MDS Alert

Section M: Make Sure Your Turning/Repositioning Program Meets Surveyors' Expectations

Heed the RAI Manual's instructions when coding M1200C.

You can employ a myriad of treatments and preventive measures when it comes to dreaded pressure ulcers, one of which is a turning/repositioning program. But is your turning/repositioning program up to snuff?

Turning/repositioning program (M1200C) is one of the various choices in Item M1200 □ Skin and Ulcer Treatments. In this item, you check all that apply in the seven-day look-back period.

Key: Individualize Each Resident's Program

To check M1200C for a turning/repositioning program, you must have specific approaches for changing a resident's position and realigning his body, according to a recent presentation by **Shirley Boltz, RN,** RAI/Education Coordinator for the **Kansas Department for Aging and Disability Services** (KDADS). The medical record should include documentation that specifies intervention and frequency.

"This item on the MDS represents a critical intervention to prevent and heal pressure ulcers," stressed MDS expert **Judy Wilhide Brandt, RN, BA, RAC-MT, C-NE** of **Judy Wilhide Consulting Inc**. in a June 8 analysis for Washington, D.C.-based **Leading Age**. "If a resident is at risk and does not have this intervention coded on the MDS, it is a matter of concern."

The RAI Manual provides two tips for coding a turning/repositioning program under M1200C:

- "The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours)."
- "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 intervention."

Important: If "every two hours" is a routine facility policy, it does not meet the criteria described in Section M of the RAI Manual to code for a turning/repositioning program, warns **Marilyn Mines, RN, BC, RAC-CT**, MDS Alert consulting editor and senior manager of clinical services for **FROST Healthcare** in Deerfield, Ill. The schedule must be specific to the resident's needs, not facility policy.

Also, Example 4 on page M-42 in Section M clearly indicates that you must have an assessment/reassessment and documentation of the resident's response to the turning and position, Mines adds.

Strategy: "A careful individualized assessment is the key to a successful program," Brandt noted. "If the resident spends most of the time out of bed, for example, then off-loading while in the chair becomes critical."

Repositioning an elder every two hours is alright if that's what he needs, Boltz said. But you will find some residents who need repositioning more frequently to prevent redness.

This is why individualizing residents' repositioning schedule is so important, Boltz stressed. You should also perform a tissue tolerance test to determine the right repositioning schedule for each resident.

What Surveyors Look For

Watch out: For instance, surveyors have specific guidance in the State Operation Manual for investigating a facility pressure ulcer prevention program. Surveyors are specifically assessing the following repositioning issues:

- **Provide supportive devices:** Even though a resident may be able to change positions independently, he may still need supportive devices to facilitate position changes. Staff may also need to provide the resident with instruction about why repositioning is important and how to do it, as well as encouragement to change position regularly and monitoring of how often the resident is repositioning.
- **Address skin integrity-preserving position changes:** If a resident is reclining and is dependent on staff for repositioning, you should address in the care plan position changes to maintain the resident's skin integrity. You may need to plan for repositioning every two hours or more frequently depending on the resident's condition and tolerance of the tissue load (pressure).

Except in rare cases, such as both sacral and ischial pressure ulcers are present, staff should not place a resident directly on the greater trochanter for more than momentary placement. Also, beware that elevating the head of the bed or the back of a reclining chair at or above a 30-degree angle creates pressure comparable to sitting and requires the same considerations regarding repositioning as for a dependent resident who is sitting.

- **Consider more frequent repositioning:** Depending on the resident's individualized assessment, more frequent repositioning may be necessary for residents who are at high risk for pressure ulcer development or who show evidence (e.g., Stage 1 pressure ulcers) that repositioning at two-hour intervals is inadequate.
- **Look for "off-loading" recommendations:** If a dependent resident who is sitting or who is in a bed or reclining chair has evidence of tissue tolerance while sitting (checking for Stage 1 ulcers), the resident may not tolerate sitting in the same position for one hour or more at a time. These residents may require more frequent position changes, or "off-loading," hourly.

Consider postural alignment, weight distribution, sitting balance and stability, and pressure redistribution when positioning a resident in a chair. Staff should teach residents to shift their weight approximately every 15 minutes while sitting in a chair.

- **Take care with wheelchair repositioning options:** Residents who use wheelchairs may be severely limited in their repositioning options and at increased risk of pressure ulcer development. Although wheelchairs with sling seats may not be optimal for prolonged sitting during activities or meals, available modifications to the seating can provide a more stable surface and better pressure reduction.
- **Why "microshift" isn't beneficial:** A "microshift" is a momentary pressure relief of five or 10 degrees or a 10- to 15-minute lift from a seated position followed by a return to the same position. There is no evidence that this approach is beneficial, and it does not allow sufficient capillary refill and tissue perfusion for a resident at risk of pressure ulcer development. Staff must provide ongoing monitoring of the resident's skin integrity and tissue tolerance to prevent development or deterioration of pressure ulcers.

Beware: Even though staff might report that a resident does have an effective turning/repositioning program, you still must have sufficient documentation to support your MDS coding, Brandt cautioned. If you don't have sufficient documentation, "nurse managers should be notified so they can take credit for this very important intervention in the medical record.