



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:

- Section O—Medications —The Assessment Process
- MDS Accuracy Quick Check—Section O—Medications
- The MDS Connection
- Automation Tips, Reminders & Updates

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**Section O—Medications
The Assessment Process**

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OASIS**

Antibiotics and other medications developed in the 20th and 21st Centuries have increased the life-span of countless individuals. Medication’s benefits are too numerous to mention but, as with everything else, there often is a down-side. Where drugs are concerned, the down-side is referred to as either **side-effects or adverse reactions**. Anytime a medication is given, we as clinicians must be cognitively aware of the fact that these drugs will affect not only the body but, in many instances, the mind, emotions, and/or behavior as well. To that end, assess-

ment, medication review, drawing connections between onset of new symptoms or behaviors, and other indications of negative reactions must constantly be

on our mind. When complying with State regulations in the assessment of the effect the medication has on the resident, we must understand the huge difference between a resident **responding** to a medication or a resident **reacting** to a medication. In this newsletter, we will address the vital component of the MDS Assessment that aids us in that effort—Section O - Medications.



GOAL
**Highest Practicable Level of
Functioning**

Section O contains four sections, **O1—Number of Medications; O2—New Medications; O3—Injections;** and
(Continued on page 2)

MDS Accuracy Quick Check—Section O



If these MDS Items are:

B5a-f = 1 or 2

- Does your staff know the greater the number of medications, the greater the possibility of adverse drug reaction/toxicity, and onset of symptoms of delirium? Do staff, along with physician and pharmacist, review medications to compare benefits versus risks?
- Does your staff know **delirium is never a part of normal aging** and that persistent or new onset of symptoms should be reported for further assessment?
- Does your staff know psychosocial distress may produce signs of delirium?
- Does your staff observe resident’s who have been isolated from people, objects or situations, as happens frequently while recuperating from an illness or receiving a treatment, for signs of delirium?
- Does staff know restraints often aggravate the conditions staff are trying to treat causing increased use of medications? *Reference: RAI Manual Appendix C, page C5-C10.*

Inside this issue:

Section O—Medications <i>(Cont)</i>	2
The MDS Connection	2
Section O—Medications <i>(Cont)</i>	3
Nursing Home Goal	3
Scenario Quiz	3
MDS Automation Tips	4
Training Calendar	4



Section O—Medications

The Assessment Process (Continued from page 1)

A PPD is considered a medication and should be counted at O1 (number of medications) & at O2—Injections if given in look-back period



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O4— Days Received the Following Medication.

The **INTENT** of **O1—Number of Medications** is to determine the number of different medications (over-the-counter and prescription drugs) the resident has **received** in the past seven days. The **PROCESS** of assessing **O1** is to count the number of different medications (not the number of doses or different dosages) administered by any route (e.g., oral, IV, injections, patch) at any time during the last seven days. Include any routine, PRN, and stat doses given. “Medications” include topical preparations, ointments, creams used in wound care, eye drops, vitamins, and suppositories. Topical preparations used for preventive skin care (i.e. moisturizers and moisture barriers) **should not** be coded here. Include any

medication the resident self-administers, if known. If the resident takes both the generic and brand name of a single drug, count as only one medication. Antigens and vaccines also are counted here—this includes PPDs given in the look-back period. To **CODE** the MDS at **O1**, review the resident’s Medication Administration Record (MAR), interview resident and family, and **code only those medications the resident has actually received**. Do not count medications ordered but not given. If a resident receives a Vitamin C capsule, add it to the medication



After a home visit, ask the resident what medications were taken during that time.

count in number of medications (**O1**). However, if a dietary supplement is given to the resident between meals and it has a vitamin as one of its ingredients, code it as a dietary supplement, not as a medication. Additionally, if the resident received an injection of Vitamin B12 or other long-acting medication such as Haldol Decanoate, prior to the observation period, code in Item **O1** if the blood level continues during the 7-day look-back period. Consultation with the physician, pharmacist, and/or PDR input will help you determine if a specific long-acting medication is still active for the observation period.

