Session: T32
A True Person Centered
Restorative Nursing Program-
Individualized Care at it’s Best!

Presented By:
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Objectives
Upon completion of this presentation, attendees will be able to:

1. Describe the key basics of how to incorporate a good assessment process to identify the individualized needs of residents for Restorative Nursing Programs
2. Describe how to incorporate resident/family choice and preferences in an effective Restorative Program

Objectives
Continued:

3. Verbalize the educational needs of all nursing staff
4. Identify documentation necessary to substantiate care planning, program implementation and follow up
5. Understand the necessary steps in program oversight.
Assessment Process
Restorative Nursing Program

The Basics

Restorative Programs

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 – for EACH program coded
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

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.”

MDS 3.0, RAI Manual, Pg. 0-35

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.”

MDS 3.0, RAI Manual, Pg. 0-35
Let’s Take a Look at the Programs:

• Urinary Toileting Program and/or Bowel Toileting Program
• Passive Range of Motion (PROM)
• Active Range of Motion (AROM)
• Splint or Brace Assistance
• Bed Mobility
• Transfer
• Walking
• Dressing and/or Grooming
• Eating and/or Swallowing
• Amputation/Prostheses Care
• Communication

Assessment Process:

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?

Assessment Process

Other assessments with a direct relationship to Restorative Nursing include:

• Pain Assessment
• Safety Risk or Fall Assessment
• Nutritional Assessment
• Cognitive Assessment
• Mood and Behavior Assessments
• Skin Risk Assessment
Example

Person Centered PLANNING:

If we follow the Process as it is INTENDED, Person Centered Care Planning is possible!!

- Admission
- Ancillary Assessments
- Resident/Family Involvement
  - RAI Process

RAI PROCESS
Incorporating Resident and Family

Collaboration is essential for Person Centered Care!
It takes:
• Planning
• Time
• Digging
• Intuition
• Patience
• Creativity!

Traditional vs. Person-Centered

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Person-Centered</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Staff directed</td>
<td>• Resident directed</td>
</tr>
<tr>
<td>• Medical/Diagnosis based</td>
<td>• Preferences</td>
</tr>
<tr>
<td>• Staff goals</td>
<td>• Habits</td>
</tr>
<tr>
<td>• Therapy goals</td>
<td>• Routines</td>
</tr>
<tr>
<td>• **Based on assessments when resident’s admitted to the facility</td>
<td>• History of Medical Management</td>
</tr>
<tr>
<td></td>
<td>• The resident’s understanding of medical management of conditions</td>
</tr>
<tr>
<td></td>
<td>• Resident’s goals</td>
</tr>
</tbody>
</table>
“Well-trained and dedicated employees are the only sustainable source of competitive strength.”

~Robert Reich
Employee Education

Ongoing Training

• How often do we have educational opportunities?
• Are we only doing the “required” training?
• Are we PROACTIVE or REACTIVE?

C.N.A. Education

• Purpose of Restorative Nursing
• Basic Components of the MDS Based Restorative Nursing Program
• C.N.A.’s need to be trained in the techniques that promote resident involvement in the activity (MDS 3.0 RAI Manual Pg. 0-36)
• Groups for Restorative Nursing
• Common Obstacles to Attainment of Restorative Goals
• Each Program is a separate, PLANNED event (Example)
• Activities and Tasks of each program, including skills and return demonstration
• Consistent implementation of care plan interventions
• Benefits of a Restorative Program

Staff Education

Topics for discussion with nurses

• Understanding of facility policies and procedures
• Understanding of state and federal regulations
• Ensuring follow-up with oversight on the unit for Restorative Nursing
• Observing Good Restorative Nursing Clinical Skills
• The importance of effective communication
• Ability to set positive examples
• How to complete effective unit rounds
• Successful use of a 24 hour report
• Give nurses opportunities to share ideas and whenever possible—use them!
Staff Education

Topics for discussion with nurses (continued)

• Do the nurses monitor the dining rooms?
• Are the nurses aware of the C.N.A.’s duties (list of residents, restorative nursing program assignments, hydration, documentation, resident checks, alarms, etc.)?
• How do the nurses handle C.N.A.’s who don’t perform to standards?
• How is report from the nurse to the C.N.A.?
• How is report from the C.N.A. to the nurse?
• How do the nurses interact with families, physicians, visitors and surveyor’s?

Staff Education!

Preparation for success

1. Provide staff clear communication of expectations.
2. Audit and monitor performance.
3. Praise positive observations.
4. Utilize information from audits to develop content for nursing meetings.
5. Be prepared to hold the nurses and C.N.A.’s accountable if they do not deliver!
6. Remember consistency with all staff!
7. Utilize objective observations for performance evaluations.
8. Illicit and consider staff input.
9. Enjoy your successes!

