LeadingAge Illinois

MOMENTUM

2023 ANNUAL MEETING & EXPO

MARCH 7-8, 2023

Renaissance Schaumburg Convention Center - Schaumburg, IL

Revitalize Your Restorative Nursing Program for Success!

Susan LaGrange, RN, BSN, NHA, CDONA™, FACDONA, CIMT, IP-BC™
Chief Nursing Officer
Pathway Health

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Objectives

Upon completion of the program, attendees will be able to:

- Identify key regulatory and best practice aspects for implementation of a Restorative Nursing Program for quality outcomes.
- Verbalize understanding of the documentation necessary to support the MDS 3.0 coding.
- Describe 3 successful leadership strategies for oversight of the Restorative Nursing Program.

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CMS State Operations Manual, Appendix PP

State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities

Table of Contents
(Rev. 211, 02-03-23)

https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

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Federal Tags Related to Restorative Nursing

- **F684**: Quality of Care
- **F676**: ADLs– Maintain Abilities
- **F677:** ADL Care Provided - Dependent Residents
- **F686:** Skin Integrity - Pressure Ulcers
- **F690**: Incontinence
- **F688**: Increase/Prevent Decrease in ROM/Mobility
- **F636:** Comprehensive Assessments & Timing
- **F658:** Services Provided Meet Professional Standards
- **F689:** Free of Accident Hazards, Supervision, Devices

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Effective July 1, 2022, classification established utilizing the PDPM nursing component classification methodology and associated weights

2) Effective July 1, 2022, resident reimbursement classification shall be established utilizing the Patient Driven Payment Model (PDPM) nursing component classification methodology and associated weights, as published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as of March 1, 2022, multiplied by 0.7858 and rounded to the nearest four decimal places.

https://ilga.gov/commission/Jcar/admincode/089/089001470003100R.html

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State Requirements

- Section 147.310 Implementation of a Case Mix System
- Section 147.315 Nursing Facility Resident Assessment Instrument
- Section 147.320 Definitions
- Section 147.325 Resident Reimbursement Classifications and Requirements
- Section 147.330 Resource Utilization Groups (RUGs) Case Mix Requirements
- Section 147.335 Enhanced Care Rates
- Section 147.340 Minimum Data Set On-Site Reviews
- Section 147.345 Quality Incentives

https://ilga.gov/commission/Jcar/admincode/089/08900147sections.html

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Examples of Documentation Necessary

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Documentation Requirements

Section 147.325 Resident Reimbursement Classifications and Requirements

General Documentation Requirements

- "A facility shall maintain resident records on each resident in accordance with acceptable professional standards and practices.
- Supportive documentation in the clinical record used to validate the MDS item responses shall be dated during the specified look-back period or other timeframe as identified in the RAI Manual. Records shall be retained for at least three years from the date of discharge."

https://ilga.gov/commission/Jcar/admincode/089/089001470003250R.html

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Documentation Requirements - continued

- "Supportive documentation entries shall be dated and their authors identified by signature or initials. Signatures are required to authenticate all documentation utilized to support MDS item responses."
- Also covers requirements for:
  - Multi-page supporting documentation
  - Directions for documenting errors or corrections
  - Late entries
  - Policies and procedures for who is authorized to make amendments, late entries, corrections, etc.
  - "Resident records shall be complete, accurately documented, readily accessible to Department staff, and systematically organized."

https://ilga.gov/commission/Jcar/admincode/089/089001470003250R.html

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Documentation Requirements- continued

- "Documentation from all disciplines and all portions of the resident's clinical record may be used to validate an MDS item response."
- "Documentation shall support all conditions or treatments were present or occurred within the look-back period ending on, and including the ARD period. The look-back period shall include observations and events through the end of the day (midnight) of the ARD. Documentation shall apply to the appropriate look-back period and reflect the resident's status on all shifts."
- "Insufficient or inaccurate documentation may result in a determination that the MDS item submitted was not validated."
- Significant change in status
- And more!

https://ilga.gov/commission/Jcar/admincode/089/08900147000325OR.html

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Restorative/Rehabilitative Nursing Basics

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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)

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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

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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 psy[illegible]unctioning."

- MDS 3.0, RAI Manual, Pg. 0-42

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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. 0-42

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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

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Reasons Why a Resident Loses Functional Ability

- Cognitive deficits
- Physical/neurological deficits
- Stamina
- Muscle tone
- Balance
- Bone strength
- Side effect of medications

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The Assessment Process

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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?

