“Striving for Excellence”
Minimum Data Set Coordinators’ Perceptions of Their Role in the Nursing Home

ABSTRACT
The purpose of the current study was to explore how Minimum Data Set (MDS) coordinators perceive their role and the assessment process. Eleven MDS coordinators from 10 geographically dispersed nursing homes (NHs) were interviewed between May and September 2013. Four broad themes emerged from content analysis: (a) information gathering, (b) interdisciplinary coordination, (c) role challenges, and (d) resources. The first two themes referred to key components and competencies in the MDS coordinators’ role, the third theme dealt with certain challenges inherent in the role, and the fourth theme highlighted resources that helped address these challenges. The current study provides insight into how MDS coordinators perceive their role, as well as some of the challenges they face to successfully enact that role. The current findings can help inform NH management staff, such as directors of nursing and NH administrators, and policy makers, on how best to support MDS coordinators’ work to enable efficient and accurate resident assessment processes. [Journal of Gerontological Nursing, 41(9), 32-41.]

Minimum Data Set (MDS) coordinators are pivotal in ensuring appropriate, quality care is provided to residents in nursing homes (NHs). In particular, they are responsible for coordinating and overseeing interdisciplinary assessment and care planning processes for all residents in Medicare- and Medicaid-certified NHs (American Association of Nurse Assessment Coordination [AANAC], 2011; Straker & Bailer, 2008). MDS coordinators also play a key role in assuring accuracy of information used for NH quality measures and payment systems. Although the process of completing MDS assessments is structured and well-defined, little research has focused on how the role of the MDS coordinator is implemented in individual NHs (Dellefield, 2008; Piven et al., 2006). In light of the clinical, financial, and regulatory significance of the MDS coordinator role and scarcity of research on this topic, further examination is warranted. Therefore, the current qualitative descriptive study explored how MDS coordinators from across the United States perceive their role.

BACKGROUND
With the passage of the Omnibus Budget Reconciliation Act (OBRA) of 1987, sweeping reforms were instituted to improve the quality of care in U.S. NHs, including the requirement to conduct comprehensive individualized assessments for all residents (Social Security Administration, n.d.). The Resident Assessment Instrument (RAI; Centers for Medicare & Medicaid Services [CMS], 2014a), implemented in 1991, addresses OBRA requirements and comprises three components: (a) MDS assessment, (b) care

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area assessment (CAA), and (c) RAI
use guidelines. Together these com-
ponents provide a comprehensive
assessment of each resident’s func-
tional capabilities and help NH
staff identify health problems. The
instrument has undergone signifi-
cant changes and revisions since
its initial implementation, most
recently in 2010, with the transition
from MDS 2.0 to 3.0.

The MDS assessment is the core
of the RAI and includes approxi-
mately 450 items that address the
basic physical (e.g., medical con-
ditions, mood, vision), functional
(e.g., activities of daily living, be-
havior), and psychosocial (e.g.,
preferences, goals, interests) health
statuses of residents to identify ac-
tual or potential areas of concern.
The CAA involves a thorough and
in-depth assessment of care areas
triggered as a result of the MDS
assessment, and provides the foun-
dation on which a resident’s in-
dividual care plan is formulated
(CMS, 2014a). MDS assessments are
generally completed upon resident
admission, every quarter, annually,
and when the resident is discharged.
In addition, assessments must be
completed if the resident shows a
significant change in status or if a
correction is made to a previous
assessment (Rahman & Applebaum,
2009).

Each NH is required to ensure
that it has an RN on staff to
coordinate the MDS assessment
process; they are often entitled
MDS coordinators. MDS coordi-
nators are accountable for coor-
dination of the full MDS process,
including all MDS assessments as
well as care planning. Federal regu-
lations require that an RN sign off
on each MDS assessment when it is
completed. However, because there
is limited availability of RNs in this
setting, MDS coordinator positions
are sometimes held by licensed prac-
tical or vocational nurses (LPNs/
LVNs), with the support and over-
sight of an RN on staff. Nurses are
not legally required to become cer-
tified to hold an MDS coordinator
position; however, several organiza-
tions offer MDS coordinator certi-
fication programs to train and pre-
pare RNs and LPNs. The AANAC
is one of the more recognized
organizations, offering programs
accredited by the American Nurses
Credentialing Center. Beyond these
regulations and resources, little is
known about MDS coordinators
and their demographics in terms of
education, experience, and certifica-
tion (AANAC, 2011).