The **INTENT OF O2—New Medications** is to record whether or not the resident (Continued on page 3)

The MDS Connection Section O—Medications



If O4a-d = 1-7

Then review MDS items

- **B5a-f = 1,2**

Review medications prescribed around the time of the onset of the indicators of delirium. Review side-effects, drug/drug, drug/food, and drug/lifestyle interactions.

Psychotropic medications (antipsychotics, antianxiety, hypnotics, and antidepressants) are among a group of medications that may cause delirium. Additionally, a **rare but often fatal side-effect** of

most antipsychotic medications and Phenergan is **Neuroleptic Malignant Syndrome**.

If your residents receive antipsychotic medications or Phenergan, and you do not know the symptoms and often fatal side effect, become familiar with its symptoms and educate staff. It could save a life.

If O4a-d = 1-7

Then review MDS items

- **E4a-eA = 1, 2, 3**

Review medications prescribed around the time of the onset of

the behavioral symptoms. Review side-effects, drug/drug, drug/food, and drug/lifestyle interactions. Psychotropic medications (antipsychotics, antianxiety, hypnotics, and antidepressants) are among a group of medications that may cause or escalate behavioral symptoms such as anxiety, abnormal thinking, hallucinations, aggressiveness, restlessness, psychosis, and numerous other negative effects.

Symptoms such as those listed may be caused by the psychotropic medication requiring immediate drug review.



Section O—Medications

The Assessment Process *(Continued from page 2)*

Code medications according to a drug's pharmacological classification, not how it is used

is currently receiving medications that were initiated in the last 90 days.

To **CODE**, code “1” if the resident received (and continues to receive) new medications in the last 90 days. Code “0” if the resident did not receive any new medications in the past 90 days. If the resident received new medication(s) in the last 90 days but they were discontinued prior to this assessment period, code “0” (no new medication).

The **INTENT** of O3—**Injections** is to determine the number of **days**, during the

past seven days, the resident received any type of medication, antigen, vaccine, by subcutaneous, intramuscular or intradermal injection. To **CODE**, record the number of **days** the resident received an injection in the answer box.

The **INTENT** of O4—**Days Received the Following Medication** is to record the number of



Include medications the resident self-administers.

days the resident received each type of medication listed (antipsychotic, antianxiety, antidepressants, hypnotics, diuretics) in the past seven days. Be sure to **CODE O4 according to the drug's pharmacological classification**, not how it is used.

Section O of the MDS has numerous coding instructions. It is imperative the clinician refer to the RAI Manual during the assessment process to assure accurate coding of the MDS and, thereby, accurate care planning.

Reference: RAI Manual chapter 3, pages 176-180.

ALERT!
MDS Manual Revisions—Be sure to check the web for quarterly MDS Manual Updates

To Download Manual
www.cms.hhs.gov/nursinghomequalityinits/20_nhqimds20.asp

Nursing Home Goal—Highest Practicable Level of Functioning Stay Informed—Section O—Medications



In order to accurately assess the resident's condition, it is vital clinicians understand the coding instructions of the MDS, use the RAI Manual during the assessment to clarify issues, and refer to reputable reference books, such as the PDR or other nursing drug references to identify the appropriate drug classifications. Failure to follow these steps

means the resident is at risk for an inaccurate assessment or care plan.

Additional concern includes home visits, doctor's office visits, hospitalizations, and/or ER visits. Remember, whenever the resident is out of the facility during the 7-day look-back period, any medication given to the resident should be captured on the MDS. Supporting

documentation from hospitals, ERs, and/or doctor's office is essential. Interviews with the resident and family after a home visit will clarify medications received during the stay. All are components to assure the facility meets the Nursing Home Goal of achieving the Highest Practicable Level of Functioning for the resident.

