QASP QM'S	WHAT TRIGGERS	WHAT CANCELS/MDS CODING TIPS	CLINICAL TIPS AND STRATEGIES
Pressure ULCER LONG STAY	**WHAT TRIGGERS?** Any number of stage 2, 3 or 4 plus either any one of these are present: • Comatose • Malnutrition • Bed mobility= 3, 4, 7, 8 • Transfer = 3, 4, 7, 8 Long stay (101 days or more)	**WHAT CANCELS?** Bed mobility self-performance = 0,1,2 AND Transfer self-performance =0,1,2 MDS is an Admission **MDS CODING TIPS:** Ensure to Code present on admission if so If resident is readmitted within 30 days after a discharge return anticipated and the wound was present on admission (not inhouse) on prior stay, ensure to still code as "present on admission" If there are discrepancies on wound documentation, ensure to clarify with wound nurse before MDS is locked. Investigate what etiologies of wounds are and if not due to pressure, do not code as such.	**TIPS AND STRATEGIES** Accurate Wound assessment on Admission. Develop an individualized care plan on new admits that includes risk factors, prevention, care & treatment of any existing pressure ulcers Timely completion of Skin risk assessment(Braden) i.e. on: • Admission x 4 weeks • Quarterly • After a change in condition. Based on the score, ensure interventions are implemented for prevention. Weekly skin checks, Weekly wound assessments Ensure Treatment orders are current Re-evaluate treatment plan if there is no progress noted Implement Nutrition and hydration interventions e.g. supplements and hydration RD assessment that addresses skin condition, abnormal laboratory results pertinent to wound healing (e.g., blood sugar fluctuations, pre-albumin/albumin, etc.) Use Pressure relief devices (e.g., heel protectors, special mattresses, gel cushions, etc.) Skin Integrity Committee at least monthly or as per Facility Policy. Communication system in place

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			regarding: • notification of nurses of any reddened areas /impaired skin condition noticed by C.N.A. and • notifying DNS, RD & • Therapy of all new open areas or any increases in size Work with wound management consultants. Periodic nurses evaluated for competency in wound evaluation
B and B	**WHAT TRIGGERS?** Bladder: Frequently incontinence = 7 or more incontinence + at least 1 episode of continence Always incontinent=no episodes of continence Bowel: Frequently incontinent 2 or more episodes of bowel incontinence + at least 1 continent bowel movement OR Always incontinent -no episodes of continence Long stay (101 days or more)	**WHAT CANCELS?** Any ONE of these are present: A cognitive skill (staff assessment) is severe PLUS short term memory problem is present OR BIMS score is equal or less than 7 Comatose Totally dependent in bed mobility = 4, 7, 8 Totally dependent in transfer = 4, 7, 8 Totally dependent in locomotion on unit 4, 7, 8 Admission MDS and	**TIPS AND STRATEGIES:** Remind C.N.A.'s on definitions of incontinence Evaluate and Treat causative factors for incontinence • diabetes • kidney dysfunction • hypertension, medication adverse side effects Evaluate for elimination patterns for at least three days and develop toilet programs developed to address individualized patterns Establish Communication of the individualized program to staff members Consider decreasing caffeine drinks if applicable/possible: coffee, tea, soda, hot chocolate since caffeine is a diuretic. Consider using a "Bladder Scan" for as an aid to assess and develop bladder training programs.

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		or 5 day MDS **<u>MDS CODING TIPS:</u>** Ensure to code "Not Rated" on Continence If with any one of these condition for Bladder: • Indwelling catheter • Condom • Urinary ostomy • has had no urine output for entire seven days Any one of these conditions for Bowel: • Ostomy • has had no bowel movement for entire seven days Consider Timing MDS during B and B training or right after the program when C.N.A documentation are being monitored closely so as to capture an accurate picture. Ask probing questions to the C.N.A.'s and as needed, document this on MDS progress notes. Consider this information when coding for incontinence on the MDS.	