The role of the MDS coordinator
has evolved and increased in com-
plexity in response to growing
emphasis on improved quality mea-
sures, direct resident input, and a
greater focus on residents’ quality of life (AANAC, 2011; Straker & Bailer, 2008). In addition to assessments becoming broader and more comprehensive, the MDS coordinator role has also changed to address the federal focus on cost containment strategies (AANAC, 2011).

To ensure appropriate reimbursement for services rendered, MDS data must be accurately documented and submitted to the CMS; these assessments can significantly impact the financial well-being of a NH. Inaccuracies can contribute to over- or underestimated reimbursements and may even result in citations and monetary penalties (Levinson, 2012). MDS data are also increasingly used for health services research (Dellefield, 2008; Shin & Scherer, 2009), further extending the potential of these data to influence policy and practice.

Despite the growing importance of the MDS assessment process, to the current authors’ knowledge, only two studies have examined how MDS coordinators perform their role. Piven et al. (2006) explored MDS coordinators’ relationship patterns in two NHs using case-study methods. They found that positive relationships between MDS coordinators and other staff contributed to system-wide improvements in clinical processes, whereas poor relationships made it difficult for MDS coordinators to advocate for improvements. Similarly, Dellefield (2008) explored the work of 24 MDS coordinators in her organization and highlighted the importance of communication and positive interpersonal relationships for the quality of care in NHs. Furthermore, she identified training, workload, turnover, and technological resources as important factors for the MDS coordinators’ effort in quality improvement. Although both studies provided important insight into the work of MDS coordinators, each focused on narrow aspects of their role (i.e., communication and organizational climates). Furthermore, these studies were conducted before the transition from MDS 2.0 to 3.0 and CMS’ implementation of their three-phase electronic health record (EHR) incentive program—factors that potentially influenced the role of MDS coordinators. In addition, neither study used a purposive national sample. One study explored only two NHs within one state (Piven et al., 2006), whereas the other study, although nationally diverse, used convenience sampling rather than a purposive sampling method (Dellefield, 2008).

A greater, more comprehensive understanding of how the MDS coordinator role is currently implemented in NHs, and the structures and processes that influence their work, will help direct continuing efforts to improve the quality of NH care. Therefore, the purpose of the current study was to explore how MDS coordinators perceive their role and the assessment process.

**METHOD**

**Design**

A qualitative study design was used to identify emergent themes related to MDS coordinators’ perceptions of their roles in verbatim transcripts of in-depth interviews. Interviews were conducted as part of a larger mixed-methods study to explore the phenomena of infection control and prevention in NHs. Various personnel involved in infection control and surveillance were interviewed, including MDS coordinators. Detailed methods for the larger study have been previously described (Stone et al., 2015). All procedures were approved by Columbia University Medical Center’s institutional review board and written informed consent was obtained from all participants.

**Sample**

Ten NHs from across the United States were purposively sampled to obtain variation in geographic location, ownership status, and bed size. The NHs were geographically dispersed, with four in the South, three in the Northeast, and three in the West/Midwest. A majority of the NHs (60%) were for-profit facilities. Number of beds ranged from 40 to 204, with an average bed size of 124.

**Data Collection**

MDS coordinators were interviewed individually and in person using a semi-structured interview guide tailored specifically to their position. Examples of interview questions are provided in Table 1. Interviews were audio-recorded and transcribed verbatim prior to analysis. Interviews lasted for an average of 47 minutes (SD = 16 minutes, range = 15 to 65 minutes).

