Revitalize Your Restorative Nursing Program for Success!

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Objectives

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

1. Identify Nursing Rehabilitation/Restorative Care consistent with the MDS 3.0 guidelines
2. Identify practical applications to overcoming implementation of programming obstacles
3. Describe necessary processes to assist staff with person-centered interventions to implement consistent with functional needs based on the comprehensive assessment process
4. Verbalize elements of a solid Restorative Nursing Program will assist the facility with quality of care as well as regulatory compliance.

CMS: State Operations Manual

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

Federal Tags

Federal tags F tags that could be cited during a survey inspection:

- F684: Quality of Care
- F676: Activities of Daily Living – Maintain Abilities
- F677: ADL Care Provided for Dependent Residents
- F686: Pressure Sores
- F690: Incontinence
- F688: Increase/Prevent Decrease in Range of Motion/Mobility
- F636: Comprehensive Assessments & Timing
- F658: Services Provided Meet Professional Standards
- F689: Free of Accident Hazards/Supervision/Devices

PDPM and Restorative

Restorative Nursing is a key role in PDPM

Capture on MDS
Credit or the care and services you provide
Achieve and maintain optimal physical, psychosocial and mental well-being
Impact in PDPM – Nursing services are reimbursed - own category

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. 0-36
“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. 0:36

**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

**Reasons Why a Resident Loses Functional Ability**

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

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
Components of Restorative Nursing Program
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-37

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.

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-37
**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 0-38

**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)

**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-38
Walking
• Planned and organized program based on resident's individualized needs:
  – Distance
  – Staff Assistance
  – Assistive Devices
  – Special Considerations
  – Surfaces consideration (tile, carpet, cement, grass, etc.)
  – A facility wide “walk-to-dine” may be appropriate for some residents but not all!

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

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

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-38

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 0-39
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
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.”

Assessment Process

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!**
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 episodes

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.”

Fecal Incontinence
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

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?

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)
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 the MDS 3.0 RAI Manual definitions/instructions

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.
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.

Implications of Section G:

Dollars/Reimbursement!! (Future Case Mix)

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?

MDS 3.0 Section GG

GG0100. Prior Functioning: Everyday Activities

Section GG | Functional Abilities and Goals - Admission (Start of SNF PPS Stay)

Coding

- Independence - Resident completed the activity by him/herself, with or without an assistive device, with no assistance from others.
- Recent Home Help - Resident needed partial assistance and/or used an assistive device to complete the activity.
- Unskilled - Resident required skilled assistance to complete the activity.
- Not Applicable.

“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.”

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.

Restorative Nursing and PDPM

PDPM is the Patient Driven Payment Model
- Effective October 1, 2019
- Will be 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 our of 7 days
  - Must be person-centered, written, communicated, evaluated and under the direction of a licensed nurse

It is imperative that you have systems in place to evaluate and place a resident in an appropriate Restorative Program upon admission in order to capture on the 5-Day Assessment!

Why??
- The 5-day PPS Assessment (ARD days 1-8) pays all covered Part A days until Part A discharge unless an Interim Payment Assessment(IPA) is completed!
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.

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
Communication Essentials with the Restorative Nursing Program to Prevent Obstacles!

EDUCATIONAL NEEDS OF THE NURSING STAFF

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
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

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!

“Well-trained and dedicated employees are the only sustainable source of competitive strength”
- Robert Reich
Person-Centered Interventions to Based on the Comprehensive Assessment Process

If we follow the Process as it is INTENDED, Person Centered Care Planning is possible!!
- Admission Assessment
- Ancillary Assessments
- Resident/Family Involvement
- RAI Process

CARE ASSESSMENTS
RESIDENT INTERVIEWS
MDS
CAAs
CAA SUMMARY
CARE PLAN
RAI Process

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Elements of a Solid Restorative Program

- 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
- Revisions to the Program
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
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

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.

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!

Effective Audit System

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?
Example of Program Audit

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Action Planning

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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

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In Summary (continued)

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

References:

MDS 3.0 RAI Manual:

CMS, State Operations Manual, Appendix PP:
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