ADL and Restorative Nursing: Optimizing Reimbursement

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OBJECTIVES
At the end of this activity, the learner will be able to:
1. Describe the core components of an effective Restorative Nursing Program including ADL tracking and documentation.
2. Recognize the key elements of a Restorative Program which affect reimbursement and quality outcomes.
3. Evaluate individual ADL knowledge and tracking systems for successful implementation.
**Restorative Candidates**

Determining who is appropriate for restorative care

- Any resident with a potential for decline
- Any resident assessed/identified with physical, mental, and/or psychosocial decline or deficit causing a deterioration in the ability to perform daily activities
- Any resident assessed/identified with decline in one or more late loss ADL’s (Bed Mobility, Transfer, Toilet Use, Eating)
- Any resident anticipating discharge to home/community, that will benefit from increased strength/endurance and other restorative programs

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**ADL’s and Restorative Nursing**

The first step is determining a need for a Restorative Nursing program.

- ADL tracking/coding
- Functional ADL Assessment
- Range of Motion Screening/Assessment
- Bowel and Bladder Assessment

**If there is a deficit, why would we not have the resident in a program?**

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**Restorative Programs**

- Urinary Toileting Program and/or Bowel Toileting Program
- Passive or Active Range of Motion
- Splint or Brace Assistance
- Bed Mobility and/or Walking Training
- Transfer Training
- Dressing and/or Grooming Training
- Eating and/or Swallowing Training
- Amputation and/or Prosthesis Care
- Communication Training
RAI Manual

“Restorative nursing program refers to nursing interventions that promote the resident’s ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.”
Pg. 0-32

RAI Manual

“A resident may be started on a restorative nursing program when he or she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational or speech rehabilitation therapy.”
Pg. 0-32

Restorative Function

Promoting a higher level of function requires:
• Identification of what the resident actually does for him/herself
• Identification of assistance needed and what level
• 24/7 view must be observed--residents vary
• Multiple sources are required in the assessment
ADL CODING
It is imperative that the ADL tracking substantiates the MDS Coding. Remember, the MDS gathers information on the resident’s actual function—not what staff think the resident can do.

Implications of Section G:
• Dollars/Reimbursement!!
• Resident Care
• Quality Measures: One of the Quality Measures that potentially looks at Restorative includes: “Percent of residents whose need for help with activities of daily living has increased.”
• Survey: What do surveyors look at when there is a decline in ADL’s?

ADL Tracking
• What is your system?
• Electronic vs. paper
• Are we tracking shifts or episodes?
• How and how often are C.N.A.’s trained?
• Orientation
• How are we ensuring compliance?
• How often are we checking the documentation?
• Who is checking the documentation?
Examples of Tracking/Coding Errors

- Limited vs. Extensive Assist—it's all about weight bearing assistance!
  - Examples
- "Holes" in tracking
- MDS coder doesn’t agree with tracking
- "Copycat" tracking
- Tracking once/shift
- Staff track what they “think” the resident can do!

ADL's that Influence the RUGs

- Late Loss ADL’s include:
  - Bed Mobility
  - Transfer
  - Toilet Use
  - Eating

ADL Scoring Form

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<th>Eating</th>
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Let’s Discuss the Programs!

All Programs need to be planned, monitored, evaluated and documented in the resident’s medical record.

Toileting Programs

Steps for an Individualized Program

- Include observations of at least 3 days of toileting patterns with prompting to toilet & recording results in a bladder record or voiding diary
- Nurse Assessment with review of voiding patterns such as frequency, volume, duration, nighttime or daytime, quality of stream

Toileting Programs

- Determination of the type of incontinence:
  - Stress
  - Urge
  - Mixed (combination of stress and urge)
  - Functional
  - Overflow
  - Transient

**The type of incontinence identification will help in determination of the program**
Toileting Program

• The toileting plan/program must be resident specific (do not count check and change programs)
• Improvement in resident continence can range from less incontinent episodes to total continence. Improvement is based on successfully voiding in the toilet (or commode, etc.) at an increased rate than if they were not on a program.
• Documentation of monitoring for voiding and increased dryness is essential to proving success.

Toileting Programs

• Scheduled Toileting Program
• Prompted Voiding
• Bladder Training
• Bowel Toileting Program

DOCUMENTATION IS ESSENTIAL!

• The 3 day Bowel and Bladder Diary should be completely filled out in order to determine an individualized program.
• The program care plan should be based on the resident individualized need.
• There should be documentation of program implementation and outcome of program.
Range of Motion

- PROM
- AROM (Includes AROM and AAROM)
- Based on resident need for program
- Planned program—not part of routine ADL cares
- The MDS only captures “functional” limitations in Range of Motion, therefore documentation will need to substantiate the need for the program based on assessment.