Medication—Section O4—Days Received the Following Medication



During the 7-day look-back period for Section O4, Mrs. P became severely short of breath in the middle of the night and was transferred (but not admitted) to the ER. Upon her return, the ER transmittal record stated Mrs. P re-

ceived 1 dose of IV Lasix. The facility's Medication Administration Record (MAR) for Mrs. P documented that during the 7-day look-back period, she received the following:

Haldol 0.5 mg po BID p.r.n. received once a day on Monday,

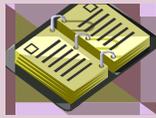
Wednesday & Thursday; **Ativan** 1 mg po QAM received every day; and **Restoril** 15 mg po QHS p.r.n. received on Tuesday and Wednesday only.

How will you code Section O4?

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<http://www.health.state.ok.us/PROGRAM/qies/mds/index.html>

MARK YOUR CALENDAR!



Upcoming MDS Training

- **February 27, 2008**
Automation

For more, see **Training Calendar** at: www.health.ok.gov/PROGRAM/qies/mds/index.html

Broadband in—Modem out

January 2008, facilities can transmit MDS data without using the old fashion modem. Download the instructions and dialer at: www.qtso.com/mdcn.html
 Contact the QIES helpdesk for any additional assistance.

Answer: Scenario—Section O4

- O4a—Antipsychotic = **3** (days)
- O4b—Antianxiety = **7** (days)
- O4c—Antidepressant = **0** (days)
- O4d—Hypnotic = **2** (days)
- O4e—Diuretic = **1** (day)

Rationale:

The medications coded are those received during the look back period. Not those ordered but not given. Code for classification not intent.

Haldol—received Mon, Wed, & Thurs = **Antipsychotic**.

Ativan—received “every day” = **Antianxiety**.

Restoril—received Tuesday & Wednesday only = **Hypnotic**.

Lasix—received in ER during 7-day look-back period = **Diuretic**.

MDS Automation Tips

Bob Bischoff—Program Manager, MDS/OASIS Automation

Where Oklahoma stands with the Nation and our Region.

3.1 Use of 9 or More Different Medications

	Q2, 2006	Q3, 2006	Q4, 2006	Q1, 2007	Q2, 2007
National	63.8	64.34	65.2	65.7	65.8
Region 6	63.8	64.19	65.0	65.7	65.9
OK	66.6	66.83	68.0	68.9	68.7



10.1 Prevalence of Anti-Psychotic Use in the Absence of Psychotic or Related Conditions--Low Risk

	Q2, 2006	Q3, 2006	Q4, 2006	Q1, 2007	Q2, 2007
National	17.2	17.2	17.3	17.2	16.8
Region 6	21.2	21.1	21.2	21.0	20.7
OK	22.8	23.2	23.9	23.6	22.8

Remember:

Our goal is the highest Practicable level of functioning.

10.3 Prevalence of Hypnotic Use More Than Two Times In Last Week

	Q2, 2006	Q3, 2006	Q4, 2006	Q1, 2007	Q2, 2007
National	4.6	4.6	4.8	4.9	4.9
Region 6	7.5	7.7	7.9	8.1	8.1
OK	9.1	9.5	9.6	10.3	10.4

Try to determine the true underlying causes before turning to medications.

Warning Message Inconsistent Submission Sequence

This warning message is generated on records that appear to have been submitted out of order. The dates in the submitted record do not sequentially follow the dates of the previous. This is a warning message that should not be ignored. In many instances this means that we are probably missing a record. This message is a very valuable tool to use in order to avoid a possible deficiency. Simply stated, we are probably missing the previous record that was either not completed or not transmitted. Internally, research the prior record completed, then determine if this transmitted record is the next record required. Contact QIES for additional help in this matter.



Time Saver Tip

When requesting CASPER (QIQM's) reports try to choose a day other than Monday. According to CMS this is the busiest day, and the system is very slow and also tends to be overloaded and causes time delays in transmitting and receiving your report requests.

Automation Tip: Security & Safeguards

When an MDS person who had access to MDS information leaves your facility, consider having all the passwords changed. Contact the QIES helpdesk for assistance.