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MDS Coordinator Relationships and Nursing Home Care Processes

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Abstract

The purpose of this study was to describe how Minimum Data Set (MDS) Coordinators' relationship patterns influence nursing home care processes. The MDS Coordinator potentially interacts with staff across the nursing home to coordinate care processes of resident assessment and care planning. We know little about how MDS Coordinators enact this role or to what extent they may influence particular care processes beyond paper compliance. Guided by complexity science and using two nursing home case studies as examples (pseudonyms Sweet Dell and Safe Harbor), we describe MDS Coordinators' relationship patterns by assessing the extent to which they used and fostered the relationship parameters of good connections, new information flow, and cognitive diversity in their work. Sweet Dell MDS Coordinators fostered new information flow, good connections, and cognitive diversity, which positively influenced assessment and care planning. In contrast, Safe Harbor MDS Coordinators did little to foster good connections, information flow, or cognitive diversity with little influence on care processes. This study revealed that MDS Coordinators are an important new source

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of capacity for the nursing home industry to improve quality of care. Findings suggest ways to enhance this capacity.

Keywords

MDS Coordinators; complexity science; care processes; quality of care; nursing home

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In response to poor nursing home quality (IOM, 1986), the United States (US) Congress mandated the Resident Assessment Inventory (RAI), a multi-dimensional instrument to guide assessment and care planning with a goal of improving quality of care. The resident level Minimum Data Set (MDS) is used to assess quality of care and to determine payment levels. Many nursing homes created a specific role, the MDS Coordinator, to coordinate completion of the RAI in order to maximize reimbursement (Hawes et al., 1995). Given the potential clinical, regulatory, and financial significance of the MDS Coordinator, how nurses enact this role may potentially influence the organization at multiple levels. Using complexity science as the guiding framework, we describe how the MDS Coordinator relationship patterns influence care processes, the foundation of quality of care.

Care Processes and Complexity Science

Care process(es) broadly encompasses resident assessment, decision-making, care planning, implementation, and evaluation. The RAI is a structure for organizing the care processes of resident assessment and care planning. The RAI, however does not guarantee good decision-making, conscientious care, or even high quality of care. The effectiveness of the RAI depends on the reliability, specificity, and comprehensiveness of baseline and follow-up assessments of residents' status (Morris et al, 1990), as well as the decision-making, implementation, and evaluation of the care provided. Since the implementation of the RAI, quality of care has generally improved; however, in many nursing homes quality of care continues to be problematic (IOM, 2001). In a recent study, Swagerty and colleagues (2005) stated, “The structure of the care planning process ensures the role of an MDS coordinator is intrinsically integrative” (p. 45). In reality, we know little about how MDS Coordinators enact this critical role or the extent to which they potentially integrate care processes and positively influence quality of care.

We drew on complexity science (Anderson, Issel, & McDaniel, 2003; McDaniel & Driebe, 2001) to understand how the MDS nurse enacts this role within the organization. Unlike traditional organizational theories where the leader directs the staff to change, complexity science suggests that change emerges through self-organization, defined as the mutual adjustment of behavior arising from interactions among staff as they meet immediate care demands (Cilliers, 1998) to accomplish their work. Multiple and varied relationships are key to effective self-organization. Complexity science predicts that MDS Coordinators will vary in their ability to influence care processes to the extent that their relationship patterns reflect three critical relationship parameters: good connections, new information flow, and cognitive diversity (Anderson et al., 2003; Stacey, 1996).

Good connections exists when there is latitude to interact and freedom to share information with others who can best use that information. Some connections occur naturally when staff members interact to do work. The number, variety, and quality of these connections influence the extent to which staff learns and the extent to which the organization is capable of change.

New information flow refers to the exchange of information within or across levels of the organization. New information of good quality provides knowledge that the staff can use to adjust their work behavior. This information may be general, such as the mission of an organization, or specific, such as communication from a Certified Nursing Assistant (CNA) to a floor nurse that a resident appears more confused than is usual. This new information flow promotes mutual exchange of information for the purpose of understanding and making sense of a situation, allowing staff to adjust their behavior to meet emerging demands.

Sufficient cognitive diversity refers to having access to others with diverse ideas which when exchanged, lead to better decision-making. Cognitive diversity may arise from different training, socio-cultural and educational backgrounds, belief systems, and work experiences.