Bed Mobility

- Scheduled and planned exercises that assist the resident in moving to and from a lying position, turning side to side, positioning while in bed
- Based on need for program (ADL coding/functional assessment)

Discussion of Example

Walking

Candidates for Restorative Ambulation:

- Residents who transfer with moderate assist
- Exhibit weakness, hemiparesis, have an amputation etc.
- Verbalize goal to ambulate
- To maintain ambulation skills recently obtained through skilled therapy services
Walking

Ambulation Activities
- Walking on even/uneven surfaces: walking in hallway, cement, linoleum, institutional vs. home carpeting, gravel, grass
- Negotiation ramps and inclines: walk up/down driveway or ramp
- Walking up and down stairs and curbs: walk up and down step/curb
- Maneuvering small spaces: walking in room or bathroom, review environment for changes in furniture placement, etc.

Documentation
- The program will be based on assessed need (ADL coding, Functional ADL Assessment, Therapy recommendations, etc.)
- The care plan should indicate distance, pace, assistive devices and number of staff assist.
- The Restorative Flow sheet should address the goals and interventions as well as documentation of staff implementation of interventions.

Transfer

Candidates
- Residents who require assistance to transfer and are able to participate
- Residents who are 1 or 2 person lift assist or require mechanical lift device but have functional ability to improve upon
- Able to utilize bed rails, grab bar or trapeze for turning and repositioning
- Residents with amputation or hemiparesis
- Residents identified for strengthening, balance and mobility training
Transfer

Transfer Program Considerations
- Provide time for task segmentation and rest periods
- Recognize that loss of strength, ROM balance effect resident's ability to transfer
- Utilize strengthening interventions in the transfer program to address individualized needs
- Utilize sliding board when appropriate (staff must be trained on use of sliding board for safety)

Documentation
- The program will be based on assessed need (ADL coding, Functional ADL Assessment, Therapy recommendations, etc.)
- The care plan should indicate individualized interventions, assistive devices and number of staff assist.
- The Restorative Flow sheet should address the goals and interventions as well as documentation of staff implementation of interventions.

Dressing/Grooming

Candidates:
- Residents identified as having a potential to improve their level of self-performance in ADL's.
- Residents who would benefit from repetitive training until skills are mastered.
- Residents who are continuing to receive or have recently received OT to work on adaptive equipment related to dressing/grooming (i.e. button hook, etc.)
- Residents who have limitations in balance, strength or ROM.
- Residents who express a desire to become more independent with ADL's
Dressing

- **Dressing** - Selecting, obtaining, putting on, fastening (buttons, snaps, zippers, Velcro, laces), taking off all items of clothing, and putting on and removing braces and artificial limbs, socks and shoes, accessories (belts, jewelry, scarf tying, and knotting a tie).

Grooming

- **Grooming** - Maintaining personal hygiene, including planning the task and gathering supplies, combing and/or styling hair, washing face and hands, brushing teeth, shaving or applying make-up, oral hygiene, self manicure (safety awareness with nail care), and/or application of deodorant or powder.

Documentation

- The program will be based on assessed need (ADL coding, Functional ADL Assessment, Therapy recommendations, etc.)
- The care plan should indicate individualized approaches and assistive devices.
- The Restorative Flow sheet should address the goals and interventions as well as documentation of staff implementation of interventions.
Eating/Swallowing

Purpose
• Dining programs are designed to maintain or improve safe dependent or self-feeding ability, maintain or improve nutrition/hydration status, and enhance socialization and self-esteem.

Candidates include:
• Residents with chewing or swallowing problems
• Residents with poor oral strength
• Residents with weight loss and loss of upper extremity strength and range of motion
• Residents with decreased postural strength or loss of endurance while sitting

Candidates cont’d
• Residents with splints, prostheses, or adaptive equipment related to eating
• Residents with feeding tubes but have potential for restoring oral ability
Eating/Swallowing

- Residents with some restorative potential for regaining eating and swallowing skills are most appropriate for eating programs.
- Programs for dysphagia and/or potential for aspiration should have a well defined dining program which includes:
  - Specified consistency of food
  - Specified consistency for liquids
  - Specific swallowing techniques
  - Specific physician's order for interventions to be utilized with the resident.

Documentation

- The program will be based on assessed need (ADL coding, Functional ADL Assessment, Therapy recommendations, etc.).
- The care plan should indicate individualized approaches, supervision required and assistive devices.
- The Restorative Flow sheet should address the goals and interventions as well as documentation of staff implementation of interventions.

Splint/Brace Assistance

The RAI Manual indicates to “Code provision of (1) verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; or (2) a scheduled program of applying and removing a splint or brace. These sessions are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident’s medical record.”

pg. O-34
Documentation

- Care Plan: Individualized goals and interventions
- Physician Order
- The Restorative Flow sheet should address the goals and interventions as well as documentation of staff implementation of interventions.

Amputation/Prosthesis

The RAI Manual indicates, "Code activities provided to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body"

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Helpful Hints:
- Therapy can assist in development of the initial Restorative Program.
- Resident's ability to follow directions and participate (documented) is essential for successful program implementation.
- The Restorative Flow sheet should address the goals and interventions as well as documentation of staff implementation of interventions.
Communication

Candidates
- Residents with CVA resulting in Communication deficits
- Verbal and/or written language deficits
- Visual acuity deficits
- Hearing deficits
- Attention deficits, depression, psychological problems and memory deficits

Communication
- Due to complexity of the neurological process of language and communication, communication goals (for some residents) may take the longest course of treatment interventions of all restorative programs.
- Goal time frames will probably be of long duration and progress slow.

