

*Restorative Nursing and the MDS*  
from "I can't" to "I think I can"

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**OBJECTIVES**

- \* At the completion of this session, participants should be able to:
  - Define Restorative/Rehabilitative Nursing (RRN)
  - Identify 3 benefits to residents and 2 benefits to the facility from RRN
  - List at least 2 ways that RRN helps facilities meet Long Term Care Regulations

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**OBJECTIVES**

- Verbalize the components of a RRN program
- Understand and apply the RAI manual criteria for coding RRN programs on the MDS
- Determine, through case studies, which RRN programs would be beneficial for the residents in the case study

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*Restorative Nursing Pre-Test*

- \* Before we begin, please complete the pre-test that is being distributed
- \* For your own use
- \* Will post the answers during the afternoon break

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*Definition*

- \* What restorative nursing **is not**:
  - Busy work
  - Therapy
  - Competitive with therapy
  - Given strictly to increase Medicare or Medicaid reimbursement

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*Definition continued*

- \* What restorative nursing **is not**:
  - For alert residents only
  - Needing highly technical equipment or persons with superior technical skills to administer
  - An option

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*What restorative nursing is:*

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- ★ RAI Manual revised 2002
  - Nursing interventions that promote resident’s ability to adapt and adjust to living as independently and safely as possible
  - Includes nursing interventions that assist or promote resident’s ability to attain his or her maximum functional potential

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*What restorative is:*

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- ★D. Atchison (1992)
  - Focuses on what patients can do
  - Maximizes resident’s abilities through the use of individualized, progressive programs
  - Goals to create independence, improve self-image and self-esteem, reduce level of care required, eliminate or minimize degrading features of long-term care such as restraints, incontinence and supervised feeding

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*What restorative is:*

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- ★Barbara Resnick, PhD., CRNP
  - A planned systematic program that focuses on helping each resident obtain and maintain the highest level of function
- ★Barbara Acello M.S., RN
  - An integral part of nursing service directed toward helping each client achieve and maintain an optimal level of wellness, self-care and independence

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*What restorative nursing is:*

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- ★B.J. Collard BSN, RN
  - Utilizes skills and expertise of each discipline to plan, implement and facilitate returning an individual to their highest practicable physical, mental and psychosocial functional level. It is not a new concept.
- ★Alice Bell, P.T.
  - One of the most effective models of care for preventing avoidable resident declines

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*What restorative nursing is:*

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- ★Rita Roedel MS, RN
  - A planned systematic program that builds on positive goals from impairment deficits. Helps the resident develop a mental attitude of “I will try” and “I can” or “I think I can”, rather than “I can’t”.

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*Specialized Rehabilitative Service vs Restorative Nursing*

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- ★Specialized Rehab focuses on:
  - Retraining, education and teaching of new skills
  - Flows from acute injury with input from all disciplines
  - Is task-oriented with specific aim to be achieved within a specific period of time

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### *Rehab vs Restorative cont.*

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- ★ Restorative Nursing focuses on:
  - Restoring or compensating for skills lost through disuse or change in physiology
  - It is based upon the nursing model with less continuing direct input from therapists
  - It seeks to maximize and prolong abilities that promote a resident's highest level of functioning

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### *Rehab vs Restorative cont.*

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- ★ Restorative Nursing focuses on:
  - Having specific objectives and is a continuing process
  - It can be an outgrowth of therapy, or can be initiated by a nurse

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### *Restorative Nursing :*

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- ★ Is a Process, a philosophy of care not a task
- ★ Embodies the nursing process
  - Assessment
  - Planning
  - Implementation
  - Evaluation

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### *Keys to successful program*

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- ★ Daily routine that is structured
- ★ Consistently provided for continuity of care
- ★ Good communication between all parties
- ★ Use of the Care Plan

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### *Principles of Restorative Care*

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- ★ Begin treatment early
- ★ Activity strengthens but inactivity weakens
- ★ Prevent further disability
- ★ Stress ability not disability
- ★ Treat the entire person

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### *Why is restorative nursing important?*

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- ★ What effect do restorative programs have on residents?
  - Improve quality of care
    - Maintain or improve function
      - Body systems interdependent: benefit to one helps another
      - Example: Increased independence in transfer and ambulation will impact continence, constipation and hydration
    - Prevent subtle declines
  - Minimize complications

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### *Importance of restorative programs*