Purpose

In reality, these relationship parameters are seamlessly interwoven. By explicating these parameters, however, we begin to identify new ways to improve quality of care through the quality of relationship patterns. In this study, we described how MDS Coordinators fostered the three relationship parameters and we explored how these relationship parameters influenced care processes.

Design

Using case study methods, we investigated the MDS Coordinator role within the real-life context of the nursing home setting (Yin, 2003). The present study reports the analysis of the first two cases, part of a larger comparative, multiple case study describing relationship patterns and nursing management practices related to better care outcomes. The analyses in this paper focused specifically on data related to the MDS Coordinators' behaviors and interactions with other staff.

Sample

Nursing homes were selected using a random number generator and were located within in driving distance of the research team. Four MDS Coordinators were employed (two in each nursing home) and all participated in the study. Other participants included staff from administration, nursing, social work, activities, rehabilitation, dietary, and environmental services. Participants signed informed consents prior to interviews and the University Institutional Review Board approved all study procedures.

Method

Field researchers collected data in each facility for a six-month period. They observed daily routines on multiple shifts including medical rounds, shift change, and care-planning meetings. They shadowed staff as they performed their work (n=38 shadow notes), directly observed (n=126 field observation notes), and interviewed them about work processes and relationships (n=57 depth interviews). Field notes and interviews were transcribed for analysis. Field researchers also collected written documents related to organizational goals and operation, for example, mission statements, marketing materials, and job descriptions. We used several means of ensuring rigor and validity (Ahern, 1999; Sandelowski, 1993; Whittemore, Chase, & Mandle, 2001). We used an interdisciplinary team with multiple perspectives, triangulation of multiple sources and types of data, multiple data collectors and analysts and external research consultants for independent critique and feedback. At the end of each case study, we presented a summary of our findings to the participants, who confirmed that we had adequately captured their communication patterns and offered no new themes. This member check supported the trustworthiness of the data (Taylor & Bogdan, 1998; Utley-Smith et al., under review).

Data Analysis

Using ATLAS-ti software (Research Talk Inc., 1999) at least two team members coded each piece of data, including interviews, field notes, and documents, using an open coding technique. Team members discussed emerging themes at weekly data analysis meetings and field researchers provided immediate feedback on the validity of the themes based on their first-hand experience in the facility. The team also discussed additional data that the field researchers should seek to substantiate or refute the themes.

Using the coded data, the first author (MLP) developed case summaries describing the MDS Coordinator's interactions and behaviors within each nursing home. Selected team members (DB, CCE, KC, QUS, and RA), evaluated the support for the identified themes, reviewed summaries independently and suggested missing themes and the first author again examined the data looking for confirming or disconfirming evidence until all team members agreed that the identified themes reflected these data.

We used data matrices in a cross-case analysis to identify variation between the two pairs of MDS Coordinators. After preliminary cross-case results were established, we again read the primary data to ensure that our results were consistent with the original data. Again, to ensure rigor, team members (DB, CCE, KC, QUS, and RA), reviewed the summaries and confirmed consistency with the data.

Results

We organized the findings around the three relationship parameters, good connections, new information flow, and cognitive diversity. Within each relationship parameter, we present the findings for each case, ending with a summary comparing the two cases and suggesting how variation in use of the relationship parameters may influence care processes. First, we provide a summary of demographics and relevant information about the MDS Coordinator role in each nursing home

Description of the Nursing Homes

Sweet Dell.—“Sweet Dell,” was an urban, non-profit, 125 bed, religiously affiliated facility with a private pay, Medicare payer mix. Residents were mostly elderly and Caucasian. The two MDS Coordinators, “Ruth and Joan” were both Registered Nurses (RNs). Ruth had worked less than one year in the MDS Coordinator role at Sweet Dell, but had previous experience as an MDS Coordinator and as an Assistant Director of Nursing in another facility. Joan had worked for 5 years in the MDS Coordinator role at Sweet Dell. They divided the MDS assessment workload by hallways. Social Work, Dietary and Activities Therapy staff completed sections of the MDS assessment appropriate to their expertise. Members of these same disciplines, along with the nurse supervisor (NUR SUP) and the director of nursing (DON) attended weekly care plan meetings with the MDS Coordinators. Licensed Practical Nurses (LPNs) and Certified Nurses Assistants (CNAs) did not attend these care plan meetings. Copies of the care plans were filed in the resident's medical record and in the “CNA book.” The MDS Coordinators were friendly, and welcomed the field researchers to observe care plan meetings and other regularly scheduled meetings and activities. Considered part of the management team, the MDS Coordinators attended management meetings and engaged in organizational decision-making. They preferred a joint depth interview with the field researcher, and agreed on most issues and explanations. In fact, they frequently completed each other's sentences. In addition to their primary role, they shared on-call responsibility for staff shortages with other management level nurses.