Staff Education

Preparation for Success-continued

• Include time everyday for staff discussion
• When there is a problem—let them be involved in solving it
• When there are successes—make sure everyone involved gets adequate praise
### MDS Coding Documentation

**Section G: ADL Documentation**

- Identifies the need for the program
- Need to have “proof” during the observation period
- All shifts
- Include # episodes
- Ensure staff understand RAI Manual definitions/instructions

### ADL’s

<table>
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<tr>
<th>Day/Date</th>
<th>NOC</th>
<th>AM</th>
<th>PM</th>
<th># Times</th>
</tr>
</thead>
<tbody>
<tr>
<td>BED MOBILITY</td>
<td>Move from a lying position</td>
<td>Turns from side to side</td>
<td>Positions body (e.g., leg on pillow, foot up in bed)</td>
<td></td>
</tr>
</tbody>
</table>

#### Example Table:

<table>
<thead>
<tr>
<th>Date</th>
<th>NOC</th>
<th>AM</th>
<th>PM</th>
<th># Times</th>
</tr>
</thead>
<tbody>
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<td>2</td>
<td>3</td>
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<td>12/25/14</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>12/26/14</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>12</td>
</tr>
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</table>
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!

How does ADL coding impact Reimbursement?

• The late loss ADL score from the MDS impacts every RUG category.
• RUGs with higher ADL scores reimburse at a higher rate.
• Late Loss ADLs:
  \textit{Bed Mobility}
  \textit{Transfer}
  \textit{Toileting}
  \textit{Eating}

ADL Coding for the MDS 3.0

• It is imperative that the ADL documentation substantiates the MDS Coding.

Remember, the MDS gathers information on the resident’s \textit{actual} function—not what staff think the resident can do.
ADL Self-Performance Algorithm

• Provides a step-by-step guide:
  – Determine how to code G0110 Column 1 Self-Performance for each ADL.
  – Use the Rule of 3.

• **Start at the top of the algorithm.**
• Work down until the coding option in the algorithm matches the ADL assessment.

KEY POINT!!!

• The key point is “Weight Bearing Assistance”
• It’s not who does more—it’s about weight bearing!

MDS Section H

Remember, the MDS is not a primary source document, therefore, you will need evidence of documentation to substantiate:

• A trial or current toileting program and response (H0200)
  – How are you able to objectively determine (and prove by documentation) response to trial program if coded?

• Urinary Incontinence
  – Do you have a system to capture 7 days of monitoring for continence in order to code?
Bowel and Bladder

- Do you have a 3 day “diary” or form that captures accurate resident patterns for 3 days?
- Do you follow this with a Bowel and Bladder Assessment?
- If you pull out your toileting plan, does the documented pattern reflect in the plan?
- Is there documented evidence to show improvement, maintenance or decline in function?

MDS O0500: Restorative Nursing

There will need to be documented evidence of 15 or more minutes a day, in the 7 day look back (observation period) for EACH program that was performed

1. Assessment Process
   - Ancillary Assessments
     • Range of Motion
     • Functional ADL
     • Bowel and Bladder
     • Balance
   - MDS and CAA’s
     • ADL’s
     • Continence and Toileting Documentation
     • Minutes of Restorative Programs
Documentation/continued

2. Person Centered 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.

Documentation: Therapy Involvement

* Formal Communication (written and verbal) when Formal Therapy discharges resident from therapy to include:
  – Current functional status
  – Appropriate Goal
  – 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, a decision will be made on the program goals and interventions for each individual resident-including RESIDENT/FAMILY input, a care plan is completed, C.N.A. documentation is prepared and communication is essential!
Objective, Thorough Charting of Function
Examples

Restorative Required Documentation

Restorative Documentation Example 1
*What is being done for the resident and resident’s response to what is being done. Weekly/monthly objective, observation summary note.*

**Correct:** Resident able to stand at bedside with 1 assist for 3 minutes. Minimum steadying support now necessary, compared to 2 weeks ago.

**Incorrect:** Resident is doing better.

Restorative Required Documentation

Restorative Documentation Example 2

**Correct:** Resident feeding self using spoon 50% of the time versus 25% of time 1 week ago. Requires 3 to 4 reminders/meal this week compared to constant reminders at every meal 2 weeks ago.

**Incorrect:** Resident is using her spoon more and is doing better.
PROGRAM OVERSIGHT

Oversight and Review of Documentation

• C.N.A. Implementation Record/Flow Sheets
• ADL Documentation
• Minutes Tracking
* Daily review of documentation during the observation period will help to ensure any concerns are addressed timely versus after the Assessment Reference Date!

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
Observations

• It is recommended that the nurse in charge of Restorative Nursing –
  – Observes at least 2 programs/week.
  – Keeps an updated, ongoing list of residents and their respective programs
  – Observes all splints weekly (20%/day)
  – Interviews resident’s and families regarding Restorative Programs
  – Keeps track of educational status of employees in regards to the Restorative Program

Systems Management

System Management

• Policy and Procedure
• Forms Management
• Identification of Current Status
• Identification of Staff Knowledge
• Assessment Process Review
• Relationship with Therapy
• Documentation
• Review of Resources
In Summary--

The Basic Components of a Restorative Program Include:

1. Policy and Procedure Management
2. Review and Selection of Forms
3. Assessment Process: Identification of a need for the program based on assessment, resident input and ADL deficit
4. Determination of which program the resident is appropriate for
5. Ensure that the program is a separate, individualized, care planned program
6. Documentation needs to substantiate the program need and implementation
7. Ongoing monitoring and re-evaluation is necessary to determine resident centered adjustments for quality
8. Staff education and competence
9. Oversight
10. Quality Assurance/QAPI

“How far you go in life depends on your being tender with the young, compassionate with the aged, sympathetic with the striving, and tolerant of the weak and strong. Because someday in life you will have been all of these.”

-George Washington Carver

Thank You For Attending Today’s Presentation!

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