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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

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Example

FUNCTIONAL ASSESSMENT

RESIDENT NAME: **ROOM #:**

DATE: ❒ Initial ❒ Quarterly ❒ Annual ❒ Significant change

The information contained within this functional assessment was obtained by direct observation and communication with the resident and by interviewing staff over all shifts during the assessment reference period and following the frequency requirements and definitions related to self-performance and support outlined in Section G of CMS's RAI MDS 3.0 Manual.

KEY:

Resident's Self Performance:
6: Independent
1: Supervision
2: Limited Assistance
3: Extensive Assistance
4: Total Dependence
8: Activity Did Not Occur

Support Needed:
6: No help needed
1: Set up only
2: One Person Physical Assistance
3: 2+ Person Physical Assistance
8: Activity Did Not Occur
N/A: Not applicable

COGNITIVE STATUS:

BIMS Score (C0500): _____ PHQ9 Total Severity Score (D0300): _____
Pertinent Cognitive Analysis Comments: _____

BED MOBILITY:

TASK:	SELF PERFORMANCE			SUPPORT NEEDED		
	Days	Evenings	Nights	Days	Evenings	Nights
Repositions self in bed						
Turns to right side						
Turns to left side						
Comes to a sitting position						
Goes from sitting to lying position						

TRANSFERS:

TASK:	SELF PERFORMANCE			SUPPORT NEEDED			TRANSFER TECHNIQUE
	Days	Evenings	Nights	Days	Evenings	Nights	
To/from Chair							
To/from Bed							
To/from Standing							

Record transfer techniques used if not independent:
Stand pivot Sliding board Lift (i.e. Hoyer) Other (describe)

LOCOMOTION/AMBULATION:

TASK:	SELF PERFORMANCE	SUPPORT NEEDED	DEVICE USED

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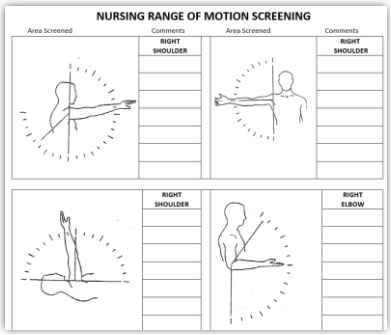
Example



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Components of Restorative Nursing Program

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Range of Motion Exercises

The MDS 3.0 RAI Manual describes Range of Motion as:

Passive Range of Motion (PROM): "Code provision of passive movements in order to maintain flexibility and useful motion in the joints of the body."

- CMS, MDS 3.0 RAI Manual, Page O-44

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GROUP AROM

1. Group restorative/rehabilitative AROM programs can be highly effective and enjoyable for residents.
2. Groups cannot be more than 4 residents to 1 caregiver/leader.
3. The caregiver/leader must be aware of the goals and approaches of each individual within the group.
4. Groups of 4:1 or less allow for individualized attention within the group.

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Splint or Brace Assistance

"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."

- RAI Manual, Chapter 3, Page O-44

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Bed Mobility

"Code activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and positioning himself or herself in bed. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record."

- RAI Manual, Chapter 3, Page 0-45

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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)

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Transfer

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-45

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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!

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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).

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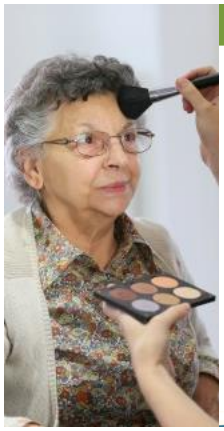

Grooming

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.

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Dining Programs

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.

Can be 2 types:

- Eating
- Swallowing

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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-45

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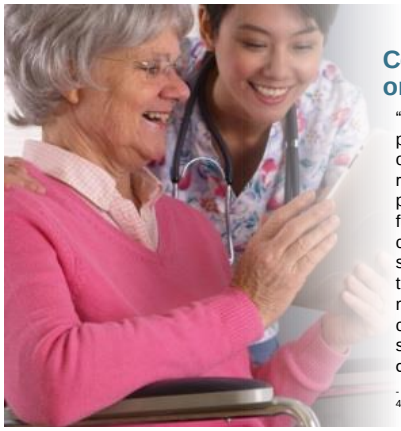

Communication

“Code activities provided to improve or maintain the resident’s self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices.”

