Restorative Nursing Progam Certification Course

MANUAL



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Restorative Nursing Progam
Certification Course

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EDD Employment Development Department
State of California

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Congratulations!

Congratulations on your decision to become certified in the Restorative Nursing Program! You have made a great decision. Your involvement in this course will assure that the residents in your facility receive care that enables them to function as independently as possible. You will also benefit by learning the most effective resident management techniques while protecting yourself from personal injury.

We know that you are dedicated to the residents in your facility. How do we know this? We know because you are here to improve your skills. And when you improve your skills, your residents benefit.

Thank you for participating in this Restorative Nursing Program Certification Course.

Great care begins with you!



How this class was created

The Restorative Nursing Certification Program (RNCP) started in 2004 as a dream, developed by a group of therapy and nursing professionals who knew that there had to be a better way to train Restorative CNAs for their critical work with the elder population. The dream became a reality thanks to the vision and support of the following organizations and key individuals:

• The Quality Care Health Foundation (QCHF) and its parent organization, the California Association of Health Facilities (CAHF) have supported the RNCP since its inception and have served as the program's chief advocates to long-term care employers;

• Long-term care employers, who have recognized the need to develop career advancement programs for the Certified Nursing Assistants (CNAs) who make up the bulk of the work force in skilled-nursing facilities (SNFs);

• California Gov. Gray Davis made state funds available to expand and enhance the long-term care workforce through his Caregiver Training Initiative. Development of the RNCP was funded through a Caregiver Training Initiative grant;

• The California Employment Development Department, under Director Michael Bernick, made the development of Career Ladder Programs for CNAs one of its priorities; and

• The California Health Care Foundation, which has assisted the effort to expand the RNCP as part of their effort to improve the quality of patient care in long-term care.

SNFs have long used Restorative CNAs (RNAs) to care for residents who require assistance with functional abilities. RNAs provide follow-up and support services for the licensed Physical Therapist (PTs), Occupational Therapists (OTs) and Speech-Language Pathologists (SLPs) who may only be available on an as-needed basis. RNAs are available to provide daily support services to SNF residents, helping to improve their quality of life and clinical outcomes.

Employers have historically offered RNA positions to CNAs who display particular ability, and RNAs are often seen as having "higher rank" than regular CNAs. It is important to note that significant numbers of RNAs eventually pursue licensed-nursing degrees.

Yet, despite the critical role they play in long-term health care, RNAs have not had a standardized, formal training and certification process-until the advent of the RNCP. In the future it is our hope that the RNCP will serve as a key component of an integrated Career Ladder for CNAs, serving as a critical bridge between the CNA and Licensed Vocational

Acknowledgments

The quality of this Restorative Nursing Program Certification Course is a direct result of the talent, expertise and professionalism of a workforce dedicated to improved resident care. These people and their employers share a commitment to improving the skill level of the nursing profession in the state of California by contributing numerous hours to course design, development and delivery. We are grateful to the following workforce individuals and their employers:

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The following organizations have generously shared their Restorative Nursing Program publications and training materials in order to assure that the creation of this manual truly reflects the most current and best practices from the field:

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Restorative Nursing Progam
Certification Course

Overview

Course purpose:
The purpose of this course is to improve the knowledge base and clinical competencies of the Nursing Assistants and licensed/registered nursing staff. Increased performance improves resident care.

Program content:
The content of this two-day course focuses on strengthening the role of the Restorative Nursing Assistant and the Restorative Nursing Program Coordinator in demonstrating clinical competencies with facility residents and understanding the keys to implementing a successful Restorative Nursing Program.

Program format:
The format of this course is interactive. Your participation is expected throughout the lectures and demonstrations.

Graduation:
Graduation from this course requires demonstration of select clinical competencies as well as successful completion of a written post-test. Certification of course completion will be awarded when these standards are met.

Good luck!

Restorative Nursing Progam Certification Course

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Course Outline

Day 1

8 a.m.

Module 1 – Leadership Keys to Success
▶*Leadership and Teamwork*

▷Break

Module 2 – Medical Overview
▶*Anatomy and Aging*

Module 3 – Demonstrating Clinical Competency
▶*Cognition*

Noon

▷Lunch

1p.m.

Module 3 – Demonstrating Clinical Competency (continued)
▶*Communication and Hearing*

▷Break

Module 3 – Demonstrating Clinical Competency (continued)
▶*Dysphagia and Eating*

5 p.m.

▷Adjourn

Day 2

8 a.m.

Module 3 – Demonstrating Clinical Competency (continued)
▶*Joint Mobility*
▶*Orthopedic Case Study*
- *ADL Training*
- *Functional Mobility*

▷Break

Module 3 – Demonstrating Clinical Competency (continued)
▶*Orthopedic Case Study (continued)*

Noon

▷Lunch

1 p.m.

Module 3 – Demonstrating Clinical Competency (continued)
▶ *Neurological Case Study*
- *ADL Training*
- *Functional Mobility*

▷Break

Module 3 – Demonstrating Clinical Competency (continued)
▶ *Neurological Case Study (continued)*

Graduation and Awards

5 p.m.

▷Adjourn

Module 1

Leadership Keys to Success

Standard/Objective

Leadership competencies

1. Understand the scope of service of the RNP.
2. Restorative Nursing Assistant (RNA) and Restorative Nursing Program Coordinator (RNPC) will verbalize an understanding of roles and responsibilities.
3. Review OBRA and Title 22 regulations related to the RNP.
4. Verbalize an understanding of admission and discharge criteria for the RNP.
5. Review types of documentation forms.
6. Verbalize effective leadership strategies for the RNP.

Restorative Nursing Progam Certification Course

Restorative Nursing Program (RNP) 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. Generally, RNPs are initiated when a resident is discharged from formalized physical, occupational or speech rehabilitation therapy. A resident may also be started on an RNP when she/he is admitted to the facility with restorative needs but is not a candidate for formalized rehabilitation therapy or when a restorative need arises during the course of a custodial stay." (From Centers for Medicare & Medicaid Services' RAI Version 3.0 Manual.)

The RNP is designed to promote/improve strength, endurance, balance and mobility.

The **Restorative Nursing Assistant (RNA)** interacts with the residents and provides skill practice in activities that will improve and maintain function in physical abilities and activities of daily living (ADLs) and prevent further impairment.

The **Restorative Nursing Program Coordinator (RNPC**) provides guidance to the RNA and oversight to the RNP.

Rehabilitation refers to the therapeutic interventions that promote the independence of the chronically ill, disabled and aged with the goal of assisting the resident in becoming a more independent person, whether the resident remains in a Skilled Nursing Facility (SNF) or is discharged to a lesser level of care or to his/her home. The **Licensed/Registered Therapists** provide this intervention.

Scope of service

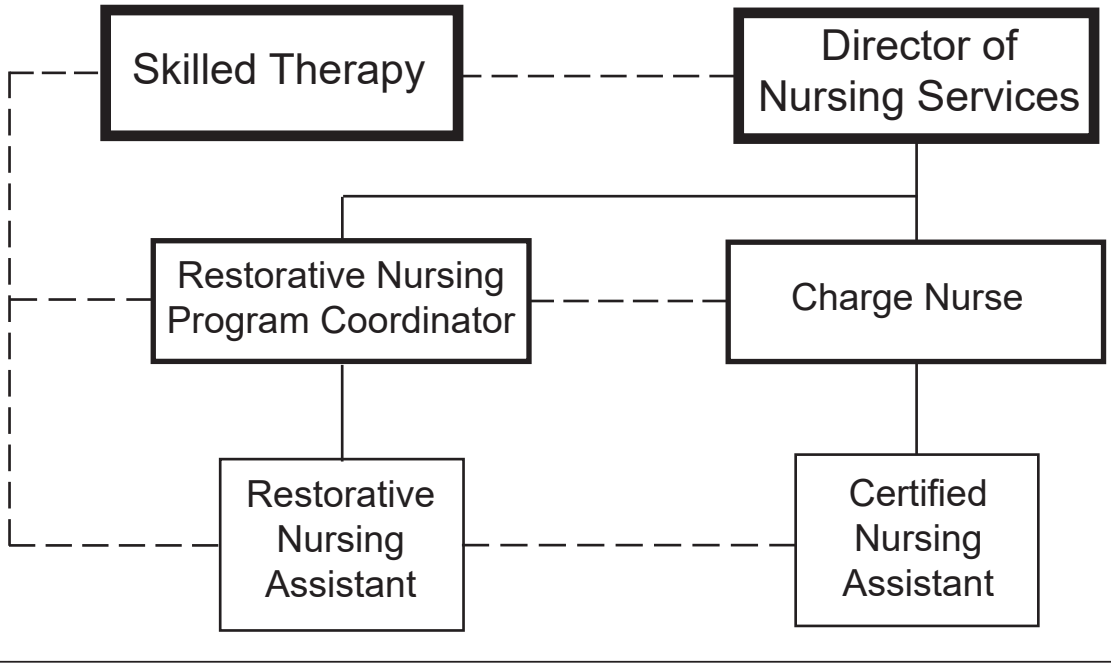
Many areas of function may be addressed by the RNP, including but not limited to the following:

- Bathing
- Dressing
- Grooming
- Toileting
- Oral hygiene
- Personal hygiene
- Ambulation
- Wheelchair mobility
- Bed mobility
- Transfer training
- Positioning
- Range of motion (active and passive)
- Bowel and bladder retraining
- Communication programs
- Exercise programs
- Splints, adaptive/assistive devices
- Dining programs
- Eating and swallowing

It is important for you to offer RNP services to meet the needs of your resident population and which you can manage based on staffing allocations and competencies. Add new programs as your staff demonstrates a comfort level and willingness to expand and as residents' needs change.