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- ★ Effect of programs on residents cont.
  - Improve quality of life
    - Better self-esteem, self-worth
    - Able to function more independently
    - Less likelihood of depression, more involvement in “life”
      - increased social interaction
      - help to decrease feelings of isolation

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### *Restorative Care:*

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- ★ Focuses on helping residents do for themselves rather than “doing for” them
- ★ Focuses on short, achievable goals
- ★ Focuses on resident’s functional potential not a diagnosis or limitations
- ★ Focuses on preventing deterioration whenever possible
- ★ Seeks to improve self-image and self-esteem

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### *Effect of restorative nursing on the facility*

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- ★ May decrease the amount of staff direct care time for residents
- ★ May increase payment
  - RUG-III system recognizes RRN programs as beneficial to residents and require more staff resources
  - 4 groups that use RRN programs in grouping criteria receive higher payment than those same groups without programs

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### *Effect of Restorative Programs on facility*

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- ★ Have an impact on Quality Indicators (QI)/Quality Measures
  - QI/QM derived directly from MDS
  - QI/QM used by survey team in off site prep to target areas for review
  - QI/QM provide benchmarking data for facility to use in their own quality improvement

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### *Restorative Nursing impact on facilities*

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- ★ QI/QM’s that relate to restorative programs include:
  - #5.1 Low-risk residents who lost control of their bowels or bladder
  - #5.3 Prevalence of occasional or frequent B&B incontinence without toileting plan
  - #9.1 Residents whose need for help with ADL’s has increased
  - #9.2 Residents who spend most of their time in a bed or in a chair
  - #9.4 Incidence of decline in ROM

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### *Review*

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- ★ Restorative Nursing is an important part of the care for residents in Nursing Homes
- ★ It is care that maximizes a resident’s abilities,
- ★ It improves quality of care and quality of life
- ★ It can positively impact the facility from staffing to payment to meeting regulations

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## *BREAK TIME*

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## *How to determine need for RRN*

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- ★ What is the one word that describes this?
  - Assessment
- ★ Where could you find information to help make that determination?
  - The MDS

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## *What is a “functional assessment”?*

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- ★ Function is the ability to manage daily routines
- ★ Functional status can be described as the survival skills needed to negotiate everyday life
- ★ Functional assessment is a snapshot of how residents are currently managing these skills

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## *Functional Assessment*

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- ★ Provides a starting point to answer:
  - Can a resident do what they need and want to do? If not, why not?
- ★ Purpose:
  - Indicate presence and severity of disease
  - Measure a person’s need for care
  - Monitor change over time
  - Maintain an optimally cost effective clinical operation

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## *The MDS Role*

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- ★ The MDS/RAI helps to gather definitive information on resident strengths and needs using a defined process
- ★ It measures resident ability to function despite disease or disability
- ★ It promotes resident focused goal setting
- ★ It assists in determining need for additional resources and services

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## *Determining Need for RRN*

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- ★ Let’s look at several MDS items that will provide information on potential need for programs
  - Section C: Communication/Hearing Patterns
  - Section G: Physical Functioning and Structural Problems
  - Section H: Continence

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### *Section C: Communication/Hearing Patterns*

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- ★ C4. Making Self Understood
  - If coded as either 1. Usually Understood or 2. Sometimes Understood may indicate good candidate for a Communication Program
- ★ C6. Ability to Understand Others
  - If coded as either a 1. Usually understands or 2. Sometimes Understands, may indicate good candidate for Communication Program

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### *Section G: Physical Functioning*

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- ★ Items G1a-j and G2 deal with ADL's
  - Transfer, bed mobility, dressing, eating, personal hygiene, ambulation, toilet use and bathing
- ★ Item G3 balance and G4 Functional ROM limitation
- ★ Provide information critical to identifying potential residents who might benefit

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### *Section G continued*

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- ★ G8 a and b help identify both resident and staff beliefs about restorative potential
- ★ G7, G8c and d provide information r/t special considerations such as speed of performance and need to separate tasks into smaller components in order to complete them

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### *Henry Ford—Inventor, philanthropist*

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“Nothing is particularly hard if you divide it into small jobs.”