Safe Harbor.—"Safe Harbor," was an urban, for-profit, corporate owned facility with over 180 beds, with a Medicare/Medicaid payer mix. Residents were racially diverse, with a mix of older and younger residents. The two MDS Coordinators, "Suze and Mia," were both RNs. Suze had worked less than one year as the MDS Coordinator at Safe Harbor, but had previous experience in the role. Mia had worked more than three years in the MDS Coordinator role at Safe Harbor and had previously been a floor nurse there. They divided the MDS assessment workload by payer source-Medicare and Medicaid, rather than by unit. Social Work, Dietary, and Activities Therapy staff completed MDS assessment sections appropriate to their expertise. Held sporadically, care plan meetings did not include floor LPNs or CNAs and families seldom attended. The MDS Coordinators were primarily responsible for care planning and filed care plans in the resident's medical record. The field researchers had difficulty gaining access to the MDS Coordinators, who often said, "Today is not a good time." Though part of the management team, the MDS Coordinators did not clearly participate in organizational decision-making. In addition to their primary role, they shared on-call responsibility, participated in finding staff to cover shortages, and assisted in passing meals trays and answering call lights when possible.

Relationship Parameter 1 Connections among staff

In this section, we describe the ways in which the MDS Coordinators facilitated connections among staff when exploring resident care or other issues. Examples of facilitating connections among staff include positive face-to-face interactions with a variety of staff across levels of the organization.

Sweet Dell.—Ruth and Joan collected MDS assessment data from several sources, including face-to-face interactions with the CNAs. In the following quote, Ava CNA described how she communicated with the MDS Coordinators:

> Ava CNA: Yeah she [Ruth MDS] says, AvaCNA can you please give me a list of all the people that walk on your side of the building? I will go in there and chat with her from time to time. I will go in there and sit with her. I talk to her more than I do Jane MDS, probably because Jane MDS does [the other side of the building]. .But I do chat with her too sometimes. She is pretty cool.

Ava CNA positively characterized the quality of the connections with the MDS Coordinators. Face to fact interactions between the MDS Coordinators fosters good connections and exchange of information. This good connection increases the chance that the CNA will communicate resident observations to the MDS Coordinator, adding to the accuracy and richness of resident assessment.

Good connections were also evident between the MDS Coordinators, and middle, and top managers. We found numerous interactions between Ruth MDS and Ethel, the Nursing Home Administrator (NHA) over a variety of topics. Illustrating the nature and latitude of her connection with Ethel NHA, the following example comes from a meeting about a new Restorative Nursing program, which Ruth MDS championed.

> Field Note. Ethel NHA looked directly at Ruth MDS and said, "Do you think it will work?" Ruth MDS said, "Yes, I do." [Ruth MDS] then suggested that maybe they could identify a RN to supervise the Restorative Program – take some of the weight off Blake (nurse supervisor). She then used Linda (nurse) as an example – someone who doesn't work full time could do it. She said there's no regulation that says it has to be a full-time nurse.

MDS Coordinators facilitated good connection between themselves and all levels of staff, setting the stage for a rich exchange of information and ideas on which to base assessment, care planning, and in the above example, development of new programming.

Safe Harbor.—Suze and Mia also described regular interactions with CNAs to collect MDS assessment data; however, quotes from two CNAs raised questions about the consistency of MDS Coordinator's connections with CNAs.

> Field Researcher. Do the MDS people come and talk to you about what is going on with the residents? Sandy CNA: “No. They never talk to me.
>
> Field Researcher. Do you ever talk to the MDS nurses? Jane CNA: “They don't want to deal with us, period.”

CNAs explained the lack of communication between the CNAs and MDS Coordinators as a lack of connection.

Suze MDS described feeling a lack of good connection with the management staff that caused her to limit discussions with that group.

> Suze MDS. I used to voice my opinion a lot but lately I have not because I feel that when I do I am being shot down or looked at like, who are you, you know, wanting to do these changes and stuff in here?
>
> Suze MDS. I don't know what to think of him [Fred NHA]. When he first started here, I thought he was going to be really [good]…but then lately he is all about budget, all about money, all about [filling beds].