Restorative Nursing Program Organizational Chart



Restorative Nursing Assistant (RNA)
Roles and responsibilities

Roles
The purpose of the RNA is to interact with the resident and provide skill practice in such activities as walking and mobility, dressing, and grooming, eating and swallowing, transferring, amputation care, and communication in order to improve and maintain function in physical abilities and ADLs and prevent further impairment.

Pre-requisite RNA qualifications:
Recommended qualifications include:
- Completion of RNP Certification Course through the Quality Care Health Foundation in California.
- Current California Certified Nursing Assistant (CNA).
- Minimum one year experience as a CNA in long-term care.
- Ability to communicate effectively in English both verbally and in writing.
- Ability to function independently with indirect supervision.
- Able to participate in physical activities that may require bending, squatting, reaching, twisting, repetitive grasping, frequent pushing and pulling and frequent lifting up to 150 pounds with assistance.
- Training in gait belt use, safe transfers and body mechanics.
- Creative problem solver.

Recommended responsibilities include:
- Administer restorative activities specific to resident needs.
- Administer Restorative Dining Program.
- Perform transfers, bed mobility, positioning and range of motion (passive/active).
- Perform general strengthening exercises.
- Ensure the placement of restorative devices/equipment (e.g., splints, positioning devices).
- Assist with turning and positioning of residents as needed.
- Document per treatment activity and summarize progress for each resident in the RNP.
- Report and chart significant changes in resident condition, evidence of pain or motivational level.
- Notify RNPC, Charge Nurse or appropriate therapy discipline of problems, referrals and reassessment needs.
- Follow appropriate safety, hygiene and infection control measures.
- Ensure adequate restorative supplies to meet the needs of the residents in the RNP.
- Maintain consistent resident care schedule and be efficient in use of time.
- Coordinate restorative treatments with other facility departments.
- Attend all meetings and in-services as required.
- Follow policies and procedures for RNP.
- Identifies potential problems/issues and reports to RNPC in a timely manner.

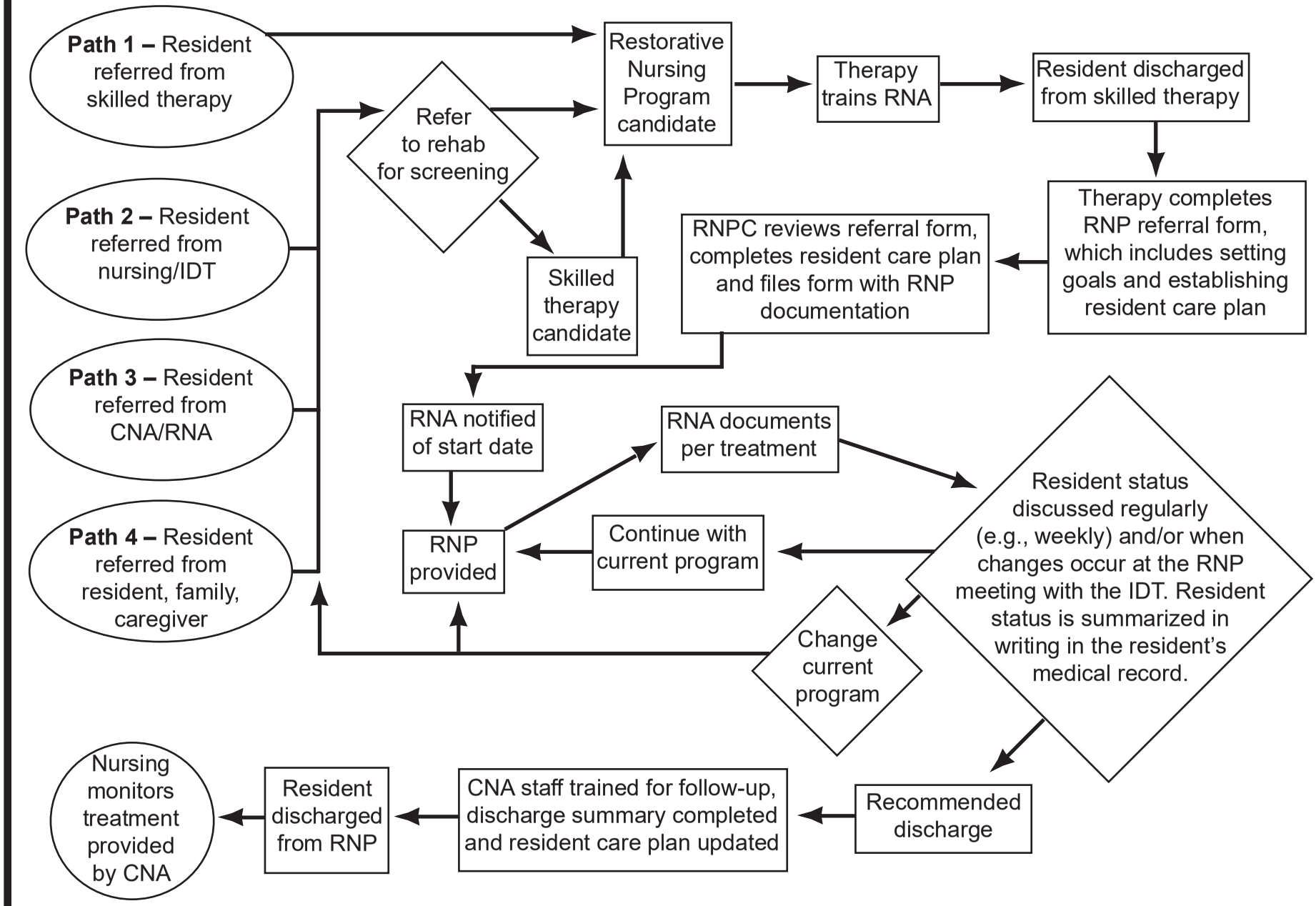
Restorative Nursing Program Coordinator (RNPC)
Roles and responsibilities

Roles
The roles of the RNPC are to provide guidance to the RNA and oversight of the RNP.

Pre-requisite RNPC qualifications:
Recommended qualifications include:
- Completion of RNP Certification Course through the Quality Care Health Foundation in California.
- Current California license as Licensed (LVN) or Registered Nurse (RN).
- Minimum one year experience as a licensed nurse in long-term care.
- Ability to communicate effectively in English both verbally and in writing.
- Willingness and ability to function as coordinator of RNP and supervisor of RNAs.
- Ability to participate in physical return demonstration for the purpose of competency skills check which may require bending, squatting, reaching, twisting, repetitive grasping, frequent pushing and pulling and frequent lifting up to 150 pounds with assistance.
- Training in gait belt use, safe transfers and body mechanics.
- Creative problem solver.

Recommended responsibilities include:
- Monitor all aspects of the RNP on an ongoing basis (e.g., skills, documentation, communications, schedules, assignments etc.)
- Review all RNA documentation for accuracy and completeness and update as needed.
- Serve as primary liaison with the professional Therapists by participating in resident assessments and coordinating the implementation of the RNP or recommendations made by the professional Therapists for nursing staff to follow.
- Oversee or participate in initiating or updating resident care plans related to the RNP.
- Assure licensed documentation in the medical record supports resident progress in the RNP.
- Communicate with the RNAs on a regular basis to review the status of individual resident programs, update programs, review charting and provide input to the RNAs regarding their skills.
- Assure input regarding the restorative needs of residents is provided at the resident care plan meeting.
- Serve as resource for other facility staff involved in the provision of restorative services (e.g., activities).
- Coordinate inservice efforts for restorative nursing and general nursing with staff development designee.
- Represent the RNP to families, Physicians and other individuals involved in the resident's care.
- Conduct the annual reviews of the RNAs.
- Report to the quality assessment and assurance (QA&A) committee.