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### *ADL RAP*

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- ★ Self performance coding of Section G1 with anything except a code of “0” (independent) will result in the ADL Functional Rehabilitation Potential RAP being triggered.
  - Caution with codes of “1” or “4”
- ★ Review of RAP will help identify additional factors that could interfere with resident's ability to perform ADL's

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### *ADL RAP continued*

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- ★ These factors may become components of a restorative nursing program
- ★ The RAP also suggests rehabilitative goals and poses additional assessment questions
- ★ The ADL supplement tool is also available on page C-28
  - Helps facility narrow scope and focus on areas for improvement

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### *Section H: Continence*

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- ★Identifies both urinary and bowel continence status and patterns
  - If bladder continence is a 2 or 3 and cognition is ok, might consider bladder retraining
  - If cognition is not ok, consider scheduled toileting
- ★Identifies use of appliances or programs

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### *Additional MDS items*

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- ★Section B: Cognitive Patterns
  - B2-Memory; B4-Decision Making; B5-Delirium
- ★Section E: Mood and Behavior Patterns
  - E2-Mood Persistence; E3-Change in Mood;
  - E4-Behavioral Symptoms; E5-Change in Behavior Symptoms

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### *Additional MDS items cont.*

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- ★Section J: Health Conditions
  - J5a&b-Stability of conditions (unstable or acute episode)
- ★Section O: Medications
  - O4a-d Use of psychoactive medications
- ★Section C: Communication
- ★Section D: Vision
- ★Section I:Disease Conditions

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### *Determining Need for RRN*

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- ★As MDS data is analyzed, several additional questions will need to be considered:
  - Would the resident benefit from a program?
  - Will restorative care be of such benefit that routine nursing care would be unable to achieve the same goal?
  - Would a program assist in increasing the resident's independence and self worth?

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### *Example from CMAR reviews*

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- ★ A resident coded as independent is not usually a candidate for RRN—what is the need?
- ★ Resident with H3a marked, but rest of MDS showed resident to be continent, but had occ dribbling and wore briefs which res. Could manage. However, res. Had some cog imp. And would take items from dining room and hide in briefs..Staff “toileted” the resident NOT because of inc. but because of behavioral issue. H3a should not have been checked.

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### *How long should program last?*

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- ★When determining how long a resident should be kept on a restorative program consider the following:
  - Has the resident attained his or her maximum potential?
  - If discharged from the program, would a decline functional level occur?
  - The length of any program must be driven by the resident's need and this should be evidenced in the assessment

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### *Example to illustrate*

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- ★ If a resident has been amb 100 ft consistently and has been doing so for the past quarter or two, try changing the distance or frequency to see if the resident can improve past this point. Only way to really know if they have reached their “highest level”

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### *Roadblocks to Overcome*

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- ★ Motivation of the resident
  - Physical problems such as pain
  - Value of activity
- ★ Recognition of effort
  - Feedback and praise
  - Important to identify appropriate rewards
- ★ Inconsistent practice
  - Lack of staff to provide scheduled program

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### *Summary*

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- ★ As you see, Restorative care is based on each resident’s assessed needs
- ★ B.J. Collard RN in an article entitled, “Restorative Nursing Care-from OBRA 87, the beginning to now”, identified that basic restorative nursing programs for LTC have to do with a philosophy of promoting, preserving, preventing and preparing.

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### *Restorative Nursing Care: BJ Collard*

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- ★ Ambulation program - Promote mobility
- ★ Incontinence Mgmt - Promote B&B function
- ★ ROM programs - Prevent contractures
- ★ Skin Management - Prevent skin breakdown
- ★ ADL & Dining prog. - Promote ADL ability
- ★ Sensory stimulation & Cognitive orientation - Preserve orientation level

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### *Restorative Nursing Care: BJ Collard*

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- ★ Socialization opportunities and Activities 1:1 - Preserve emotional health and Promote social functioning
- ★ Communication prog and interventions - Promote communication
- ★ Integration of religious/spiritual practices into daily routine and assistance with end of life issues - Promote spiritual well-being and prepare for death

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### *Restorative Nursing Programs*

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MDS Programs and Coding Criteria

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### *MDS Restorative Nursing Programs*

- ★RAI Manual pages 3-191 through 3-197
- ★3 programs and 8 activities identified
- ★3 programs are:
  - ROM Passive
  - ROM Active
  - Splint or Brace assistance

These programs must be planned, scheduled and documented in the clinical record

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### *Restorative programs cont.*