**Analysis**

Transcripts were analyzed using content analysis, which allowed researchers to discover the focus of
the respondents using the emerging themes from the text (Stemler, 2001). Two trained researchers (R.I.B., P.K.S.) thoroughly reviewed the transcripts to familiarize themselves with the data and establish overall impressions. The researchers subsequently derived codes and systematically applied them to the transcripts using NVivo qualitative data analysis software (version 10). Codes were further analyzed to identify emerging themes, which were continually refined until exhaustive and all of the data could be captured within one of the themes. To ensure the consistency of coding, two of the 11 transcripts were double coded and compared for interrater reliability. Mean percent agreement was 97.4% (SD = 0.8%) and mean Kappa was 0.72 (SD = 0.04).

Rigor
Several steps were taken to ensure methodological rigor. Purposive sampling was used to increase transferability and a geographically diverse sample was obtained (Creswell, 2013). However, transferability may be reduced due to heterogeneity among the NHs in terms of size, ownership, and state and local policies (Shento, 2004). A triangulation of sources was used by examining the consistency of different data from 10 NHs around the United States, which served to increase credibility. Iterative questioning was used during the interviews, including returning to previously raised issues, extracting related data by rephrasing questions, and adjusting questions based on previous interviews with other respondents (Creswell, 2013). Biweekly team meetings with data coders and members of the larger study team were held throughout the data collection and analysis process to provide opportunity for peer scrutiny and feedback (Shento, 2004). Confirmability was enhanced with the use of two independent researchers in coding the data and discussing all discrepancies to achieve consensus (Creswell, 2013; Shento, 2004).

RESULTS
Eleven MDS coordinators (eight RNs and three LPNs/LVNs) from 10 NHs were interviewed between May and September 2013. Two of the three LPNs/LVNs reported being the only individuals responsible for MDS coordination in their facility. Mean experience as an MDS coordinator was 6 years, ranging from 2 to 9 years. Information about MDS coordinator experience was missing for one respondent. Eight MDS coordinators reported having received MDS certification, of which five were AANAC-certified.

Four broad themes emerged from content analysis: (a) information gathering, (b) interdisciplinary coordination, (c) role challenges, and (d) resources. The first two themes referred to key components and competencies in the MDS coordinators’ role, the third theme dealt with certain challenges inherent in that role, and the fourth theme highlighted resources that helped address these challenges. Themes and representative quotes are shown in Table 2.

Information Gathering
Information gathering emerged as a key component of the MDS coordinator role. Respondents emphasized collection and synthesis of multiple data sources as a core competency of their work and described thoroughly reviewing resident charts, talking to various staff involved in resident care, and interviewing residents and their families. As one respondent noted, data collection “involves clinical competence...[and] observational and critical thinking.” Another respondent

TABLE 1
EXAMPLES OF INTERVIEW QUESTIONS

<table>
<thead>
<tr>
<th>Question</th>
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<tr>
<td>1. Tell me about your role as a Minimum Data Set (MDS) coordinator. What are your responsibilities?</td>
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<tr>
<td>2. Tell me about the process of preparing for scheduled assessments and collecting and submitting MDS data at your facility.</td>
</tr>
<tr>
<td>3. What are the primary sources of information that you use to complete the MDS assessment? What are some additional sources you might use?</td>
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<tr>
<td>4. About how many hours are spent completing MDS comprehensive assessments? Quarterly assessments?</td>
</tr>
<tr>
<td>5. About how many assessments (comprehensive and quarterly) are completed in this facility during a typical month?</td>
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<tr>
<td>6. Does your facility use electronic medical records, apart from MDS assessments?</td>
</tr>
<tr>
<td>7. Are the MDS data that are collected and submitted used in any way by the facility (apart from fulfilling requirements)?</td>
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<tr>
<td>8. Please describe the training you received as an MDS coordinator. Do you believe it was sufficient?</td>
</tr>
<tr>
<td>9. Do you receive any continued training on a regular basis? Please describe.</td>
</tr>
<tr>
<td>10. If you have a question about how to complete an MDS assessment, who do you ask?</td>
</tr>
</tbody>
</table>
### TABLE 2