RESTORATIVE NURSING PROGRAM FLOW CHART



Admission criteria

A resident may be referred to the RNP from Skilled Therapy, Nursing/IDT, CNA/RNA or from resident/family when one (or all) of the following criteria are observed:

- Skilled Therapy Program not indicated or RNP May be used as an adjunct to skilled therapy.
- Decline in physical and/or mental functioning
- Change of condition (e.g., unsteady gait, frequent falls, weight loss)
- Potential for improvement with training/ retraining (e.g. dining, continence, strengthening exercise, etc.)

A resident may be involved in more than one RNP function area concurrently. Frequency is dependent on resident need, motivation and outcomes. Take caution to assure that as many residents as possible benefit from the RNP involvement and staffing resources are preserved.

Assessments

The functional skills of all residents are assessed upon admission to the facility. Residents are reassessed every 90 days or more often if there is an identified decline in function. The assessments are mandated for Medicare facilities and are documented on the Minimum Data Set (MDS). The MDS, Section D0500, is used to document resident's RNP activity. See the Resident Assessment Instrument Version 3.0 Manual for further information.

When a resident's need is identified, a referral to rehabilitation for screening may be recommended. The therapist completes the screen and trains the RNA in resident-specific program skill practice. If nursing refers the resident to the RNP and therapy screening is not required, then the RNPC communicates directly to the RNA.

A Licensed Nurse must oversee quarterly Joint Mobility Assessments. However, the RNA may be involved in the measurement process. Successful joint mobility management is dependent on consistent measurement practices.

Physician orders

State and federal regulations are vague in terms of whether or not Physician orders should be obtained for Restorative Nursing Services. Good clinical practice is to obtain a Physician order for any service that is not routinely given to all residents. Most facilities have opted to require Physician's orders to minimize their legal exposure in the event that something goes wrong and an injury occurs.

These days, many facilities enter RNP orders into their computer system so that their activity records can be printed for documentation. It is recommended that each facility develop and implement a standard policy on RNP orders. When orders are obtained for RNP services the language describing the service should be clear and specific.

The order must state: who will provide the services; what service will be provided; what the frequency will be and the duration of the order. A recommended example of a RNP order is: "RNA to ambulate resident with FWW, FWB, up to 100 feet five times per week for 30 days." When the service is stopped, a discharge order must be obtained and documented.

Unfortunately, nursing facilities may have staffing difficulties and need to "pull" the RNA to help with resident assignments. However, if an order exists for a service to be performed, it must be provided. That is, someone must still provide the RNP services that the Physician has ordered.

Documentation

Documentation requirements for the RNP are similar to those followed for resident clinical care per state and federal regulations. Title 22 states:

> "Meaningful and informative nurse's progress notes shall be specific to the resident's needs, the resident's care plan and the resident's response to care and treatments."

Medicare states:

> "Rehabilitative nursing care services are performed daily for such residents who require such services, and are recorded routinely." Therefore, when care is provided, treatment must be documented. The format for documentation is not mandated and can follow your facility protocols. Sample forms are provided in the Appendix.

Referral Form

When the resident need is identified, a referral to rehabilitation for screening is recommended. Typically, a resident is referred to the RNP near the end of his/her skilled therapy program. Prior to discharge, the therapist determines resident-specific RNP needs, trains the RNA in appropriate techniques and completes the Referral Form that initiates the Resident Care Plan.

Resident Care Plan (RCP)

The Resident Care Plan (RCP) provides the guidelines for the implementation of interventions to assist in meeting the resident's goals. Decisions are based on assessments from all members of the interdisciplinary team (IDT). The RNPC assures implementation of the RCP specific to the Restorative Nursing Program. All direct care providers must demonstrate knowledge of the RCP and participate in updating the resident care plan as needed.

Activity Record

The RNA documents following each session on the Activity Record. Content may include:

- Activity provided
- Minutes of activity (required for Medicare and MDS, Section D0500)
- Level of assistance and support
- Initials of RNA providing care
- Meal intake percentage for Restorative Dining Program
- Problems, progress, outcomes
- Unusual occurrences (e.g., pain, refusal, withhold, change in condition)

A summary of the resident's status should be completed on a regular basis (e.g., daily, weekly, monthly) by the RNA. Content may include:

- Activity provided (e.g., Restorative Dining Program, ambulation)
- Resident response to activity (e.g., "c/o pain," "I don't have the energy," "tolerates without difficulty")
- Outcomes/progress/lack of progress (e.g., good, maintained, improving, decline, etc.)

Example: "Resident maintained skills this week. Complained three times of lack of energy. Walked 100 feet FWW 2/5 days. Resident follows swallow protocol when supervised at meals."

Licensed Nurse's Weekly Summary

The Licensed Nurse's Weekly Summary in the medical record should reflect the resident's involvement and progress in the Restorative Nursing Program.

Discharge criteria

A resident may be discharged from the RNP when one or all of the following criteria are met:

- Meets the goals of the program.
- Refuses consistently and/or does not have appropriate motivation to participate.
- Cannot tolerate the program as a result of an alteration in physical or mental status (e.g., pain, change in medical condition, etc.)
- Fails to benefit from the program

Discharge Summary

When a resident is discharged from the RNP, a Physician's order should be obtained, a Discharge Summary completed by the RNPC and the Resident Care Plan updated. The Discharge Summary should be documented in the Medical Record. One option is to include the Discharge Summary in the narrative section of the RNP records.

The Discharge Summary should describe:

- Initial functional problems
- RNP treatment program
- Highlights of the program, total time period, frequency, interventions provided, resident's response, reason for discharge
- Program status at the time of discharge (e.g. level of functional skill that the resident has at the time of discharge, amount of assistance required for each task and approaches that enable the resident to be as independent as possible)
- Recommended interventions for floor staff

Post discharge

Discharge from the RNP should include the following steps:

- RNPC should update the RCP to reflect RNP discharge status
- Communicate changes to Resident Care Plan to CNA and Charge Nurse and demonstrate techniques if necessary
- Establish protocol for periodic re-assessment of each resident following discharge from the RNP to assure that the resident is maintaining function.

Regulations

Skilled-nursing facilities are regulated by many laws and regulations. Facilities must strive to continue to maintain compliance with those regulations. The staff who work in Restorative Nursing Programs need to realize their role in this regulatory process. If all staff do the best job possible, they will be contributing to our residents' quality of life and quality of care.

Leadership and teamwork

In order to implement a successful Restorative Nursing Program (RNP) the leaders of the program must not only have the vision and commitment but also be able to motivate staff and facilitate change. There must be support from Administration and Nursing Administration. This support improves the chances of the program's success.

The Restorative Nursing Program Coordinator (RNPC) is a critical element to gaining Administration's support. An important aspect of the RNPC's role is to assure that Administration understand the RNP, the roles of the RNPC and the RNA and the importance of attaining resident and program goals.

Administration's support of the RNPC and the RNA will assist in removing any obstacles, making necessary policy changes, and taking needed actions to assure that all levels of staff follow through with the expectations of the program.