- RAI Manual, Chapter 3, Page 0-46

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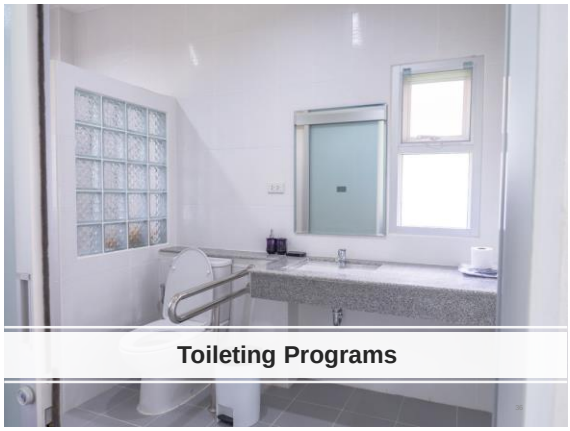

Toileting Programs

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MDS 3.0 RAI Manual

Section H: Planning for Care

"The steps toward ensuring that the resident receives appropriate treatment and services to restore as much bladder function as possible are

— determining if the resident is currently experiencing some level of incontinence or is at risk of developing urinary incontinence;

— completing an accurate, thorough assessment of factors that may predispose the resident to having urinary incontinence; and

— implementing appropriate, individualized interventions and modifying them as appropriate"

CMS MDS 3.0 RAI Manual Page H-3

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Bowel & Bladder 3-day Voiding Diary ☐ Annual ☐ Admission ☐ Readmit ☐ Continence/condition change /catheter removal

	NA Initials	Time	Use of Toilet, Commode, Urinal			Stream	Condition of Pad, Brief, Undergarment		Ability to Request	Bowel Movement
			Resident placed on toilet/commode/urinal, did Resident urinate/void?	Refused to use toilet or commode urinal	Res. not able to use toilet	Urine stream Weak (Wk) or Strong (Str)	Circle for condition of pad even if used toilet	Amount of urine on pad	Res. asked to use toilet	Bowel Movement Circle Inc. if incontinent
Date:			Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
Day 1			Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
Am		10: am	Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
		11: am	Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
Q 1 hrs		12: pm	Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
		1: pm	Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
		2: pm	Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
Comments- note patterns, characteristics:										
Licensed Nurse Signature:										
Day 2			Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
Day 2			Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
			Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
Pm		7: pm	Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
		8: pm	Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
Q 1 hrs		9: pm	Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
		10: pm	Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
Comments- note patterns, characteristics:										
Licensed Nurse Signature:										
Date:		11: pm	Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
		12: am	Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
Day 3		1: am	Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.
		2: am	Voided Not voided	Refused	Not able	Wk Str	Dry Wet	S M L	Yes No	Yes No Inc.

3-Day Diary Example

3-Day Diary/Data Collection: (Example)

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Why a 3-Day Diary?

- The **MDS 3.0 RAI Manual** indicates: "Review records of voiding patterns (such as frequency, volume, duration, nighttime or daytime, quality of stream) over several days for those who are experiencing incontinence."

AND

- **F690** Incontinence indicates: "Voiding patterns (such as frequency, volume, nighttime or daytime, quality of stream) and, for those already experiencing urinary incontinence, voiding patterns over several days"

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

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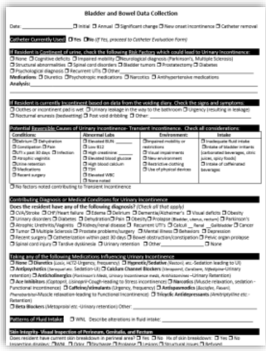
Assessment Process


Bladder and Bowel Data Collection

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Toileting Programs

Based on a 3 day diary for determination of accurate, individualized pattern; followed by a nurse assessment determining:

- Prompted Voiding Program
- Scheduled/Habit/Timed Program
- Bladder Training

**It is imperative that the 3 day is accurate!

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Toileting Programs

Scheduled toileting plans are formal plans that must be followed as indicated in the care plan

- The toileting plan/program must be resident specific

  **don't count check and change programs

- Bladder Training is a short term program

The goal is to reduce incontinent

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MDS 3.0 RAI Manual

"If the toileting program or bladder retraining leads to a decrease or resolution of incontinence, the program should be maintained."