Suze's perception of increasing resistance to her comments in the daily meetings and perception of having different goals than Fred NHA contribute to a lack of connections with the management team.

In summary, the Sweet Dell MDS Coordinators demonstrated multiple good connections across levels of the organization. Good connections improve the likelihood that CNAs will communicate resident assessment information to the MDS Coordinators for more accurate assessment and individualized care planning. In contrast, the Safe Harbor MDS Coordinators did not demonstrate multiple good connections across levels of the organization.

Relationship Parameter 2: New Information Flow

In this section, we describe the ways in which the MDS Coordinators facilitated information flow when engaging in resident care and other issues. Examples of facilitating in new information flow include exchanging information or ideas across the organization.

Sweet Dell.—Two examples illustrate how Joan MDS encouraged new information flow with floor nursing staff. In the following quote, Joan MDS described how she interacted with the charge nurse on a daily basis.

> Joan MDS. [I talk with the floor nurse] mainly [about] certain patients, how are they doing, what is their condition, if they had changes in medication, is this helping/not helping, that kind of information.

The frequency of face-to-face interactions about resident status promotes information exchange and early recognition of changes in resident status. Joan MDS described how she communicated new information concerning resident status changes to Abby DON.

> Joan MDS. I'll let [Abby DON] know something that I saw; I'll tell her if [resident] has a pressure sore, or has swollen feet or something; she needs to follow-up on that type of information. Or [if] somebody was restrained and had no water.

Joan MDS communicated new assessment information to Abbey DON, so that she can intervene to manage and/or prevent further progression of the identified care issue/symptom.

Considered part of the management team, Ruth and Joan participated in management discussions and decision-making. Ruth MDS suggested improving the admissions procedure by basing it on the MDS assessment. Though the initiative did not materialize, a new focus on Quality Indicators (QIs) began.

> Field Note. Ruth MDS said [she has been] arguing that the QI???s come right from the MDS, so why not attend to these things from the start….Ruth explained to me [field researcher] that now there will be a QI meeting [every] Wednesday. They are going to begin to do QI reviews of 2-3 residents at a time at morning report.

In this example, Ruth MDS shared information with Ethel NHA who used the information to adjust clinical priorities, focusing on quality improvement efforts.

Safe Harbor.—A policy prevented CNA access to the resident's medical record, where care plans were kept limiting the information available to them for resident care. Although they are aware of the policy, Suze and Mia express frustration over lack of care plan implementation.

> Suze MDS. My work is hard with the CNAs because they do not look in the charts at all and the care plans are in the charts. So they do not know what the care plans are for the residents at all. They just do for all the residents the same because it is easier when you have so many and move around so much… So for the most part, care plans are not carried out here and that makes the whole thing seem like a waste for everyone and frustrates me. I work on these care plans and never see the resident improve or the care plan is not carried out and there is no support for this at all.

> Mia MDS. I try not to show my frustration…sometimes the care is not given the way it is suppose to be and people are lying in beds and not changed on time, or missing their restraints or something that we have to pay attention to. Somehow, I feel there is no complete communication [to] the staff.

Without access to care plans, the CNAs provided care without full information. Suze's and Mia's sense of frustration over the poor care was apparent, along with their feelings of powerlessness to address one of the underlying contributors to poor information flow, CNAs inability to access care plans. Neither Suze nor Mia were observed to foster interactions with CNAs that might have improved information flow.

In summary, the Sweet Dell MDS Coordinators encouraged new information flow through frequent and consistent interactions with staff. In addition to facilitating new information flow at the direct care level, Ruth influenced new information flow at the management level, resulting in a system change to focus on QIs. In contrast, the Safe Harbor MDS Coordinators encouraged little new information flow. Though they were aware of the CNAs inability to access the care plans, and of the consequences to resident care, they expressed frustration and powerlessness to influence this situation.

Relationship Parameter 3: Cognitive Diversity

In this section, we describe the ways in which the MDS Coordinators facilitated diversity of thought when exploring resident care or other issues. Examples of facilitating cognitive diversity include suggesting alternative ideas or strategies or linking people of different disciplines to problem solve.

Sweet Dell.—Informed by her knowledge of the resident's medical history, Joan MDS suggested an alternative way to make sense of a resident's symptoms.