TEAMWORK COMMITMENT	SUCCESS FACTORS
Administrative support	The recommended success factors that enhance commitment from top management are: • Establish criteria for hiring staff into the Restorative Nursing Program • Allow the *time* to cover the necessary components of an effective Restorative Nursing Program training • Schedule new nursing staff time with the Restorative Nursing staff • Involve the Medical Director in the implementation of the program • Invite the Administrator and Director of Nursing to participate in the "Leadership Keys to Success" section of the Restorative Nursing Program training (e.g. overview, scope, etc.) • Develop a policy that includes limited circumstances in which Restorative Nursing staff is "pulled" from their duties (i.e., *should be the exception and not the rule*) • Adjust work responsibilities for the Restorative Nursing Program Coordinator to allow the time required to develop and coordinate the program. • Celebrate successes (e.g. graduation parties, certificates, commendations, measured outcomes, etc.) • Support routine, consistent meeting times for the Restorative Nursing Assistants, Restorative Nurse Program Coordinator and other team members to manage the resident's RNP program (e.g. weekly and PRN)

Leadership and teamwork (continued)

TEAMWORK COMMITMENT	SUCCESS FACTORS
Training	No specific regulations govern the mechanics of providing Restorative Nursing Program training. However, programs typically include a CNA selection process, instructor preparation and presentation, classroom instruction, training materials, demonstration/return demonstration, competency checks, post-test and certification. The actual content and handouts should be determined by the restorative care areas to be implemented based on the facility-specific resident population needs. Recommended success factors include: • Orientation of new and existing staff • Competency reviews (annual and PRN) • Ongoing skills checks by Restorative Nursing Program Coordinator and the Director of Staff Development • Annual performance appraisals (share with RNA on hire so they will know what criteria will be used to evaluate their performance each year) • Use of Restorative Nursing Program competency exams on hire and annually • Ongoing training to meet the needs of resident population • Ongoing training based on quality improvement plan • Expanded training to CNAs to enhance ADL skills • Involving RNAs in new employee orientation
Interdisciplinary (IDT) approach	Recommended success factors for integrating the roles of all interdisciplinary members include good understanding of the RNP purpose, roles and responsibilities of team members: • Nursing provides leadership for the RNP with emphasis on a TEAM approach • Licensed Nurses and CNAs provide input regarding their residents through discussion and documentation of changes, progress and/or lack of progress • RNA provides direct care to resident, documents routinely and communicates resident's needs to RNPC and IDT • Therapy Department offers training and provides oversight for the clinical aspects of the program • Dietary provides the space and set-up for the Restorative Dining Program and the appropriate food texture and assistive devices as determined by Physicians, Nursing and Speech/Occupational Therapy • IDT checks RNP at least quarterly and PRN for change of condition

Leadership and teamwork (continued)

TEAMWORK COMMITMENT	SUCCESS FACTORS
Assignments/ schedules	A major transition from being a CNA on the floor to working as an RNA is learning how to independently manage a complicated schedule. There are many competing activities occurring – from meals and naps to the beauty parlor and all the other activities that go on during a day in a resident's life. Therefore it is necessary for the RNA and the RNPC to schedule resident RNP activities. Recommended success factors include: • Select the best person for the RNA and RNPC position (see RNA Hiring Interview Grid in Appendix) • Start with the activities that are by their nature less flexible (i.e. restorative feeding must be at mealtime) • Schedule active residents when other activities are not scheduled • Residents who need exercise programs in the gym (therapy room) will need to be scheduled during those times when it is not in use by the professional therapists • Encourage capable residents to come to the gym at their scheduled time in order to strengthen their sense of independence • When several residents are scheduled in the same location at the same time, organize and set-up activities to meet their needs ahead of time • Use a dry erase board, computerized form, or paper and pencil schedule to organize RNP caseload (see sample RNP Resident Roster form in the Appendix) • Review schedule and make necessary adjustments every week until you are comfortable with flow of resident activities • Assure the schedule form includes specific RNP activities and tasks for each resident • If possible, plan RNA work schedules so that all three Restorative Dining Program meals are staffed • Plan RNA and RNPC back-up staffing for vacations, holidays and sick time • Allow time to complete required documentation • Schedule breaks and necessary meetings so they don't interfere with the RNP activity schedule

Leadership and teamwork (continued)

TEAMWORK COMMITMENT	SUCCESS FACTORS
Documentation	The main purpose of documentation is to record services performed and communicate the resident's progress to other caregivers. Your documentation should tell a "story" that addresses all aspects of the services provided for your assigned residents (see sample RNP Referral Form, Restorative Dining Program Referral Form, RNP Activity Record and Restorative Dining Program Activity Record in the Appendix). The referral forms are completed by Nursing or Therapy. Recommended success factors include: • Document each time services are provided (i.e., initials, total time of activity, resident response, significant occurrences, refusals, withhold of activity and reason). • Always document pain when it occurs, assuring that you stop the activity immediately and notify Nursing or Therapy • The person providing the service should be the one documenting. • Schedule time for writing and completing narrative summaries (i.e., daily, weekly, monthly). • Narrative notes should address resident's response to each intervention that is provided. • Licensed Nurse's Weekly Summary in the medical record should reflect resident's involvement and progress in the RNP. • Write legibly.
Resident Care Plan (RCP)	The initial RNP Resident Care Plan (RCP) is developed by the therapist or the nurse for the RNA to follow and the RNPC to oversee. Recommended success factors include: • Assure the RNA understands the resident's problems, goals and approaches for the RNP. • When changes to the resident's activities are needed, discuss with the RNPC. • Schedule routine, consistent meetings with the RNA, RNPC and therapists to discuss the resident's progress or lack of progress and adjust the RNP activities and RCP as needed. • Participate in Interdisciplinary Resident Care Plan reviews of resident's assigned to the RNP.

Leadership and teamwork (continued)

TEAMWORK COMMITMENT	SUCCESS FACTORS
Program Management and Supervision	The principles of program management include: planning, organizing, staffing, directing, controlling. Recommended success factors include: • Planning – establish a written program description • Organizing – establish policies and procedures, forms, job descriptions, organizational chart, performance evaluations, etc. • Staffing – establish personnel functions (e.g., number of RNAs, selection process of RNAs and appointment of RNPC, orientation/in-services, staffing plans, schedules for seven-day RNP coverage, etc.) • Directing – establish a routine for ongoing communication among the RNAs, RNPC, and therapists. Provide supervision for the program. Give clear directions • Controlling – establish ongoing methods for monitoring the program implementation, identify areas for performance improvement and involve staff, define reporting methods to the QA&A Committee, complete performance evaluations as scheduled, and provide ongoing in-services
Quality Assurance Performance Improvement	Quality Assurance Performance Improvement (QAPI) is a systematic, comprehensive, and data-driven approach to maintaining and improving the safety and quality of care provided to residents in a skilled nursing facility. All members of the facility's interdisciplinary team are involved in practical and creative problem solving. Quality Assurance (QA) is an ongoing process of identifying how the facility is performing in relation to standards and why the performance is at risk or has failed. Performance Improvement (PI) is a continuous study and improvement of the internal opportunities and new approaches to fix causes of systemic problems or barriers that aim to improve health care delivery and resident quality of life. RNP is an integral part of residents' health an well-being and must be included in the facility's QAPI Program and reported to the QA&A Committee. Recommended success factors include: A systematic approach to monitoring the success of the program. Addressing all residents' functional status on admission, quarterly and PRN. ADL Resident Care Plan that reflects resident's status completely and accurately. Routine chart audit (i.e., RNP activity record, narrative notes, weekly/monthly summaries) for completion, accuracy and outcomes. Submitting records to the QA&A Committee

Module 2

Medical Overview

Standard/Objective

1. Understand major muscle groups.
2. Understand three characteristics of the normal aging process.
3. Understand common medical problems/pathologies addressed by the RNP.

Basic anatomy and physiology

The body systems that produce movement are the skeletal system (joints), muscles and nerves.

Joints

The direction of movement may be described by the way a joint moves. In general *hinge*-type joints produce *flexion* and *extension*, while *ball-and-socket* joints produce *rotation*.

Muscles

Movement is produced by the *contraction* (or *shortening*) of a muscle that crosses a joint.

Most movement is the result of several muscles working together to perform a task.

Muscles that work together are a *group* (see section on “Range of Motion”) and can be classified as:

- Flexors
- Extensors
- Rotators

The major muscle groups are the ones that bend (*flex*) and straighten (*extend*) the head and trunk, wrist, elbow, ankle, knee and hip. The *rotator* groups turn the head, shoulders and forearms.

While some muscles shorten (*contract*) across a point, the opposing muscles must get longer in order for full movement to occur.

