of cognitive decline and suggest the need to identify reversible causes. You may find it helpful to determine the following:

- To what extent is resident dependent for locomotion, dressing and eating?
- Could the resident be more independent?
- Is resident going downhill?

Reference RAI Manual,
Chapter 3, page 40.

Observe the resident at different times of day & different types of activities for clues to their functional abilities.

Cognitive Skills for Daily Decision-Making Section— B4

The Assessment Process *(continued from page 2)*

converse with a resident and hear responses from them that give you clues as to how the resident is able to think (judgment), if he understands his strengths and weaknesses (insight), whether he is repetitive (memory), or if he has difficulty finding the right words to tell you what he wants to say (aphasia).

To assess an aphasic resident it is very important that you hone your listening and observation skills to look for non-verbal cues to the resident's abilities. For example, for someone who is unable to speak with you but seems to understand what you are say-

ing (expressive aphasia), the assessor could ask the resident the necessary questions and then ask him to answer you with whatever non-verbal means he is able to use (e.g., writing the answer; showing you the way to his room; pointing to a calendar to show you what month/season it is). Observe the resident at different times of the day and in different types of activities for clues to their functional abilities. Solicit input from the observations of others who care for the resident.

In all cases code the cognitive items with answers that reflect your best clinical judgment, realizing the difficulty in assessing

residents who are unable to communicate. MDS Items B1, B4, B5 and B6 can be successfully coded without having to get verbal answers from the resident. Interdisciplinary collaboration will be helpful in conducting an accurate assessment.

Examples of observing the resident make daily decisions include; choosing items of clothing; knowing when to go to scheduled meals; using environmental cues to organize and plan (e.g., clocks, calendars of upcoming events); need to use a walker & uses it faithfully.

Reference: RAI Manual, Chapter 3, page 3-46.

ALERT!
MDS Manual Revision- December 2008- Be sure to check the web for quarterly MDS Manual Revisions To Download Manual www.cms.hhs.gov/nursinghomequalit

Cognitive Skills for Daily Decision Making-B4 Nursing Home Goal-Highest Practicable Level of Functioning

Code the following example for MDS Item "B4" Cognitive Skills for Daily Decision-Making."

If a resident seems to have severe cognitive impairment and is non-verbal, but usually clamps his mouth shut when offered a bite of food, would the resident be considered moderately or severely impaired?

More information about how the resident functions in his environment is needed to definitively answer the question. From the limited information provided about the resident, one would gather his communication is only focused on a particular circumstance, in which it would be regarded as rarely/never" in the relative number of decisions a resident

would make during the course of a week, and the MDS Item B4 would be coded as "3", severe impairment.

Can the staff decide if the resident responds in a like manner to similar requests made during the 7-day observation period? If "responses" are more the norm, the resident may only be moderately impaired or better.

Reference RAI Manual , Chapter 3, page 3-47.

SCENARIO QUIZ—Section B4

Mrs. K was admitted to the facility six weeks ago. Upon admission she had modified independence in daily decision-making skills, intact short and long-term memory, and good recall abilities. Since that time, Mrs. K has had a stroke,

which left her with deficits in this area. She is not aware of her new physical limitations and taken unreasonable safety risks in not using her walker unless reminded. The staff has also remarked that they have to remind Mrs. K the correct items

to take to the bathroom when time for bathing activities.

How will you code Section B4-Cognitive Skill for Daily Decision-Making?



MDS Automation Tips

Bob Bischoff MDS/OASIS Automation Coordinator

Status MDS 3.0

MDS 3.0 is still scheduled to go into effect October 1, 2009. I would like everyone to be as prepared as possible. CMS has cancelled our All State training on MDS 3.0, which was scheduled to occur May 2009. The timeline for transition of MDS 3.0 has also been removed from the CMS web site. I strongly encourage you to go to www.qtso.com and click on MDS 3.0. This will take you to a CMS direct link, which will then direct you to the CMS 3.0 web page. Keep up with all the information and releases by checking this web page often. Be careful about attending any MDS 3.0 training. As of now, the MDS 3.0 manual has not been released. Contact QIES periodically or the above web address for status updates or changes.

Top Five Automation Errors linked to Deficiencies

1-1-2008 through 12-31-2008

| | |
|-------------------------------|-------|
| #377 Record Submitted Late | 8.42% |
| #70 Assessment Completed Late | 3.07% |
| #217 RAPS Late | .76% |
| #216 R2b Late | .71% |
| #393 Annual Late | .56% |

Order your MDS Error Summary Report through Certification And Survey Provider Enhanced Report, (CASPER) using the same date criteria defined above and see how you compare. Please try to improve in the Record Submitted Late category, as this is on the rise in Oklahoma and significantly above the Nation and Region.

MARK YOUR CALENDAR!



Upcoming MDS Training Tentative Dates

- **April 16, 2009**
Clinical Focus
- **April 30, 2009**
Automation

For more, see the MDS Training Calendar at:

<http://qies.health.ok.gov>
 Click MDS, then click Educational Resources

Broadband In Effect

Conversion from dial up to broadband is in effect. The software with instructions can be downloaded at:

<https://www.qtso.com/mdcn.html>

Contact the QIES Help Desk for assistance, or MDCN at 1-800-905-2069.

QI/QM Incidence of Cognitive Impairment

Where Oklahoma stands with the Nation and our Region 6

4.1 Incidence of Cognitive Impairment

| | Q3, 2008 | Q2, 2008 | Q1, 2008 | Q4, 2007 | Q3, 2007 |
|----------|----------|----------|----------|----------|----------|
| National | 11.85 | 12.15 | 11.82 | 11.66 | 11.69 |
| Region 6 | 13.40 | 12.73 | 12.08 | 12.31 | 12.32 |
| OK | 9.49 | 8.90 | 8.49 | 9.15 | 9.62 |

The Technical QI/QM cognitive impairment definition is resident has any impairment in daily decision making ability (B4>0) and has short term memory problems (B2a=1). Note, when these items are coded on the MDS assessment, excluding the admission assessment, this QI/QM will trigger. The Technical QI/QM manual can be downloaded by going to: https://www.qtso.com/download/mds/MDS_QIQM_Tech_Specs.pdf or attending QIES MDS automation training.

Answer: Scenario Section B4
 Enter one number that corresponds to the most correct response.

0. Independent decisions consistent /reasonable

1. Modified Independence some difficulty in new situations only.

2. Moderately Impaired decisions poor; cues/supervision required.

3. Severely Impaired Never/rarely made decisions.

Correct Answer:

2. Moderately Impaired.

Rationale:

Mrs. K has to be cued/reminded to use her walker for locomotion and where bathroom is located.

Automation Tip

MDS Automation Coordinators should always review final validation reports and watch for **Header Record Errors**. If this error message displays, it will always be the first error message on the report and will note discrepancies with Medicare and Medicaid numbers. This is a self filling item for AA6a & AA6b. If left uncorrected this increases your chances of a deficiency for inaccurate information (Tag F278).