REV UP
Your Restorative Program for Quality!

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After attending this presentation, the attendees will be able to:

1. Verbalize the key components of a Nursing Restorative Program necessary for quality of care and Quality Measures.

2. Describe documentation necessary to substantiate program implementation.

3. Identify strategies to oversee and monitor Restorative Program Implementation.
DOCUMENTATION OVERLOAD!!!
Restorative Nursing Programs

JUST THE THOUGHT OF IT!!!
RESTORATIVE PROGRAMS

Time to REV UP!!!!
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
– Therapy recommendation

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

MDS 3.0 RAI Manual, Chapter 3, Pg. 0-32
“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.”

MDS 3.0 RAI Manual, Chapter 3, Pg. 0-32
1. Based on resident’s identified needs and preferences
2. Need to be planned, organized and documented (not part of routine care)
3. At least 15 minutes/day
4. Programs aimed towards improving or maintaining function
5. Care Plan should identify individualized goals and interventions (ongoing review for revisions)
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
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?
• 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?
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!
• Addresses resident level of function for a specific time period
• Identifies potential need for more indepth assessment/investigation (i.e. CAA’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/Had 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
1. Improve Resident Function!
2. Improved Care
3. All staff understanding of Quality Measures
4. Accurate MDS coding! (prevention of roller coaster coding!)
5. Consistent Implementation of Care Plan interventions!
6. Good Communication
7. Ongoing oversight
Nurse Assessments

- Bowel and Bladder Assessment following a 3 day data collection/diary.
- Range of Motion Screening or Assessment
- Functional ADL Assessment
- Review of History and Physical
- Resident Interview
• Formal Communication (written and verbal) when Formal Therapy discharges resident from therapy to include:
  – Current functional status
  – Appropriate Goal(s)
  – Interventions
* Once therapy discharges and resident is in a Restorative Program, the program is under the direction of nursing.
Putting it all Together

Once you have all of your data and assessment information,

1. A decision will be made on the program goals and interventions for each individual resident and a care plan is completed,

2. C.N.A. documentation is prepared and

3. Communication is essential!

4. Documentation System is set up

5. Oversight of the program!
Brief Overview 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
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
• 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
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
• Includes “activities provided to improve or maintain the resident’s self-performance in moving between surfaces or planes either with or without assistive devices. These activities are individualized to the resident’s needs, planned, monitored, evaluated, and documented in the resident’s medical record.”

MDS 3.0 RAI Manual, Pg. O-34
Walking

• Planned and organized program based on resident’s individualized needs:
  – Distance
  – Staff Assistance
  – Assistive Devices
  – Special Considerations
  – Surfaces consideration (tile, carpet, cement, grass, etc.)

* A facility wide “walk-to-dine” may be appropriate for some residents but not all!
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 - 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.
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.
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.”

-MDS 3.0 RAI Manual, Chapter 3, pg. O-35
Amputation/Prosthesis Care

• Includes “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”

-MDS 3.0 RAI Manual, Chapter 3, Pg. O-35
Communication

• Do you have Communication programs in your facility?
• What is your assessment process?
• How can facilities utilize Speech Therapy in the process to individualize care?
• 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.
• All Programs must be:
  – based on the resident’s individualized needs, care planned, monitored, evaluated, and documented in the resident’s medical record.

  – MDS 3.0 RAI Manual, O0500
1. Assessment Process
   – Ancillary Assessments
     • Range of Motion
     • Functional ADL
     • Bowel and Bladder
     • Balance
   – MDS and CAA’s
     • ADL’s
     • Minutes of Restorative Programs
2. Care Plan (original and revisions)
3. Implementation Records for C.N.A.’s
4. C.N.A./Restorative Aide documentation
5. Monthly Charting
6. Change of Condition Charting
7. Quarterly Review (progress, participation, resident response to programs over the quarter)
8. State Specific charting—some states have specific requirements.
Review of Documentation

• Ongoing review of documentation will also ensure:
  – Opportunities for on-the-spot education are addressed
  – Opportunities to address resident refusals in a timely manner (discussing risks/benefits and reason for refusals)
  – Changes are made in a timely manner to resident needs and added to the care plan
Restorative Program Oversight
• 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.
• 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?
Oversight - 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?
Program Oversight

• Are staff implementing the programs as planned?
  – Observations of technique
  – Observations of minutes
  – Documentation
  – Resident interviews

* Are programs implemented as planned?
Program Oversight

Recommendations:

- Review of Policies and Procedures
- Review of Staff Education
- Review of Communication (Therapy and Nursing)
- Forms Review
- Review of Assessment Processes
- Review of Implementation
- Review of Care Planning
- Review of Outcomes (Are resident’s meeting goals?)
- Review of Quality Measures over time
- Quality Assurance Involvement
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
The Moment of Truth

“Any time customer comes in contact with any aspect of an organization and has the opportunity to form an impression.”

A Committed Facility Team with a Mission and Vision for Restorative Nursing will leave a lasting impression!