Nerves

The neurological system not only supplies the electrical impulses that signal muscles to contract, it is also responsible for the sensory components of movement, which include:

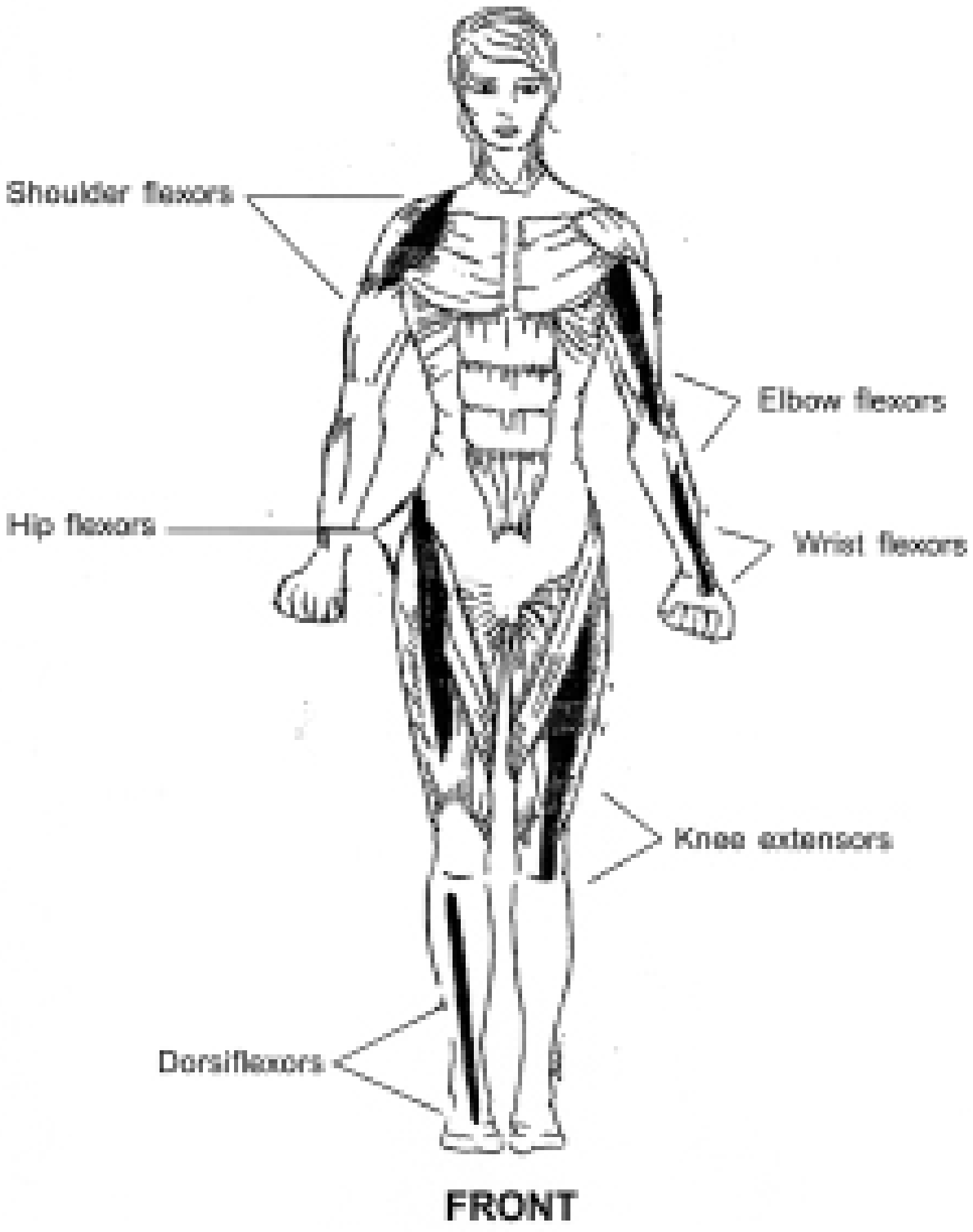
- Pressure
- Temperature
- Proprioception (awareness of position)
- Pain

Vital signs are also mediated by the neurological system:

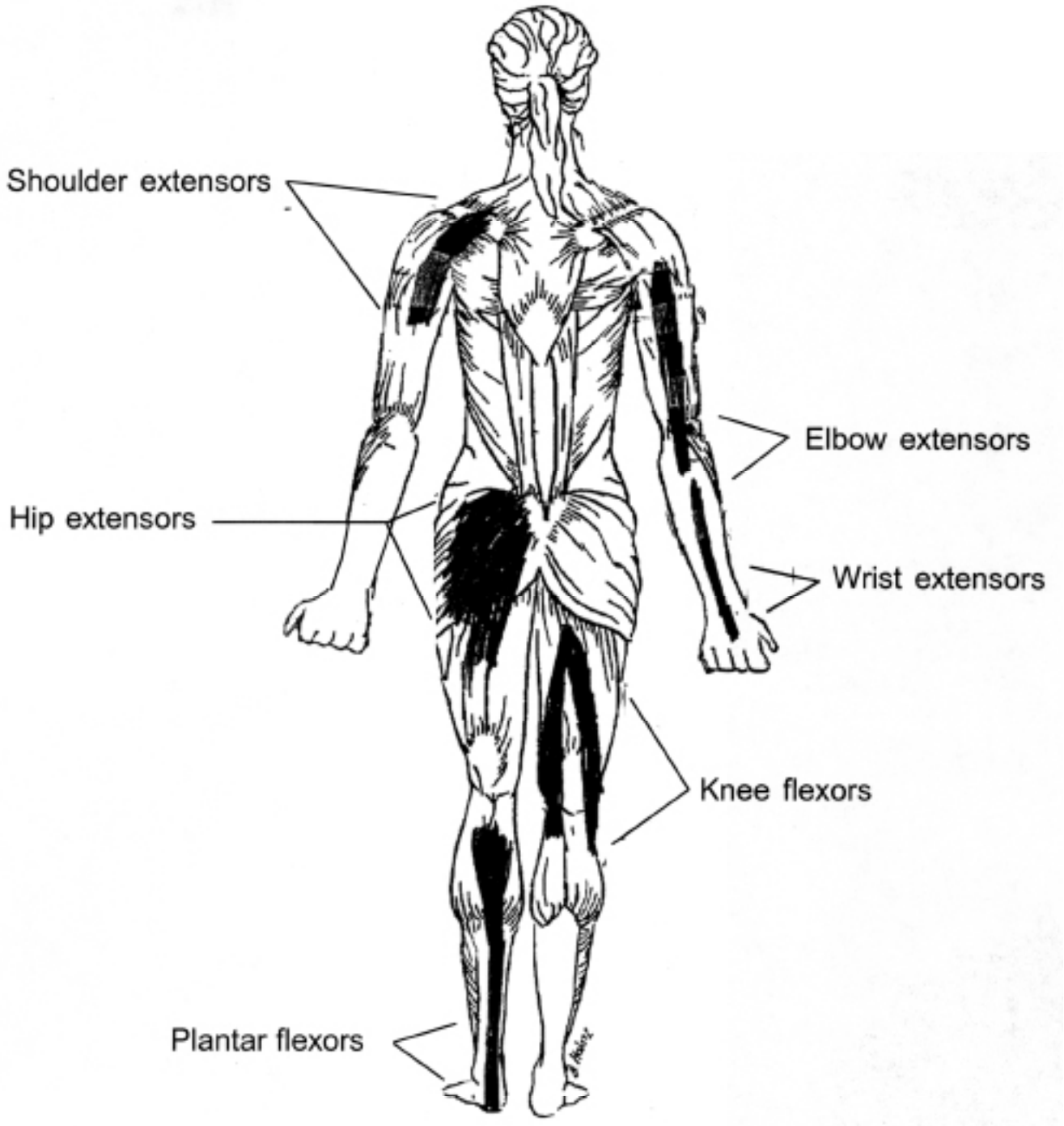
- Blood pressure
- Temperature
- Pain
- Heart rate
- Respiratory rate

Major muscle groups

When supervising an exercise program, it is important to know what each muscle group does to contribute to mobility. The following is a list of the major muscle groups.



Major muscle groups (continued)



Biological aspects of aging

Definition

Aging is a normal process that occurs with the passing of time. Aging past maturity implies a slowing down of biological function.

Coping with aging

Success with aging comes with being familiar with normal losses, being able to accept the losses as they come and then being able to work around them.

Skin

- Less active sebaceous glands, reduced sweating.
- Fragile blood vessels of the skin.

Skeletal

- Loss of calcium in bone – osteoporosis.
- Postural changes – head forward, kyphosis and changes in lordotic curve.
- Joint stiffness.

Muscle

- Loss of muscle strength (18-20%) and increased body fat (40-50%) by age 80.
- Antigravity muscles lose strength first.
- Loss of energy reserve, loss of endurance.



Nervous system

- Slowing in speed of action and reaction of the nervous system and motor responses.