- ★The 8 activities requiring training and skill practice using repetition, physical or verbal cueing and/or task segmentation are:
  - Bed Mobility      Transfer
  - Walking            Dressing or Grooming
  - Eating/Swallowing Amputation/Prosthesis Care
  - Communication    Other

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### *Restorative programs cont.*

- ★These activities can be either geared to improvement or to maintenance depending on the assessed need of the resident
- ★Additional programs often classified as restorative, especially for payment purposes are:
  - H3a: Any Scheduled Toileting Plan
  - H3b: Bladder Retraining Program

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### *Re-Cap*

- ★So far we have:
  - Defined RRN
  - Why it is important
  - How RRN care helps meet LTC requirements
  - Listed ways to identify residents who may need programs
  - Identified what the restorative programs are

Now we will discuss the criteria for coding RRN programs on the MDS

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### *Coding Criteria*

Coding criteria found in RAI manual p 3-192 through 3-194

- ★Measurable objectives and interventions must be documented in the care plan and in the clinical record
  - Federal regulation at 42 CFR 483.20(k) F279 mandates facilities develop a comprehensive care plan for each resident that includes measurable objectives, timetables to meet resident needs as identified in the comprehensive assessment.

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### *Coding Criteria #1 Objectives*

- ★The plan of care must describe services that will be provided to attain or maintain the resident's highest practicable well-being
- ★The plan of care should reflect problem statements developed as a result of the assessment process, be resident centered, measurable outcomes of care (called objectives or goals), time frames to meet the objectives and interventions to help resident meet the objectives.

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### *Coding Criteria #1 continued*

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- ★ After identifying specific components of the problem, need to determine reasonable expected care outcome.
- ★ Outcome should be action oriented and documented as a goal for the resident
  - Goal provides specific objective for resident to meet
  - Outcome should be measurable to enable team to evaluate the effectiveness of the plan

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### *Making goal specific and measurable*

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- ★ Identify need/problem
- ★ Identify task for resident
- ★ Identify how much resident will do
- ★ Identify time frame

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### *Example:*

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- ★ Need/problem—Increase independence in eating
- ★ Task—Resident will eat without assistance
- ★ Measurable parameter (what resident will do)—50% of each meal
- ★ Time frame—within 3 weeks
- ★ “Resident will consume 50% of each meal without staff assistance within 3 weeks”

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### *Example of Nursing Rehab Goals found in records*

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- ★ “Resident will be continent”
- ★ “Resident will maintain functional ability”
- ★ “Resident will maintain independence
- ★ “Resident needs will be met”

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### *In reality:*

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- ★ The resident whose goal was to be continent had never been incontinent
- ★ The resident whose goal was to maintain functional ability & independence had suffered major declines
- ★ The last resident actual problem was related ADL grooming program that included picking out appropriate clothing, set up & encouragement to shave and cueing.
- ★ The goals were not stated in terms of what the resident hoped to achieve based on the “real” problems

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### *Goals must be understood*

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- ★ The following was noted on a record, “ROM UE & LE: MDS no functional limits”

**What do you think they were trying to say??**

- Staff clarification was obtained
- ★ What was really intended was to strengthen the LE so the resident could walk

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### *Interventions*

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- ★ Once goals/objectives are identified, approaches need to be identified
- ★ Approaches/interventions must be specific to resident's individual needs/strengths
- ★ Approaches serve as instructions for resident care and provide continuity
- ★ Should be resident centered and identify "how" the resident will meet the goals

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### *Coding criteria #1 continued*

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- ★ Good rule of thumb for interventions includes:
  - Have an action verb such as "eat" or "consume"
  - Include an amount, distance, quantity such as, "50%"
  - Include method such as "with verbal cues"
  - Add frequency, such as "all meals"
  - Include any additional clarifications or directions such as, "if resident stops eating, do \_\_\_\_\_"

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### *Common Restorative Approaches*

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- ★ Set up—Preparing equipment and supplies
- ★ Verbal cues—Simple hints that prompt resident to do something. Keep cues brief, clear and concise; may need to repeat
- ★ Demonstration—Show resident what you want him or her to do. Use verbal directions while demonstrating
- ★ Hand over hand—Place your hand over resident's hand and guide to perform activity

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### *Example:*

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- ★ Need—Left foot drags when ambulating, Physician ordered brace, resident does not currently apply brace due in part to limited flexibility
- ★ Objective—resident will independently apply brace daily within 3 months
- ★ Approaches—
  - Staff to train resident daily on how to apply brace using verbal cues and demonstration