<table>
<thead>
<tr>
<th>Theme</th>
<th>Quote</th>
<th>No. of MDS Coordinators Endorsing the Theme (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information gathering</td>
<td>I just go and try to find all the information from the nurses, charts, and everywhere.</td>
<td>9 (82)</td>
</tr>
<tr>
<td>Importance of documentation</td>
<td>Everything that I put into the computer I have to have proof... I have to have written proof or something to back up everything I write in [the MDS assessment].</td>
<td>6 (55)</td>
</tr>
<tr>
<td>Interdisciplinary coordination</td>
<td>You have to be a very friendly and involved person because you have to communicate with [everybody] in the building.</td>
<td>7 (64)</td>
</tr>
<tr>
<td>Leadership</td>
<td>I lead the interdisciplinary team in conducting thorough and accurate assessment for all the residents we have here at the nursing home.</td>
<td>7 (64)</td>
</tr>
<tr>
<td>Role responsibilities</td>
<td>Every [resident] gets reviewed every 3 months... It's based on when they were admitted to the facility.</td>
<td>11 (100)</td>
</tr>
<tr>
<td>Workload</td>
<td>Sometimes there's not enough time in a day, but I always say [the work is] to be continued... We just do the best we can to get everything done.</td>
<td>8 (73)</td>
</tr>
<tr>
<td>Perception of role performance</td>
<td>I play a big role [in] every state inspection... We have to be one step ahead of them, too, so every week we check our quality measures.</td>
<td>6 (55)</td>
</tr>
<tr>
<td>Resources</td>
<td>Every day you learn. Every week you learn something new.</td>
<td>11 (100)</td>
</tr>
<tr>
<td>Continuous training</td>
<td>Computer charting and all that is going to be a jewel... You won't have to really get up and make copies or anything. You [will] have everything right there at your fingertips.</td>
<td>7 (64)</td>
</tr>
<tr>
<td>Benefits of outside resources</td>
<td>I have to keep referring to the manual or making sure or talking to my consultant... so I know for sure that what I'm doing is correct.</td>
<td>11 (100)</td>
</tr>
</tbody>
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*Note. MDS = Minimum Data Set.*
stressed the need to “look at everything, because there are little things that people think are not important, but [are].” MDS coordinators reported spending a great deal of time reviewing available information about each resident and comparing different sources of information for consistency and accuracy before entering information in the MDS assessment.

The importance of ensuring documentation existed to support the entered information was emphasized. As one coordinator noted, “A lot of times for nursing, if it’s not documented, it’s not done.” This requirement for documentation appeared to pose some difficulty, particularly when discrepancies occurred between what was documented in residents’ charts and what emerged from discussions with staff, family, or residents. One respondent described instances when basic demographic information was incorrectly documented, emphasizing the need to confirm information with a resident: “You at least need to have eyeballed them to actually see, because what could be on the hospital paperwork…their gender or whatever, is wrong…. You need to really go see them.” In those cases, the information could be corrected after observing and interviewing the resident. However, in cases when documentation was more difficult to verify, another respondent explained, “[Even] if I think the information is incorrect, I have to use what’s documented. I can’t put what I feel [is correct] because there is no documentation to support it.”

Interdisciplinary Coordination

MDS coordinators described their responsibilities of coordinating meetings with the various disciplines within the facility to complete the MDS assessment process and develop care plans. Leadership skills were seen as a necessary component of their role “to get it all together, as a team,” as one MDS coordinator expressed. MDS coordinators also described that they “lead the interdisciplinary team” and are “responsible” for everyone’s input.

Communication skills were also emphasized as a crucial component of their work, especially the significance of having “a lot of points of communication,” according to one coordinator. These points included the need to communicate with many different staff members within the facility and maintaining frequent communication (formal and informal). To facilitate such frequent communication, respondents emphasized openness and friendliness as core competencies for their work. As one respondent said, “If you have that [open and friendly] attitude and you’re very involved with the staff, then they will give you the things that you need, and they will be there for you.”

Role Challenges

All of the MDS coordinators discussed the complex and varied challenges inherent to the MDS assessment processes. Eight coordinators spoke of the heavy workload they experienced and described having to conduct assessments on multiple residents daily, with each assessment taking 30 minutes to 3 hours, depending on the type of assessment and condition of the resident. One respondent noted, “Sometimes there’s not enough time in a day.” However, two respondents described how having more than one MDS coordinator working in the same facility made the workload more manageable, with one stating, “I mean, we have a good team. There are four of us full-time, so it does help make things go.”