CMS MDS 3.0 RAI Manual Page H-3

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Fecal Incontinence

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Fecal Incontinence

Potential Treatments/interventions (based upon the type) of Fecal Incontinence

- Eating increased amounts of fiber;
- Drinking sufficient liquids;
- Use of medications to develop more solid stools that are easier to control;
- Pelvic Floor Exercises and Biofeedback that strengthen the pelvic floor muscles may improve bowel control.
- Surgery may be an option for fecal incontinence that fails to improve with other treatments or for fecal incontinence caused by pelvic floor or anal sphincter muscle injuries;
- Electrical Stimulation

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

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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?

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O0500 Restorative Nursing - MDS

In order to code Section O0500 for Restorative Nursing Programs, there must be documented evidence in the medical record for at least 15 minutes/day for each program during the ARD look back period. (We need to document actual minutes)

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Documentation to Substantiate Program Implementation and MDS Coding

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MDS Coding Documentation

Section G (For now….): ADL Documentation

- Identifies the need for the program
- Need to have "proof" during the observation period
- All shifts
- Include # episodes
- Ensure staff understand the MDS 3.0 RAI Manual definitions/instructions

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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.

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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 actual function - not what staff think the resident can do.

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Implications of Section G:

- 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 surv at when there is a decline in A

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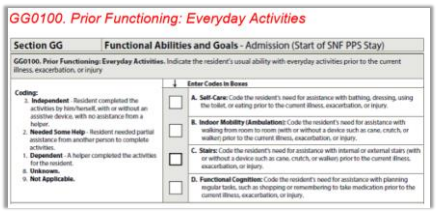
MDS 3.0 Section GG



GG0100. Prior Functioning: Everyday Activities

Section GG	Functional Abilities and Goals - Admission (Start of SNF PPS Stay)
GG0100. Prior Functioning: Everyday Activities. Indicate the resident's usual ability with everyday activities prior to the current illness, exacerbation, or injury	
Coding: 3. Independent - Resident completed the activities by him/herself, with or without an assistive device, with no assistance from a helper. 2. Needed Some Help - Resident needed partial assistance from another person to complete activities. 1. Dependent - A helper completed the activities for the resident. 8. Unknown. 9. Not Applicable.	Enter Codes in Boxes A. Self-Care: Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury. B. Indoor Mobility (Ambulation): Code the resident's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury. C. Stairs: Code the resident's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury. D. Functional Cognition: Code the resident's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

“Record the resident’s usual ability to perform self-care, indoor mobility (ambulation), stairs, and functional cognition prior to the current illness, exacerbation, or injury”

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

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Section GG0130

- Assess the resident’s self-care performance based on direct observation, as well as the resident’s self-report and reports from qualified clinicians, care staff, or family documented in the resident’s medical record during the three-day assessment period.
- Residents should be allowed to perform activities as independently as possible, as long as they are safe.

GG0130: Self-Care (3-day assessment period) Admission (Start of Medicare Part A Stay)

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

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Restorative Nursing and PDPM

PDPM is the Patient Driven Payment Model

- Used under the SNF Prospective Payment System (PPS) to classify SNF patients in a covered Part A stay (replacing RUG IV)
- Every resident will be categorized into a Nursing Component
- Similar to RUG-IV, all categories will have a Function Score based upon Section GG (not Section G)
- Still using Late Loss ADLs
- Similar to RUG-IV: Behavioral Symptoms & Cognitive Performance and Reduced Physical Function categories have Restorative end splits.
- Draft guidance indicates:
  - 2 or more programs
  - Programs in O0500 require at least 15 min/day, 6 out of 7 days
  - Must be person-centered, written, communicated, evaluated and under the direction of a licensed nurse

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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

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Key Points for Quality, Reimbursement AND Compliance

- Proper coding of G and GG
- Comprehensive Assessment Process!
  - Balance assessment and coding
- Proper ROM programs
- Solid Restorative Dining Programs
- Each discipline must be clear on goals and interventions
- Documentation, Documentation, Documentation

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Overcoming Obstacles

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Obstacles

- Staff doing more for the resident and not encouraging participation
- Unrecognized delirium
- Unrecognized pain or poor pain control
- Constipation
- Depression
- Inconsistent implementation of care plan interventions
- Fear
- Temporary Illness interruptions
- Resident choices/preferences
- Staffing pattern challenges

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Communication Essentials with the Restorative Nursing Program to Prevent Obstacles!