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Physical Restraint	**WHAT TRIGGERS?** Daily use of any of these: • Trunk restraint in bed • Limb restraint in bed • Trunk restraint in chair • Limb restraint in chair • Chair prevents rising Long stay (101 days or more)	**WHAT CANCELS?** If their stay is 100 days or less. **MDS CODING TIPS:** Code only if the effect of the device is restraining the resident. Do not code if resident is able to remove the device at will. Do not code if resident is able to remove the device as easily as it was placed. If possible, time the MDS so that it is during restraint reduction period so as not to be coded as used daily.	**TIPS AND STRATEGIES:** Least restrictive methods prior to applying a restraint e.g., low beds, mats, etc. Therapy to work with resident prior to applying a restraint Obtain Consent Educate the resident/family on risk factors Accurate assessment to ensure devices being used are not a restraint. Review restraint use at least quarterly to evaluate appropriateness and need for continued use. Restraint reduction committee meets at least q month Use least restrictive measures

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Influenza VACCINE SHORT STAY The higher the % the better	**WHAT TRIGGERS?** Received in this facility or outside facility Declined the vaccine when offered Ineligible due to medical contraindications AND Their stay is 100 days or less	**WHAT CANCELS?** Not in facility during the current or most recent flu season No credit to this QM if we code -Did not offer **MDS CODING TIPS:** If possible, move ARDs to capture Vaccine administration. To be credited for this QM, an <u>October 1 through March 31</u> is what is being considered as influenza season (*this is for QM purposes but influenza season is still dependent on geography).* Once given, always copy mds coding for vaccine until next flu season Ensure to code the following if it applies: • Received influenza vaccine outside the facility. • Not eligible due to medical contraindication.	**TIPS AND STRATEGIES:** Staff awareness of current influenza season Establish a process for obtaining the consents, documenting if offered and declined Establish an internal tracking process to ensure that documentation is completed and available for review Obtain vaccine consents asap on admission. Give vaccine on or before ARD of the 1st MDS- 5d or admission

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		• Offered and declined. On PCC, ensure to open the links on immunization tab to view entire information. This item is refreshed on PCC. Ensure to acknowledge responses as accurate before locking.	
PNA VACCINE SHORT STAY The higher the % the better.	**WHAT TRIGGERS?** Pneumococcal vaccine status is up to date or Offered and declined the vaccine or Ineligible due to medical contraindications AND Their stay is 100 days or less	**WHAT CANCELS?** No credit to scores if we code -Did not offer **MDS CODING TIPS:** Prevnar is considered a pneumonia vaccine and should be coded as up to date if it has been administered. Code "Ineligible" if allergic to vaccine components Once given, always copy mds coding for vaccine until the next 5 years if resident received at age less than 65 years and always if resident received vaccine at age 65 or more	**TIPS AND STRATEGIES:** Get vaccine consents ASAP on admission. Establish a process for obtaining the consents, documenting if offered and decline Establish an internal tracking process to ensure that documentation is completed and available for review Resident/Family education on importance of Vaccines Administer the vaccine on or before ARD of the 1st MDS- 5d or Admission All adults 65 years of age or older should receive the vaccine. If vaccination status is unknown, the individual should be vaccinated. If the resident has a moderate to severe illness, he or she should not be vaccinated until the condition improves or stabilizes. Residents with a minor illness, such as a cold, may receive the vaccine.

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		On PCC, ensure to open the links on immunization tab to view entire information. This item is refreshed on PCC. Ensure to acknowledge responses as accurate before locking.	
UTI	**WHAT TRIGGERS?** UTI in the last 30 days as evidenced by having ALL 4 criteria 1. Physician dx of UTI in last 30 days, 2. Signs and symptoms of UTI such as fever, burning, frequent urination, pain or tenderness in the flank, confusion, mental status change, or pyuria 3. Positive test, study or procedure, and 4. Current medication or treatment for UTI AND Long stay (101 days or more)	**WHAT CANCELS?** Will not trigger if MDS is an Admission and or 5 day. **MDS CODING TIPS:** Do not code UTI if any one of the 4 criteria is not present.	**TIPS AND STRATEGIES:** Establish a Hydration Program. Make water accessible at all times and offered to dementia residents Ensuring s/s vs treating for lab report. Updating PCC dx list and resolve UTI if applicable. Ensure Staff proficiency in perineal/catheter-care and handwashing Indwelling Foley catheters are changed according to the MD order Train Licensed Nurses on proper communication of Changes of Condition to MD so appropriate treatments and dx are given (use SBAR).