Three coordinators discussed balancing the heavy workload with being thorough and accurate in their assessments and that taking time with each assessment was essential for accuracy. One coordinator commented, “I’d say, at least if you want to do an accurate job [completing the assessment], you have to spend…at least a couple of hours.” Consequently, accuracy can suffer when coordinators have too heavy of a workload, which one respondent described: “[Some facilities] bomb the MDS assessors with too [many] MDS assessments to be done…. You can only do so much, so you tend to be rushing and then that really compromises accuracy.”

Related to workload, the mandated assessment schedule created an important context for the MDS coordinators’ assessment process, highlighted by all respondents. Most respondents emphasized the importance of adhering to the required schedules and described strategies to keep track of each resident’s schedule. This tracking was most commonly done through developing a calendar indicating assessment schedules for each resident that they then shared with other staff to ensure they completed their part of the assessment in a timely manner. One coordinator explained,
KEYPOINTS

1. Minimum data set (MDS) coordinators play a major role in the reliability and accuracy of nursing home (NH) resident assessment data.

2. MDS coordinators highlighted challenges they faced, particularly related to heavy workload and the increasing complexity of their role.

3. Factors that facilitate efficient and accurate resident assessment processes include maintaining an open line of communication between NH administrators, management staff, and MDS coordinators; improving health information exchange; and ensuring that the Resident Assessment Instrument manual is kept up-to-date, accessible, and user-friendly.

4. MDS coordinators’ heavy workload requires special attention as it may affect the accuracy of MDS assessments, which has tremendous financial implications.

“[We] are responsible to make sure the other [members of the interdisciplinary team] do their sections. So it’s kind of a little stressful because you have to meet a deadline.”

One of the subthemes that emerged as part of role challenges was that MDS coordinators perceived their role to be of great importance, which caused added stress. This was due to the pressure to make sure that all necessary work was being completed accurately and in a timely manner. Six respondents noted the significance of their role, describing themselves as key personnel because they “know exactly what is going on in the house.” They also mentioned the important role they played in annual state inspections, as surveyors would contact them for records and broad knowledge of the facility. Furthermore, several respondents noted how important their position was in terms of ensuring correct and timely reimbursements to the facility, with one stating, “I make sure that all staff enters all the services that are being provided to our residents to ensure proper reimbursement.” This was perceived to be of great importance because, as one respondent phrased it, “Now we’re talking about money that makes the world go round.” Although this great importance of the MDS coordinator role was described as an additional stressor, it was also a source of pride, with one respondent noting, “I’m proud of myself and I work hard” and another adding, “Really, we’re striving for excellence.”

Resources
Respondents spoke of strategies and sources of support to overcome challenges and enhance the efficacy of their role. Although they had varying levels of education and experience, they all noted the importance of continuous training (formal and informal). Several described receiving continuous on-the-job learning, with many learning from senior staff members or predecessors with more MDS coordinator experience. One respondent explained, “I used to ask the MDS [coordinator], my tutor, how I will be an excellent MDS [coordinator] and I do remember her response: ‘by doing it’.”

In addition to continuous informal, on-the-job training, many sought formal continuing education and training through seminars and webinars outside the facility, particularly when changes were made in MDS policy or procedures, such as the most recent shift from MDS 2.0 to the revised MDS 3.0. Furthermore, the RAI manual was commonly mentioned as an important resource for on-the-job training and as a continuing source of information even for the more experienced MDS coordinators. Three respondents referred to the RAI manual as “our bible.”

Access to outside consultants, either within the facility’s corporate structure or with outside organizations, was commonly mentioned as a valuable resource. These outside resources mainly served to assist with issues that were atypical or uncommon, as well as to “know for sure that what I’m doing is correct.”

Availability of computer technology also enhanced the efficacy of their role. Several coordinators mentioned the benefits of completing MDS assessments electronically, with one noting, “It’s computerized, so it’s really not that hard to do once you sit down to do it, if you have all you need sitting in front of you.” Various helpful features of MDS software were also described, such as automatically generated calendars to indicate the assessment schedule for each resident and electronic flags to indicate which fields of the assessment were incomplete.