Senses

- Up to twice as much light is needed to see as when in 20s.
- Vision adjusts more slowly from light to dark conditions.
- Glare negates vision.
- Decreased color discrimination.
- Faulty depth perception.
- Peripheral vision diminishes.
- Decreased eye-hand coordination.
- Decreased ability to make fine discrimination in touch and temperature.
- Decreased perception of pain and pressure.
- Diminished taste and smell.
- Loss of position sense.
- Presbycusis – “old-age deafness.”
- Hear lower voices and organ music the best.
- Takes longer to react to sound.
- Impaired discrimination between sound and noise (essential vs. unessential sound).
- Impairment of sound localization.

Respiratory system

- Lungs are less flexible – reduced capacity to cough and breathe deeply.
- Larynx – voice becomes weaker and higher in pitch.

GI system

- Decreased bladder capacity and changes in bowel function.
- Decreased bladder muscle and sphincter tone.
- Increased residual urine is left in bladder after voiding.
- Decreased metabolism.

Psychosocial aspects of aging

Residents may have four to eight chronic or degenerative processes with two to three of these processes in an acute state.

Sensory changes

- Decreased or lack of incoming information.
- Decreased ability to assess the environment.
- Altered sleep patterns.

Psychosocial changes

- Loss of regular pattern of activity.
- Separation from meaningful life experiences.
- Change in pattern of social associations.
- Role changes.
- Loss of significant others.
- Self-esteem.
- Strong need for someone with whom to identify.
- Stress resulting in increased speed of aging and/or disease process and/or onset of new medical conditions.

Coping with stress

- Positive attitude toward stress.
- Keep activity level high (active physical stress eases psychological stress).
- Need for 50/50 balance of stress and relaxation for a healthy environment in spite of living in a stressful society.

THOUGHT

Geriatrics is not an abstract. It is potentially an age group all of us will belong to if we live long enough.



Medical problems/pathologies
Orthopedic

ORIF vs. THR patients

ORIF	THR
ORIF = Open Reduction Internal Fixation – "pinned hip"	**THR = Total Hip Replacement**
• **Incisional and bone pain**	• **Incisional pain only**
• **Position will be limited by pain**	• **Precautions on positioning:** – Six to eight weeks – No hip flexion past 60º-90º – No adduction – No internal rotation
• **Usually TDWB to NWB six or more weeks**	• **Often PWB to WBAT**
TDWB = Touch Down Weight Bearing	**PWB = Partial Weight Bearing**
NWB = Non-Weight Bearing	**WBAT = Weight Bearing As Tolerated**
• **Difficulty with transfer and gait is secondary to limited weight-bearing and pain**	• **Less pain with mobility** • **Dislocation risk as there often is no pain**

THOUGHT

If some important activity is taken away (i.e. walking), you must replace it with another equally important activity.

Medical problems/pathologies (continued)

Neurological

Common characteristics of CVAs

Cerebro**v**ascular **A**ccidents

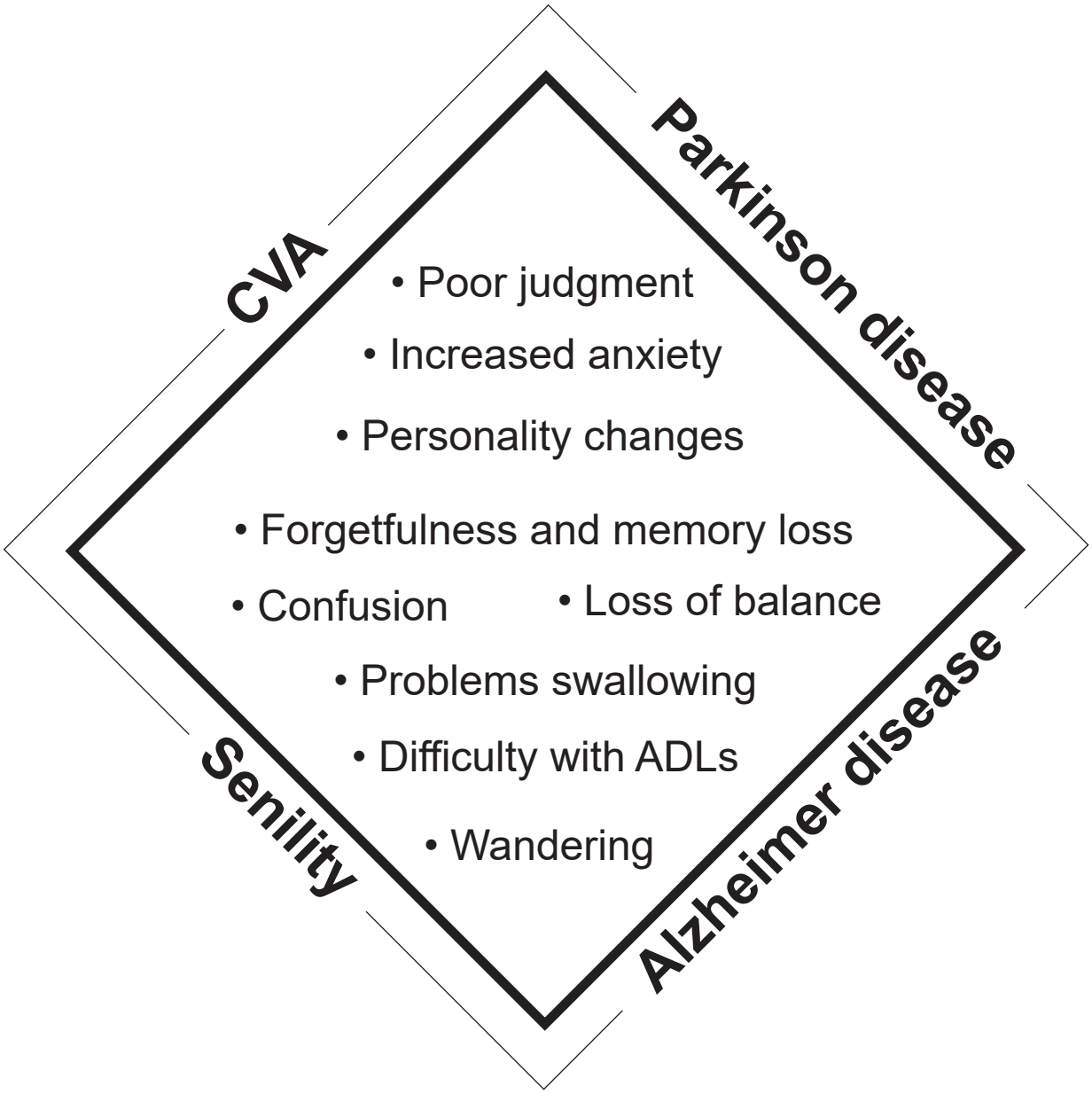
- Muscle weakness or paralysis.
- Sensory impairment – loss of feeling.
- Depression is common.
- Emotional lability – inappropriate crying or laughing unrelated to situation.
- May be disoriented.
- May have problems with eye-hand coordination and balance – more severe in the *right* CVA, *left* hemiplegic.

Different characteristics of right and left CVAs

Right CVA **Left hemiplegia**	**Left CVA** **Right hemiplegia**
• Visual impairment/neglect of *left* side of self in environment and written material.	• Visual impairment/neglect of *right* side of self in environment and written material.
• Poor safety judgment, impulsive.	• Slow, cautious behavior.
• Short attention span – highly distractible, may fixate on inappropriate topics.	• Difficulty changing topics and tasks.
• May speak clearly but not make any sense as to content. • Limb *apraxia* – may misuse objects such as comb, razor, toothbrush, etc. • May use *yes* and *no* inappropriately. • Difficulty reading clocks. • May be confused about time and space, gets lost easily.	• May be *aphasic* – complete breakdown in any or all communication, writing, speaking, listening. • May be *anomic* – unable to name objects even though their usage is understood. • Verbal apraxia – may mix up sounds and words. • Uses jargon, made-up words.
• Fast learner – but quickly forgets newly learned tasks.	• Slow learner – but once a task is learned, it is retained.

Medical problems/pathologies (continued)

Chronic neurological



Case Studies

See Pages 182-184 for filled-out case study forms

Case Study: Orthopedic

Mrs. Cora Connelly is an 83-year-old female who was recently hospitalized after falling at home, sustaining multiple fractures of the lower and upper extremities. She sustained a fracture of the right hip requiring a total hip replacement (THR), fracture of the left tibia which was casted and a right Colles' fracture which also was casted.

Mrs. Connelly was transferred to ABC Rehab and Care Center for rehabilitation. Upon admission, she was NWB on the left lower extremity and was under total care as a result of low pain tolerance, right (dominant) hand being casted and limited mobility in the lower extremities.