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SELF REPORT Moderate TO SEVERE PAIN LONG STAY **SELF REPORT Moderate TO SEVERE PAIN SHORT STAY**	**WHAT TRIGGERS?** Almost constant or frequent pain AND moderate to severe pain at least once Or Resident reports very severe/horrible pain of any frequency AND LONG STAY MEASURE: Stay is 101 days or more SHORT STAY MEASURE: Stay is 100 days or LESS	**WHAT CANCELS?** If resident could not complete pain interview **MDS CODING TIPS:** • Timing of Pain Interview: *Example: If the resident has discomfort following therapy, ADLs, or procedures, medicate before the activities and do not interview immediately following the therapy* •Explain to resident that pain medication will not be taken away if he or she states there is no current pain • Use a visual pain scale to have a more accurate picture for the resident r/t the degree of pain being experienced • Consider using Verbal descriptor Scale (Mild, Moderate, Severe) instead of Numerical if resident is having a hard time with the numerical Scale	**TIPS AND STRATEGIES:** • Treatment plan to include addressing underlying condition such as arthritis, cancer, fractures, osteoporosis, multiple sclerosis, dental caries, and skin impairment • Individualize pain medication i.e. prior to treatment and/or procedures • Consider having medications scheduled/routine basis • Consider PRN medication for breakthrough pain • Involve Therapy for methods such as a. transcutaneous electrical nerve stimulation b. relaxation techniques c. range of motion d. ADL programs e. thermotherapy f. distraction exercises g. massage h. positioning devices i. cryotherapy • Consider consultations to pain management clinics

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ADL Decline	**WHAT TRIGGERS?** 4 Late Loss ADL's measured: 1. Bed Mobility 2. Transfer 3. Eating 4. Toilet Use Compares latest MDS to the MDS AT LEAST 46 days ago. Triggered if: One point decline in 2 or more late loss ADL's *Example:* *Bed mobility and transfer from limited to extensive* Or 2-point decline on any one of the 4-late loss ADL's Example: Bed Mobility went from Supervision to Extensive AND Long stay (101 days or more)	**WHAT CANCELS?** Any of these conditions: • Comatose • Hospice care (MDS section O) • Prognosis of life expectancy is less than six months. (MDS section J) • All four late-loss ADL items indicate total dependence on the prior assessment (4, 7, 8 coded) • Three of the late-loss ADLs indicate total dependence on the prior assessment, and the fourth late-loss ADL indicates extensive assistance **MDS CODING TIPS:** • Review all Documentation in the 7 day look back period vs just basing from C.N.A.'s. (Review all source	**TIPS AND STRATEGIES:** • Provide quarterly calendar to Therapy at the beginning of the month. • Therapy to screen quarterly and as needed for possible decline and the need for RNA or Therapy. • ADL training of C.N.A.'s upon new hire. • Ensure RNA meeting is occurring routinely to catch ADL declines. • Consider group RNA activities as applicable. • Activities department to include activities that promote mobility and exercises. • Determine root cause for the decline • Management of pain and or depression • Consider adaptive equipments

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		documents i.e. Licensed Nurse and Therapy documentations. • Code Total only if all documentation are Total (review LN and Therapy docs) • Interview and use Probing questions to the Staff. As needed, document this on the MDS progress notes and consider this information when coding ADLs. • Consider Timing of MDS if possible i.e. to capture after Therapy Treatment so as to capture progress and not decline • Consider SCSA MDS for improved ADL's.	