Although all MDS assessments are completed and submitted electronically, none of the facilities had fully implemented EHRs. The lack of EHRs was described as a barrier, as it required more work in acquiring necessary information and records to complete MDS assessments. Most respondents who
discussed this spoke positively about the potential of having EHRs implemented at their facilities, with one saying, “Computer charting and all that is going to be a jewel.” Four of the facilities reported using computerized charting software for clinical nurse assistants’ charting, which was seen as beneficial, although it still required manually entering information from the computerized charting software into the MDS assessment form.

**DISCUSSION**

The current qualitative study explored MDS coordinators’ perceptions of their role. Respondents identified core components and competencies of the MDS role, highlighted challenges inherent in the role, and described resources to help overcome those challenges. Respondents particularly emphasized the importance of communication in their work, the need to seek patient information from multiple sources, and a heavy workload that threatened the accuracy of the assessment process.

Consistent with findings from Piven et al. (2006) and Dellefield (2008), communication was a vital component of the MDS coordinator role. Respondents in the current study highlighted the importance of keeping open lines of communication with all staff members involved in resident care to obtain accurate information about residents and receive timely updates when a resident’s condition changed. Dellefield (2008) and Piven et al. (2006) also highlighted the importance of good relationships to empower the MDS coordinator to advocate for change within the facility, amend care processes, and influence quality of care. Communication in the context of advocating for change within the facility was not discussed by any respondents in the current study and they were not asked about this aspect specifically. Therefore, further research is needed to explore the importance of direct feedback from MDS coordinators to management staff, such as directors of nursing (DONs) and NH administrators, on quality of care within facilities outside of regular state inspections. Given that state inspections are conducted annually but MDS coordinators have the opportunity to communicate with management staff more frequently, effective direct feedback from MDS coordinators to management staff could have a much quicker effect on quality of care.

Another identified facilitator of the MDS coordinator role was the various sources of information MDS coordinators consult to complete thorough and accurate assessments. This facilitator is consistent with the findings of Dellefield (2008). Similarly, Straker and Bailer (2008) found that information gathering from multiple sources was key for a thorough MDS assessment. MDS coordinators in Straker and Bailer’s (2008) study added that direct patient interviews were the most useful method of information gathering. Respondents in the current study also emphasized the importance of interviewing residents when possible to confirm documented information and collect supplementary details.

Respondents in the current study discussed the challenges associated with relying on multiple different sources of data, which was considered time-consuming and a potential threat to accuracy. Similarly, Dellefield (2008) reported the importance of charting systems to support MDS assessment and noted that computerized charting systems feeding directly into assessment systems were perceived to greatly influence accuracy. Even without EHR–MDS integration, EHRs are potentially beneficial because all pertinent information from the different disciplines involved in resident care can be found in one place. None of the participating facilities in the current study had implemented EHRs at the time of interviews. No federal mandate on EHR adoption for NHs exists and, consequently, NHs are not eligible for the CMS’ EHR incentive programs (CMS, 2014a). Cost has been identified as a major hindrance to EHR adoption (Cherry, Carter, Owen, & Lockhart, 2008); consequently, financial incentives seem to be a significant contributor to facilities’ readiness to adopt EHRs (Wolf, Harvell, & Jha, 2012). Benefits of EHR adoption to the MDS process, as perceived by participants of the current study, indicate that measures to financially incentivize EHR adoption in NHs should be explored. Future researchers should examine how EHR implementation impacts MDS coordinator assessment processes, workload, and accuracy, as well as overall efficiency in NHs and ultimately improved resident outcomes.