Prior to hospitalization, Mrs. Connelly lived alone and was one year post a left hip fracture. She and her family felt that she was not safe enough to return home and therefore would be staying for long-term care.

Starting upon admission, Mrs. Connelly received Occupational and Physical Therapy.

Her discharge status was as follows:

- Limited assistance bed mobility from supine to sit.
- Limited assistance for transfers from bed to wheelchair and occasional extensive assistance for toilet transfers.
- Ambulates with platform walker and limited assistance for 40-50 feet. Much encouragement and reassurance are required as Mrs. Connelly expresses much fear of falling again.
- Independent with upper body dressing.
- Limited assistance needed with lower body dressing with adaptive equipment.
- Limited assistance needed with bathing in shower.
- Extensive assistance sometimes is needed with toileting.
- Flexion and abduction on the lower right extremity are 3+/5. Knee flexion and extension on lower left extremity are 4/5. Right wrist extension is 3-/5 and wrist flexion is 3+/5.
- Resident uses resting hand splint at night for wrist drop and has an exercise program to follow. CNAs have been trained to put on splint at night.

Goals for RNP

- Resident to ambulate 120 feet SBA with use of walker (e.g., walk to dining room and back.)
- Resident to transfer in/out of bed and on/off toilet with supervision.
- Bed mobility to supervised level.
- Resident to be pain free after exercises.
- Resident to tolerate hand splint at night without pressure or irritation.

RNP Plan of Care

- Ambulation three to five times per week with walker.
- Range of motion (ROM) and strengthening exercise program five times per week for lower extremities.
- Activities of daily living (ADL) program three times per week for lower body dressing.

Case Studies

Case Study: Multiple Medical

Tessie Tripper is a 79-year-old female, 5-feet-4, weight 148 lbs (67.2 kg), with a history of DMII, macular degeneration, CHF, mild COPD and multiple DJD. She is eight years status post left THR (elective); her diabetes is controlled with diet alone. Daily medications include Celebrex, Xanax, Lotensin, a multi-vitamin with zinc and Senokot. She recently stopped taking Premarin after long-term use.

Mrs. Tripper's husband died from complications of Alzheimer disease one year ago. She had been his primary caregiver. After her husband's death, she sold her three-bedroom home and moved to an apartment on the advice of her daughter. After just six weeks in her apartment, Mrs. Tripper began to exhibit signs of confusion, phoning her daughter several times a day, buying more groceries than she could use and neglecting her housekeeping, hygiene and appearance. She left her apartment and moved in with her daughter and son-in-law and their two high-school-aged children. Her mental and physical condition improved quickly, although she frequently complained of fatigue and weakness in her left leg. Over the next several months she seemed to be adjusting to the busy household and even began going to church and socializing with friends (which she had not been able to do while caring for her husband).

Mrs. Tripper's condition has now changed. Within the last three weeks she has fallen twice that she acknowledges, though her daughter believes that she may have fallen at least two more times when she was home alone. Her most recent fall resulted in a fracture of the left distal radius without any other apparent injuries. Her daughter, concerned for her mother's safety, arranged for placement in an assisted-living facility where Mrs. Tripper stayed for only two days before complaining of chest pains and shortness of breath. She was admitted to acute care, observed for two days and discharged with a diagnosis of exacerbation of COPD. She apparently did not have a heart attack, but her Physician has recommended skilled-nursing care "until she gets her strength back".

On admission to the SNF, Mrs. Tripper was alert and oriented, B/P 98/60, HR 104. She was screened by the Therapy Department, and it was determined that neither her diagnosis, hospital stay, nor functional status could support justification for Physical or Occupational Therapy. Despite the cast on her left forearm, she is independent with bed mobility, able to walk from her bed to the bathroom and requires only set-up assistance with clothing management and grooming. She complains of fatigue and spends most of the day in bed.

Her daughter is willing to take Mrs. Tripper back to her home only if she is assured that her mother is able to walk independently (level surfaces and eight stairs) and care for herself.

Goals for RNP

- Increase functional out-of-bed tolerance to four hours.
- Restore safe, independent ambulation without assistive device, household level (flats and stairs.)
- Independent bathing, dressing and grooming.

RNP Plan of Care

- Supervised ambulation five times per week to resident's tolerance.
- Routine exercise program five times per week for strengthening, balance and activity tolerance.
- ADL program five times per week for room-level ambulation and functional mobility.

Case Studies

See Pages 185-190 for filled-out case study forms

Case Study: Neurological

Mr. William Lowe is a 59-year-old male who came from a weeklong stay in an acute-care hospital secondary to dense CVA with right hemiparesis, dysphagia and aphasia. Prior medical history includes obesity, diabetes, COPD and arthritis.

Mr. Lowe was transferred to a skilled-nursing facility (SNF) for rehabilitation involving Physical Therapy, Occupational Therapy and Speech Therapy. Prior to the CVA Mr. Lowe had been independent at home, working as a truck driver and right-hand dominant. At the time of evaluation, he required maximum assist with bed mobility, sitting balance and transfers. He was nonambulatory. Right extremities were flaccid requiring max assist with upper- and lower-body dressing. He also needed max assist with grooming, hygiene and feeding. He was non-verbal, following simple directions with max cueing and had a severe swallowing problem with pocketing of food on the right.

Mr. Lowe participated in PT, OT and Speech Therapy and was discharged at the following level of care:

- Minimum assist with bed mobility.
- Min assist transfers using the hemi-walker with step-pivot technique.
- Min assist ambulation with hemi-walker and right AFO up to 60 feet on level surfaces. Right leg drags some with gait. Increased assistance/cueing is needed as he will occasionally lose his balance in crowded environments. Resident experiences mild SOB with physical exertion.
- Mod assist with lower-body dressing.
- Min assist with upper-body dressing and set-up for grooming.
- Min assist for toileting and hygiene.
- Requires set-up in the dining room with plate guard and dycem in Restorative Dining Program.
- Right upper extremity is non-functional and requires a resting hand splint due to flexor tone and pain in right hand.
- Verbal communication consisting of “uh-huh,” “yeah” and “huh-uh” with fair accuracy.
- Auditory comprehension and understanding are limited to short sentences and phrases.
- Laryngeal excursion is good, Mr. Lowe is able to cough and clear, no overt signs of dysphagia with mechanical soft diet and nectar thick liquids.
- Swallow protocol includes alternating sips and bites, cueing to chew completely, swallow and clear mouth between bites and check for pocketing on the right.

Goals for RNP

- Resident to ambulate to and from the toilet and dining room.
- Maintain functional mobility and strength to allow for active participation in SNF activities.
- Prevent contractures and pressure sores.
- Safe and efficient swallow.

RNP Plan of Care

- Transfers and ambulation practice with hemi-walker with AFO while monitoring for SOB.
- Soak and range program for right upper extremity.
- Application of right resting splint and monitoring for redness and pressure.
- Restorative Dining Program with swallow protocol.

Case Studies

See Pages 191-196 for filled-out case study forms

Case Study: Dementia

Mrs. Ava Wave, a 73-year-old female, was diagnosed with Alzheimer disease about two years ago. Her neurologist told the family she appeared to be in the “middle stage” of the disease.

She has moderate problems with recent memory, although her immediate and remote memory are intact. She needs minimal help with dressing and personal hygiene. She feeds herself without difficulty but experienced a 15-pound weight loss, has become weak and has fallen without apparent injury.

Mrs. Wave is able to write at the sentence level and comprehends reading at the short paragraph level. She is showing increased difficulty with word finding and agitation regarding loneliness, complaining that “My son never calls me or comes to visit me,” despite daily visits and phone calls from the son.

She was admitted to SNF level as her spouse was no longer able to take care of her. She had been wandering in the neighborhood and getting lost, forgetting family names, phone numbers and addresses. She is also experiencing “sundowner’s syndrome,” has become combative and refuses to take her medication from her husband.

She was referred to Speech-Language Pathology by Physical Therapy, as she cannot remember strengthening exercises or to follow safety precautions while using assistive devices.

Nursing also reports the resident has refused to consume medication (“I already took them.”) In addition Mrs. Wave’s relationship with her spouse has deteriorated as functional daily communication has been reduced to minimal comments secondary to Ava Wave’s inability to recall the events of the day.

The Speech-Language Pathologist evaluated Mrs. Wave and recommended an assistive communicative device, with the RNA establishing consistency and use of memory cueing systems.