Communication
- Speech Therapy can assist in development of the initial Restorative Plan of Care, as well as with resources for transition to Restorative Nursing.
- The Restorative Flow sheet should address the goals and interventions as well as documentation of staff implementation of interventions.
Important Note

• The “plan of care” for Restorative is derived from the functional deficit identified in Section G of the MDS.
• “The clinical record shall identify a restorative nursing plan of care to assist the resident in reaching and/or maintaining his or her highest level of functioning.”
• Care Plan-Goals may be
  – Improvement or maintenance
  – The Program Implementation Record sheet (flow sheet) should match the care plan.

Importance of Timely Identification

If resident is not assessed and put into an individualized Restorative Program prior to the look back period, no minutes will be captured during the observation period and the program will not be coded in O0500, Restorative Nursing Programs.

MDS Coding for RUG-IV

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:
• HS0200C, H0500** Urinary toileting program and/or bowel toileting program
• O0000A,B** Passive and/or active ROM
• O0000C Splint or brace assistance
• O0000D,F** Bed mobility and/or walking training
• O0000E Transfer training
• O0000G Dressing and/or grooming training
• O0000H Eating and/or swallowing training
• O0000I Amputation/prostheses care
• O0000J Communication training
• **Count as one service even if both provided
Rehab Low or Rehab Plus
Extensive Low

- There needs to be 45 minutes or more of therapy per week and at least 3 days of any combination of the 3 disciplines AND 2 or more Restorative Nursing Services received for at least 15 minutes with each administered for 6 or more days.
- Documentation of days(minutes) cannot be missed!

Case Mix

- For many case mix states (but not all), it is required to have 2 or more programs at least 6 days/week for 15 or more minutes/day.
- Documentation must substantiate the minutes/days.
- Does your documentation justify the programs?

Documentation

- Weekly, Monthly and Quarterly Restorative Reviews
  - Progress
  - Participation
  - Resident Response to Program
- Consistency of documentation
  - Assessments vs. coding vs. monthly/weekly nursing summaries, etc.
Reimbursement

- Every RUG has an ADL score attached
  - Ranges from $ to $$$$$

**It is CRUCIAL to have accurate tracking and coding of ADL's!**

Quality Measures

The Quality Measures that have a direct relationship to Restorative Programming include:

- Percent of Residents Experiencing One or More Falls with Major Injury
- Percent of Residents who Self-Report Moderate to Severe Pain
- Percent of High-Risk Residents with Pressure Ulcers

Quality Measures

- Percent of Long-stay Residents with a Urinary Tract Infection
- Percent of Low-Risk Residents Who Lose Control of their Bowels or Bladder
- Residents Who Have/Have a Catheter Inserted and Left in Their Bladder
- Percent of Residents Who Were Physically Restrained
- Percent of Residents Whose Need for Help with Daily Activities Has Increased
- Percent of Long-stay Residents Who Lose Too Much Weight
Auditing for Compliance and Quality

- Review/audit your forms and/or system for ADL tracking. Are we making it user friendly to capture the information we need?
- Audit ADL tracking documentation during the look back period (holes, accurate information, copycat charting, etc.)
- Audit documentation of minutes for Restorative Programs during the look back period.

Restorative Nursing Record

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| Diagnosis: | Osteoporosis, Arthritis, Rt shoulder fracture, GERD |
| Rehab Potential: | To improve ability to ambulate with rolling walker from 75 ft to 100 ft daily |
| Treatment Orders: | Ambulate resident at least 25 ft using gait belt and rolling walker. Gradually increase distance as resident builds endurance. Same limits. 1 tour a week |
| Equipment: | Rolling walker, gait belt, etc. |
| Other Instructions and Precautions: | Resident is unsteady and weak. Follow with w/c when ambulating. |

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| Initials & Signatures | 7/10  
Karen McEntyre, CNA  
| 7/11  
Madeline Dart, CNA |

Auditing System

- Assessment forms:  
  - Range of Motion  
  - Bowel and Bladder  
  - Functional ADL Assessments

Are you able to objectively determine:  
- The need for the program?  
- Progress, maintenance or decline from one assessment period to the next?
Auditing System

- Have you audited your education sign-in sheets to ensure all staff have attended education on Restorative Programming and documentation (including ADL tracking)?
- What systems are in place for staff who do not comply?

Benefits of Restorative Programs

- Residents will receive Quality Care
- Facilities will get reimbursed for the quality of care they provide
- Improvement with Quality Measures
- Workload of C.N.A.’s will get easier!
- Increase the likelihood of Regulatory Compliance
- Can assist the facility in Marketing Strategies

QUESTIONS?

THANK YOU FOR YOUR PARTICIPATION!

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