Several challenges in MDS coordinators’ work were identified, the most notable being heavy workloads and the complexity of their role, as well as having to juggle multiple residents who require different assessment schedules and types. These challenges are consistent with the findings of Dellefield (2008), who identified workload as one of the structural factors adversely affecting MDS coordinators’ work. In the current study, MDS coordinators remarked that lack of time and a heavy workload could result in inaccuracies in MDS assessments. This is of particular concern due to the financial implications of such inaccuracies. For example, a 2012 report revealed that in 2009, inaccurate reimbursements to skilled nursing facilities cost Medicare billions of dollars (Levinson, 2012). Consequently, CMS has started applying civil monetary penalties and citations to NHs if it is discovered that inaccurate MDS assessments have been submitted (Levinson, 2012). This penalty may
be particularly useful for DONs to keep in mind when assessing staffing needs or advocating for improved staffing on behalf of nursing. To the current authors’ knowledge, no federal or state regulations on minimum staffing of MDS coordinators in NHs exist. Given the potential effect of high workload on the accuracy of MDS assessments and the tremendous cost of inaccuracies, minimum and optimal staffing in this field warrants further research.

MDS coordinators’ stress related to the complexity of their role and heavy workload was further magnified by virtue of the importance of their role to multiple aspects of NH functioning. A similar finding emerged in Dellefield’s (2008) study, although MDS coordinators perceived that administrators were not well-informed about the importance of the MDS process, causing tension. This was not discussed by respondents in the current study; however, they described their role as empowering and many reported being proud of the work they do.

Respondents identified several strategies to overcome the challenges they described, such as developing comprehensive calendars to keep track of assessment schedules and working in teams to better manage workloads. Furthermore, respondents identified the RAI handbook as well as access to outside consultants as helpful resources to support their work. This is consistent with the findings of Straker and Bailer (2008), who reported that the RAI manual was cited as the most reliable source to resolve MDS issues. Given the reliance on the RAI manual, a continued emphasis should be placed on maintaining a current and accessible RAI manual for all NHs. Currently, up-to-date versions of the RAI manual are available for download on the CMS website and also accessible within the software used to submit MDS assessments. However, MDS coordinators need to be alert and make sure to check regularly for updates (CMS, 2014c).

Although federal regulations require RNs to sign off on all MDS assessments, two of the current respondents who were not RNs reported being solely responsible for MDS assessments. It is unclear whether another individual not serving as an MDS coordinator, such as a DON, was signing off on the assessments in these instances to fulfill federal regulations. The current authors do not have information about the reasons behind an LPN/LVN serving as an MDS coordinator in these two instances, although the well-documented shortage of RNs in long-term care (Jurasech, Zhang, Ranganathan, & Lin, 2012) is likely a contributing factor. Further research is needed to explore the prevalence of LVNs/LPNs serving as MDS coordinators and potential effects on the quality and accuracy of MDS assessments.

**IMPLICATIONS FOR NURSES**

Nurses are instrumental in ensuring thorough and accurate resident assessments and documentation, which have important implications for the quality of care in nursing homes. Findings of the current study indicate that effective teamwork and open communication by nurses across all departments is important to facilitate timely and error-free resident assessments. Furthermore, nurse MDS coordinators need to have the time and resources to be properly trained and remain current with the latest updates to the RAI. In addition, there is a need to advocate for improved staffing, particularly for RNs, to ensure that MDS coordinators’ heavy workloads do not affect the accuracy and timeliness of MDS assessments.

**CONCLUSION**

MDS coordinators play a major role in the reliability and accuracy of NH resident assessment data. The current study provides insight into how MDS coordinators perceive their role, as well as some of the challenges they face in their work. The current findings can help inform NH administrators, DONs, and policy makers on how best to support MDS coordinators’ work to enable the development of high-quality care plans and efficient, accurate, and consistent resident assessment processes, including maintaining an open line of communication between NH management staff and MDS coordinators; improving health information exchange through adoption of EHRs; and continuing to ensure that the RAI manual is kept up-to-date, accessible, and user-friendly. Further studies are needed to understand the work of MDS coordinators in NHs, given the growing complexity of the MDS coordinator role. Specifically, future research should explore the impact of EHR implementation on MDS coordinators’ work as well as further examine MDS coordinator communication with other staff and administrators and its potential impact on quality of care. Additional research should also examine MDS coordinators’ workload, as it may affect the accuracy of MDS assessments, which has tremendous financial implications.

**REFERENCES**


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