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EDUCATIONAL NEEDS OF THE NURSING STAFF

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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
- Groups for Restorative Nursing
- Common Obstacles to Attainment of Restorative Goals
- Each Program is a separate, PLANNED event
- Activities and Tasks of each program, including skills and return demonstration
- Consistent implementation of care plan interventions
- Benefits of a Restorative Program

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Nurse Education

Examples of Topics for education 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

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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!

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"Well-trained and dedicated employees are the only sustainable source of competitive strength"

- Robert Reich

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Leadership Strategies

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Oversight of the Restorative Process

- Policies and Procedures
  - Best Practice approach
  - Regulatory Compliance
  - Consistent with the RAI Process
  - Forms decision (paper, EHR?)
- Staff Education
- Relationship with Formal Therapy
- Program Implementation
- Oversight and Evaluation

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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

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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

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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

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Documentation for Restorative Nursing

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

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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

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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.**

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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

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Effective Audit System

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Audit of the Entire Program!

- Is there a formal restorative program in place?
- Has facility-wide training been completed for the Restorative Nursing Program
- Do you keep an up-to-date Restorative Nursing master list?
- Do you complete monthly and quarterly summaries of resident progress, participation and resident response to each program?
- Do you have in place functional assessments to identify baseline and ongoing status?
- Are Restorative Nursing flow sheets available to track implementation each shift/day?
- Do care plans indicate person-centered goals and interventions for the Restorative Nursing Program?

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Example of Program Audit

RANGE OF MOTION AND SPLINT AUDIT TOOL

Resident	Rm #	Date	ROM Completed per plan of care	Splint/Brace Application per plan of care	Comment	Documented	Minimum quarterly review note by nurse	Nurse Aide

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Action Planning

Action Plan

Area of Action	Recommendations	Goal Date	Responsible Person(s)

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In Summary--

The Basic Components of a Restorative Program Include:

- Policy and Procedure Management
- Review and Selection of Forms
- Assessment Process: Identification of a need for the program based on assessment, resident input and ADL deficit
- Determination of which program the resident is appropriate for
- Ensure that the program is a separate, individualized, care planned program

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In Summary (continued)

1. Documentation needs to substantiate the program need and implementation
2. Ongoing monitoring and re-evaluation is necessary to determine resident centered adjustments for quality
3. Staff education and competence

   *Skills checklists, competency evaluations, etc.
4. Oversight and audits for compliance
5. Quality Assurance/QAPI

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Questions?

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References and Resources

- Centers for Medicare & Medicaid Services. MDS 3.0 RAI Manual: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/mds30raimanual.html
- Centers for Medicare & Medicaid Services., State Operations Manual, Appendix PP (Rev. 208, 10-21-22): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

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References and Resources

- State of Illinois, Joint Committee on Administrative Rules. Administrative Code, Title 89: Social Services, Chapter I: Department of Healthcare and Family Services, Subchapter d: Medical Programs. Part 147 Reimbursement for Nursing Costs for Geriatric Facilities: https://ilga.gov/commission/Jcar/admincode/089/08900147sections.html
- State of Illinois, Joint Committee on Administrative Rules. Administrative Code. Title 77: Public Health, Chapter I: Department of Public Health. Subchapter c: Long-Term Care Facilities Part 300 Skilled Nursing and Intermediate Care Facilities Code: https://www.ilga.gov/commission/jcar/admincode/077/07700300sections.html

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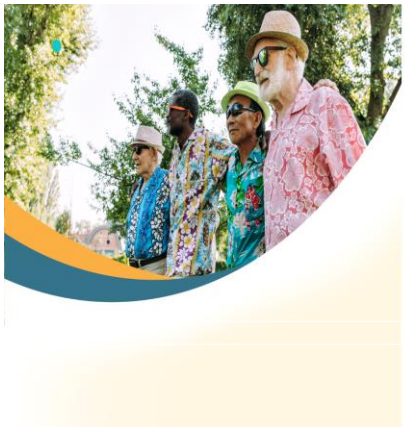

LeadingAge Illinois

MOMENTUM

2023 ANNUAL MEETING & EXPO

MARCH 7-8, 2023

Renaissance Schaumburg Convention Center - Schaumburg, IL

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