> Joan MDS. So, I asked, ‘Why is she in bed?’ and [the nurse] said ‘Oh, she just hasn't been feeling well the last few days.’ So I tell the charge nurse, ‘You might want to look for a

> urinary tract infection because she has a history of urinary tract infections.' MAYBE that's something that's happening. The nurse said, 'Ok, I'll get a urinalysis.'

The MDS Coordinator expressed an informed perspective, which prompted the nurse to gather further clinical evidence to confirm or disconfirm a particular clinical hypothesis that might result in early detection of a urinary tract infection.

Besides contributing their own perspectives to improve assessment and decision-making at the resident level, the Sweet Dell MDS Coordinators drew on inter-disciplinary perspectives to capture the most accurate resident assessment, on which to base decision-making and care planning.

> Joan MDS. We have a meeting every Wednesday…I pull the nurses' charts and with activities, social workers, occupational therapy, and we talk about [residents]. This gives us an opportunity to get the care plans correct and discuss any discrepancies in the care plans. So, if I thought a resident did not verbalize often, but Jane ACT and Meg SW have spoken to her then I would get the full picture of the situation.

However, JoanMDS recognized that important perspectives were missing from these meetings.

> Joan MDS….it's the nurses and the CNA watching that resident constantly…they know how agitated that person gets…We can [care plan] from our judgment, but still, that nurse and the CNA are with this patient all the time. They might have a better solution …

She recognized that including the perspectives of direct care staff improved the quality of assessment and care planning, so she set up an additional method to get their ideas.

> Joan MDS. I haven't been out there working with Mrs. So & So, so how can I give you an opinion about what she needs as a restraint or prevention for a fall? I want you (nursing staff) to give me a slip of paper that says what your interventions are--which [staff now have] been very good at doing.

Although the MDS Coordinators fostered involvement of floor staff within staffing constraints, writing interventions on a piece of paper limits important interaction by people with diverse perspectives which may lead to better care planning. Face to face communication about care issues is more likely to generate two-way dialogue and problem solving and create opportunity for generating new ideas to address care issues.

Safe Harbor.—Suze MDS reported that she sometimes collects MDS assessment data by observing the CNA giving care to a resident. She explained that CNAs try to save time by taking over the bathing for the resident, instead of fostering the resident's self-care abilities. In the following example, Suze MDS described the type of interaction that she has with the CNA.

> Suze MDS. I will say, 'If you hand her a washcloth, is she able to wash her face?' They will say, 'I never tried that.' So I will say, 'Let's try that." Because a lot of times, you know, when you go in there, the CNA sees a different perspective.

CNAs may wish to simplify their work by treating all residents the same instead of evaluating the ability of the resident to bath independently. This timesaving measure of 'doing for' a resident may reflect the CNA's perception of management expectations. This observation offered Suze MDS an opportunity to understand the CNA's perspective and offer an alternative approach, which more accurately assesses and engages the resident's self-care ability**.** The CNA is encouraged to reflect on and describe the various care strategies she has used, and their effect on the resident. This interaction holds promise for reinforcing a resident-focused care approach.

In summary, the Sweet Dell MDS Coordinators shared their clinical perspectives with floor nurses to improve assessment accuracy and decision-making. Although these MDS

Coordinators talked about the importance of including floor nurses and CNAs in care planning, given system constraints this happened infrequently. In contrast, there was no evidence that Safe Harbor MDS Coordinators tried to engage LPNs and CNAs in care planning. However, Suze MDS did appreciate that learning the CNAs' perspective about bathing residents helped her tailor her bedside teaching. This interaction provided a natural opportunity for suggesting alternative approaches consistent with restorative care principles. This approach also brings much needed clinical expertise to the bedside directly influencing CNA care delivery.

Discussion

Applying the three relationship parameters to the MDS Coordinator relationship patterns in two nursing homes led to insights into how MDS Coordinator behaviors and interactions may differentially influence care processes. Overall, the Sweet Dell MDS Coordinators routinely engaged in and fostered new information flow, good connections, and cognitive diversity across all levels of the organization. This allowed them to gather and to exchange new information informally at the point of care based on good connections with staff. Further, these local interactions promoted staff input and improved the accuracy of assessment and the quality of decision-making. Even though LPNs and CNAs were not formally involved in care planning meetings, the Sweet Dell MDS Coordinators recognized the value of using the cognitive diversity of the direct care staff for assessment and care planning. As a result, the MDS Coordinators fostered good connections to get CNAs and LPNs to write down interventions for use in care planning. Familiarity with existing clinical processes and system structures permitted the MDS Coordinators a perspective not available to any other member of the organization. The MDS Coordinator's “bird's eye view” coupled with their good connections to top management generated a system-wide positive change to begin focusing attention on evaluating care through focus on QIs.