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### *Example continued:*

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- Staff to assist resident in ROM to spine daily
  - "chair program" 5 reps, adding 2 reps daily until 10 are reached, then continue increasing by 5 until 30 are reached
- Staff to assist resident in ROM to LE using exercise mat following same progressive schedule as above
- Activities to reinforce ROM with group exercise program and ball kicking

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### *Coding criteria #2-LN Evaluation*

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- ★ There must be evidence of periodic evaluation by a licensed nurse in the clinical record
  - One of the most frequently absent or incomplete criteria as identified by our case-mix accuracy reviews
  - Intent is for a licensed nurse to assess the resident's progress in relation to the objectives/goals and interventions

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### *Coding criteria #2 continued*

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- ★ In other words, “Analyze the effectiveness of the plan”
  - Is it accomplishing what was intended?
  - Review care plan goals, interventions and implementation
  - Determine if modification or revision to any of the components of the program need to occur
  - Do new problems need to be addressed?

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### *Example of evaluation:*

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- ★ Evaluation in record was, “Resident continues to walk”
  - How far?
  - Is this better or worse than at last assessment?
  - Does the plan need to be modified?
  - Are there any other approaches that could be of benefit to maintain or improve resident function?

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### *Example r/t evaluation*

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- ★ Recent CMAR visit resident had a very individualized **toileting plan** established
- ★ Interventions included cueing to toilet every hour and the obtaining and wearing of a watch that was set to alarm every hour
- ★ Resident and staff knew about the program and were following it
- ★ NO LN evaluation in the record, thus could not count it as that criteria for a “program” was not met

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### *Another example*

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- ★ Resident on a **walking program**, with a goal to “maintain strength
- ★ Documentation by RA showed that the resident walked 60 to 120 feet during the assessment period as well as much of the quarter
- ★ LN eval did not pose the “why” question or address this variance
- ★ There was no analysis of the data, and the lack of a measurable goal made it difficult to determine if the resident was making progress

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### *Coding criteria #2 continued*

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- ★ What does “periodic” mean?
  - No time frame established by regulation or noted in the RAI manual
  - However, since MDS must be completed quarterly, it would make clinical sense that the evaluation would occur with that frequency as the restorative programs cannot be coded on the MDS unless they meet all of the criteria noted in the manual
  - May be more frequently depending on the program and progress of the resident.

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### *Coding Criteria #2 cont.*

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- ★ The frequency of documentation also flows from payment requirements:
  - For Medicare A residents, weekly documentation should be present
  - For non Medicare A residents, monthly notes may be sufficient

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### *Coding criteria #2 continued*

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- ★The evaluation must be in the clinical record.
  - This documentation requirement is separate from any daily documentation done by restorative aides or nursing assistants related to delivery of care
  - The documentation can be anywhere in the clinical record
  - Having policies and procedures may help

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### *Coding criteria #2 continued*

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- ★Despite the CMS clarification on page 3-194, second bullet, a note written by a restorative nursing assistant and countersigned by a licensed nurse **will not** be sufficient in this state to meet criteria #2.
- ★The periodic evaluation must be done by a licensed nurse.
- ★It is a standard of practice to document resident care and the response to that care

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### *Coding criteria #3-NA's Trained*

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- ★Nurse Assistants/aides must be trained in the techniques that promote resident involvement in the activity.
  - Basic restorative care is part of the nursing assistant certification program
  - It is a fundamental level of knowledge
  - Additional training in restorative nursing techniques and philosophy may be required for more formalized RRN programs

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### *Coding criteria #3 continued*

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- ★Whether using RA's or NAC's, facility must ensure staff providing the care have the knowledge, skills and abilities needed
- ★Promoting resident involvement is a key to positive outcomes
  - As stated earlier in overcoming roadblocks, seeing value to activities or having pain will effect participation

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### *Coding criteria #3 continued*

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- ★Promoting resident involvement
  - Involving residents in all aspects from planning decisions to choices of “when” programs will occur will help assure positive outcomes
  - Residents do have the right to refuse treatment, but facilities have obligation to explore “why” and try to resolve and overcome barriers

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### *Criteria #4-Nursing responsible*