In contrast, the Safe Harbor MDS Coordinators used the relationship parameters to a lesser extent in their relationship patterns. Information flow between the MDS and some CNAs was inconsistent, and likely complicated by the fact that CNAs did not have access to the care plans created by the MDS Coordinators. Though the Safe Harbor MDS Coordinators seemed to recognize poor information flow contributed to poor care plan implementation, they lacked the connections to middle and upper management necessary to advocate for system improvements to increase information flow to CNAs.

The quality of MDS Coordinator relationships with management varied greatly between the two facilities. In Sweet Dell, the MDS Coordinators were clearly involved in management decision-making activities and this involvement likely provided opportunities to foster good connections with other management staff. They used these connections to educate management about the MDS assessment and to make suggestions for system improvements, e.g., admission process; restorative nursing. Because the Safe Harbor MDS Coordinators were not clearly involved in organizational decision-making activities with other management staff, perhaps they had fewer opportunities to share their clinical knowledge and system expertise. Though Safe Harbor MDS Coordinators attended a brief daily management meeting, their role was limited to reporting the number of MDS assessments scheduled for that day. The underlying cause for the lack of good connections between the Safe Harbor MDS Coordinators and the management team in daily management meetings was not apparent in the data. Perhaps the Safe Harbor management team did not appreciate the value of the MDS Coordinators in influencing resident quality of care beyond their role in meeting federal regulations for documenting resident assessments and influencing financial reimbursement. More accurate assessment yields greater knowledge about nursing care efforts and this may be linked to a higher level of reimbursement.

What might account for the variation in the relationship patterns between the two nursing homes?In terms of facility characteristics, bed-size and business model differentiated these two nursing homes. Safe Harbor had 30% more beds than Sweet Dell (180 versus 125). Perhaps the additional workload and paper work limited their ability to actively foster these relationship parameters. Second, unlike Sweet Dell who divided their workload by hallway, the Safe Harbor MDS Coordinators divided their workload by payer source across the nursing units. (Medicaid/Medicare). Working consistently on the same hallways may have allowed the Sweet Dell MDS Coordinators better opportunity to get to know staff and foster higher quality relationships, thus facilitating the relationship parameters. Natural opportunities for information sharing occurred since the MDS Coordinators spent more time on the hallways. In contrast, division of workload by Medicare/Medicaid payer status meant that the Safe Harbor MDS Coordinators moved among all the units, interacting with different sets of nursing staff with less time spent on each unit. The limited exposure to nursing staff on each unit negatively influences their ability to foster good connections, information flow, and cognitive diversity.

In terms of nurse characteristics, the MDS Coordinators were all RNs with several years of experience in the role. Personal characteristics, interacting with the work environment, may also have played a role; the Sweet Dell Coordinators seemed empowered and confident; the Safe Harbor MDS Coordinators seemed frustrated, powerless, and demoralized. Of note, both Safe Harbor MDS Coordinators left their positions 6-8 months after completion of data collection.

Relationship patterns typically evolve with little mindfulness towards deliberately cultivating high quality connections, new information flow, and cognitive diversity. These findings have implications for nurse educators, MDS Coordinators, managers and administrators. For nurse educators, given the relevance of these relationship parameters for the self-organization of staff and the emergence of quality, training practitioners to use and foster the relationship parameters might improve the overall effectiveness and quality of nursing care. Training may be especially valuable to MDS Coordinators because of their integral role in assessment and care planning and the challenge of balancing the clinical, regulatory, and financial aspects of their positions. Given the breadth of their clinical expertise and system knowledge, MDS Coordinators provide a valuable perspective for improving care quality as well as system operations. For managers and administrators, these findings suggest that the MDS Coordinator is a valuable organizational resource whose input would improve organizational decision-making. Consistent with the research by Swagerty and colleagues (2005), we agree that the MDS Coordinator role is “intrinsically integrative,” with potential to impact quality of care. However, the potential of the MDS Coordinator to influence important care processes such as assessment, decision-making and care planning may be moderated by the quality of their relationship patterns across the organization. Maximizing that potential by attention to relationships patterns among staff can help to unlock that capacity of the MDS Coordinator to positively influence care processes and improve quality of care.

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