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- ★Activities are carried out or supervised by members of nursing staff
  - The December 2002 revised RAI User's Manual contains clarification that licensed professionals may perform repetitive exercises and other maintenance treatment or supervise aides performing those maintenance services (these services can't be coded in therapy P1b)

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### *Criteria #4 continued*

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- ★ Although therapists may participate, nursing staff are still responsible for the overall co-ordination and supervision of restorative programs

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### *Criteria #5- Group size*

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- ★ This category does not include groups with more than 4 residents per supervising helper or care giver
  - Intent is to assure that each resident, even in a group setting, receives individualized attention
  - By limiting number of participants to 4 per staff person or helper, a safer environment can be provided

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### *Criteria #5 continued*

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- ★ Providing RRN programs in a group setting must flow from resident need not staff convenience
- ★ Each resident must be able to gain benefit from the activities provided in the group setting, thus group attendees should have like problems or areas of focus

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### *Coding Criteria #6-Time*

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- ★ A 6<sup>th</sup> requirement for coding RRN programs is referenced on the top of page 3-194 in RAI User's Manual
  - The time the program(s) are provided must be coded in time blocks of 15 minutes or more
  - The 15 minutes or more per day can occur throughout the entire day or all at one time

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### *Coding Criteria #6 continued*

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- ★ If a program or activity occurs for less than 15 minutes on any particular day, it cannot be coded on the MDS, as a "day" of RRN
- ★ Individual activities/programs cannot be combined together to meet the 15 minute requirement
  - For example, 5 min of passive ROM and 10 min of active ROM cannot be combined together in order to check one or both of the ROM programs.

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### *Example from CMAR review*

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- ★ Multiple examples of facilities with programs being clearly provided, many with effective LN evaluations but no time recorded anywhere in the clinical record
- ★ Another resident had received an ambulation program for 7 days, again good documentation, but 15 minutes was only provided 2 of the 7 days, the rest was only 5-10 minutes. Could only count 2 days.

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*Gene Fowler,  
American Journalist*

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“Writing is easy. All you do is stare at a blank sheet of paper until drops of blood form on your forehead.”

85



*Documentation*

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★ We have discussed documentation in several different areas already today combined with care planning and the licensed nurse evaluation. However I want to address this issue in a broader context, as it relates to assessment information in general

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*Documentation continued*

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★ Standards for documentation of assessment information are the same as those that apply to other areas of clinical record documentation.

★ 42 CFR 483.75 Clinical Records F514 states that documentation must be completed in accordance with accepted professional standards

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*Documentation cont.*

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★ The record must be:

- Complete
- Accurately documented
- Readily accessible
- Systematically organized

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*Documentation continued*

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★ There must be enough information to show that:

- The facility knows the status of the resident
- There are adequate plans of care
- There is documented evidence of the effects of the care provided
- It provides a picture of the resident’s progress or decline

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*MDS Documentation*

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★ RAI Manual page 1-23

- MDS is a “primary source document” not a sole source document
- Information in the clinical record must support not conflict with the MDS
- Resident care and the response to care must be documented

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### *MDS Documentation cont.*

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- ★ Documentation must chronicle, support and be consistent with MDS findings
- ★ For Medicare PPS, documentation must substantiate need for Part A SNF services and describe the resident's response to those services

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### *Specific MDS Item requirements*

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- ★ B1: Comatose
  - Page 3-42 to 3-43 states that there must be physician documentation of a diagnosis of coma or persistent vegetative state in order to code
- ★ E: Mood and Behavior
  - Page 3-60 states it is important to document chronic symptoms as well as new onset. As always the medical record should support resident status reported on the MDS.

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### *Specific MDS item requirements*

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- ★ E continued
  - Page 3-63, first clarification 3<sup>rd</sup> bullet, states that the documentation of signs and symptoms is a matter of good clinical practice and it is up to the facility to determine the form and format of such documentation

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### *Specific MDS Item Requirements*

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- Page 3-66 E4. Behavioral Symptoms, second paragraph under Intent states that documentation in the clinical record of the resident's current status may not initially be detailed but once the frequency and alterability of behavioral symptoms is accurately determined, subsequent documentation should reflect resident's status and response to interventions

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### *Specific MDS item requirements*

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- ★ H3: Continence appliances and programs
  - Page 3-125 defines the word "program" to mean a specific approach that is organized, planned, documented, monitored, and evaluated.
  - In the 3<sup>rd</sup> paragraph, the last sentence, it states documentation in the clinical record should evaluate the resident's response to the toileting program.

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### *Specific MDS item requirements*

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- ★ Section I, Disease Diagnoses:
  - Page 3-127 under "Intent" states that disease conditions require physician documented diagnoses in the clinical record. It is good clinical practice to have the resident's physician provide supporting documentation for any diagnosis.
  - Page 3-135 I2, several specific infections require supporting documentation be in the clinical record before you can code (I2a, I2b, I2d, I2h, I2j)

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### *Specific MDS item requirements*

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- ★M5 Skin Treatments
  - Page 3-167 Turning/repositioning programs. The definition of program is a “specific approach that is organized, planned, documented, monitored, and evaluated.”
  - Page 3-168, first clarification and Page 3-169 second clarification, state that good clinical practice dictates that staff should document treatments in M5. Flow sheets could be used, but the form and format of such documentation is determined by the facility.

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### *Specific MDS item requirements*

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- ★P3 Nursing rehabilitation/restorative care
  - Page 3-192 lists the criteria that must be met before any restorative program can be coded.
  - First criteria is that measurable objectives and interventions must be documented in the care plan and in the clinical record.

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### *Specific MDS item requirements*

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- ★P3 continued
  - Second criteria is there must be evidence of periodic evaluation by a licensed nurse present in the clinical record.
  - Page 3-194, first clarification states that good clinical practice would indicate that the results of “reassessment” should be documented in the record.

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### *MDS Documentation*

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- ★ While MDS is a source document, not all items can stand alone
- ★ There must be corroborative data that is non conflicting for many items in the clinical record
- ★ There must be internal consistency within and between MDS items

100



### *Purpose of Documentation*

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- ★ It is used to communicate information
  - It describes an incident, care provided, treatments rendered and the general condition of the resident
  - It is a record of fact and provides a narration of information

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### *Purpose of Documentation*

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- ★ It provides a permanent recording
  - Medication and treatment orders and evidence of receipt of same, assessments, plans of care, laboratory findings, actions and responses are all recorded
  - Most data is preserved in chronological order providing a historical as well as current picture of the resident’s life in the facility

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### *Purpose of Documentation*

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- ★ It provides a means to assess, evaluate and analyze information
  - Enables others to review, offer advice and make suggestions for improvement or modification of resident care
  - Enables others to know what has been done and what is being done
  - Provides a basis for future action

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### *Purpose of Documentation*

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- ★ It serves as an identification tool for happenings/events
  - Who is/was involved
  - When did the event occur
  - What was done or not done
  - How was it done
  - Where did the event happen

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### *Documentation*

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- ★ Did I really write that?
- ★ Let's look at some interesting examples of documentation

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### *Documentation bloopers*

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- ★ Resident was alert and unresponsive
- ★ She is numb from her toes down
- ★ May have lollipops orally
- ★ The resident had waffles for breakfast and anorexia for lunch
- ★ Skin somewhat pale, but present
- ★ Discharge status: Alive, but without permission
- ★ I keep reassuring her that her memory will improve, but again today she forgot to pay her bill

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### *In Summary*

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- ★ LTC regulations make RRN care a necessity
- ★ RRN care requires the whole interdisciplinary team's involvement
- ★ RRN programs are the most cost effective way to utilize existing resources and produce maximum outcomes
- ★ With a well managed effective program, resident outcomes are usually positive

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### *BREAK TIME*

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### *Answers to Pre-Test*

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- ★1. C: reference Introduction to nursing rehab care from AANAC MDS manual 2003
- ★2. B-False: reference RAI Manual
- ★3. D: reference is F309, F310 and F311; SNF PPS Medicare Manual Part A
- ★4. B-False: reference is RAI Manual page 3-194, 4<sup>th</sup> clarification

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### *Answers to Pre-Test cont.*

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- ★5. C: reference RAI Manual pages 3-191 and 3-192
- ★6. A: reference RAI Manual page 3-192
- ★7. A-True: reference RAI Manual page 3-191; F311
- ★8. E-All of the above: all resources used for this program infer these

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### *CASE STUDIES*

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- ★Is the resident a candidate for RRN, and if so, why?
- ★What program(s) would be appropriate?
- ★Develop a program with problem statement, goal(s), interventions
- ★Write an LN evaluation of the program if applicable

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