Goals for RNP resident

- Decrease agitation regarding her perception of visitation frequency using memory cuing system 100% of the time.
- Consume medication with confidence of timeliness using memory-cueing system 100 percent of the time.
- Follow set protocol established by PT using memory-cueing system with minimum cueing.
- Increase her ability to recall daily events to increase her functional communication using memory-cueing system.

RNP Plan of Care

- Calendar schedule of daily events for orientation.
- Visitor and medication log for daily occurrences.
- Hourly diary of activities.
- Personal information guide for ongoing reference.

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Module 3

Demonstrating Clinical Competency

Standard/Objective

Cognition, hearing and communication

Cognition

1. Verbalize/write three examples of a cognitive problem for the middle stage of dementia.
2. Verbalize/write three guidelines for providing assistance to cognitively impaired residents.
3. Verbalize/write what the best environment for working with the cognitively impaired would include.
4. Identify cueing systems associated with Alzheimer disease.
5. Identify useful compensatory strategies for each stage of Alzheimer disease.

Hearing

1. Verbalize/write three compensatory techniques for communicating with the hearing impaired.
2. Understand the difference between sensorineural and conductive hearing loss.
3. Identify appropriate wear schedule for resident who is a new hearing-aid user.

Communication

1. Verbalize/write three communication strategies associated with *left* hemisphere damage.
2. Verbalize/write three suggestions for communicating with *right* CVA residents.
3. Identify deficits associated with *right* CVA residents.
4. Understand the use of a communication board.
5. Identify compensatory techniques for motor speech disorders.

Cognitive disorders

Definitions

Cognitive impairment:

Decreased ability to mentally process information

General characteristics of cognitive impairment:

- Confusion
- Impulsiveness
- Delusions
- Inappropriate social interactions
- Limited attention
- Reduced alertness
- Poor judgment
- Problem solving deficits

Dementia:

Loss of intellectual and cognitive functioning interfering with social and/or occupational functioning. May or may not be progressive.

- Pre-senile dementia – before age 65
- Senile dementia – after age 65
- Primary degenerative dementia – progressive

Memory impairment:

- Immediate – minutes, hours
- Recent – days, weeks
- Remote – years

	CVA-Depression-UTI **Reversible/false/direct**	Alzheimer **Irreversible/true/indirect**
Goal is to return to prior level?	Yes.	No.
Treatment focus?	To **improve** function with therapy and RNA.	To **maintain** function, minimize further deterioration. Emphasis is on decreasing agitation and improving orientation, functional communication, memory recall and overall emotional health.
Aware of their deficits?	Usually – and **very concerned**.	Usually not – **no concern**.
Memory?	Inconsistent but **not worse** at night.	Recent memory is worse than remote memory, with immediate memory remaining intact – **worse at night**.
Onset?	Usually specific and **can be pinpointed** to day or week.	Onset is **difficult to pinpoint** and vague.

Some residents have mixed characteristics/deficits and benefit from both direct and indirect treatment techniques.

Cognitive disorders (continued)

Etiology Diagnosis and medical conditions	False dementia **Reversible** cognitive deficits	True dementia **Irreversible** cognitive deficits
• Parkinson disease		X
• Huntington chorea		X
• Alzheimer disease		X
• Pick disease		X
• Multi-infarct dementia		X
• Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)		X
• Cerebrovascular accident (CVA)	X	
• Traumatic brain injury (TBI)	X	
• Urinary tract infection (UTI)	X	
• Thyroid disorder	X	
• Metabolic imbalance	X	
• Medication use and interaction	X	
• Anesthesia effects (post surgical)	X	
• Low blood sugar	X	
• Depression	X	
• Brain tumor	X	X
• Subdural hematoma	X	X
• Anoxia	X	X
• Hydrocephalus	X	X
• Alcohol abuse history	X	X

Cognitive disorders (continued)

Specific characteristics

of Parkinson disease, Huntington chorea, Alzheimer disease, Pick disease, etc.

	Parkinson disease, Huntington chorea, for example	Alzheimer disease, Pick disease, for example
Onset of cognitive deficit	Gradual medical deficits first, then cognitive deficits	Initial problem is intellectual functioning and then medical
Language	Normal	Aphasia
Speech	Dysarthric	Normal
Memory	Retrieval problems	Unable to learn
Cognition	Slowed	Poor judgment
Affect	Depressed	Unconcerned
Posture	Stooped	Normal
Tone	Increased	Normal
Movement	Tremor	Normal
Gait	Abnormal	Normal

Cognitive disorders (continued)

Communication approaches

Reversible (false dementia/direct)	Irreversible (true dementia/indirect)
What is today's date?	Today is June 22. Look at your book.
Who is the president?	The president is George W. Bush.
What did you have for breakfast?	Your journal says you had pancakes for breakfast.
No, this is not a restaurant.	Yes, this is a great restaurant, isn't it?
Don't give up. Try again. Lots of practice.	You're right, we should rest.
Why do you need to lock you wheelchair brakes?	Let me lock your brakes for you.
Who visited you yesterday?	Look in your book. See where your son signed.
Could you suggest a better time for your nap?	Time to nap so you're rested for the dance tonight.
No, there is no money. Your son has it at home.	You're right. You have lots of money. It is safe.

Alzheimer stages (appearance and awareness)

	Early stage (often first noticed at home)	Middle stage (longest stage, 2-10 years following diagnosis)	Late stage (terminal stage, 1-3 years)
Appearance	• Clothing appropriate. • Gait and posture OK.	• Looks unfinished. • Won't change clothes. • Removes appliances. • Posture decreases.	• Abnormal.
Awareness	• Has knowledge of past, present and future. • Thinks he/she still has responsibilities.	• Only remote and immediate memory intact. • Unconcerned about whereabouts. • Thought retention decreases. • Gives up on responsibilities.	• Retains some remote memory over learned memory from the past.

Alzheimer stages (behaviors)

	Early stage (often first noticed at home)	Middle stage (longest stage, 2-10 years following diagnosis)	Late stage (terminal stage, 1-3 years)
Behaviors	• Tearful/depressed. • Has insight to self. • Interacts socially appropriately at a high/normal level although less outgoing • Speech and language functional. • Reports forgetting things occasionally. • Loses or misplaces objects. • Poor judgment – makes bad decisions. • Trouble with handling money, managing finances or paying bills. • Denies any problems. • Increased anxiety, personality changes, frustration.	• Socially ambivalent. • Social contact – buddy. • Reverts to native language. • Searches for things. • Delusional – "I am in charge." • Resistant to ADLs but may need help. • Relocation upsetting. • Increasing memory loss, shorter attention span. • Decreased concentration, orientation and learning. • Problems begin with finding right words but very verbal. • Problems begin with reading, writing and numbers. • Repetitive statements, stories and/or movements. • May have oral or pharyngeal dysphagia or feeding problems. • Perceptual – motor problems. • May have hallucinations (see or hear things that are not there). • Will have fixed ideas that are not real.	• Wanders and paces. • Doesn't recognize loved ones or self in mirror. • Severe comprehension and communication deficits. • Social graces absent. • Total care needed. • Forgets spouse's name. • Loses weight even with a good diet. • Little capacity for self-care. Max assistance with ADLs. • Loss of balance, strength, coordination. • Difficulty with or unable to communicate or use words. • Unaware of recent events. • Shows marked personality and emotional changes. Often with a flat affect. • Loss of bladder and bowel control. • May have seizures, skin breakdown, infections. • May exhibit unusual behaviors: Squirreling things away in a drawer; "hiding" possessions in odd places; may put things in their mouth.

Alzheimer stages (examples)

	Early stage (often first noticed at home)	Middle stage (longest stage, 2-10 years following diagnosis)	Late stage (terminal stage, 1-3 years)
Examples	• Loses keys, forgets briefcase. • Forgets which bills have been paid, what cards have been played in bridge, important phone numbers. • Hides things, gets upset much more easily. • Gets lost driving the car to the store or confused when going for a walk.	• Forgets visits or care from hours or day before. • Repetitive statements or movements such as tapping or folding. • Difficulty with functional movements such as getting into a chair, setting the table, walking down the hall. • Sleeps often and has disruptive sleep patterns. May try to get up at night and get ready to "go to work." • Unable to follow directions. • Unable to find familiar locations, often will wander. • Suspicious – may accuse someone of stealing things. • Loss of impulse control – sloppier at meal time, may get dressed incorrectly. • Large appetite for junk food or wants other peoples food. Forgets last meal, then gradually loses interest in food all together. • Odd or unrelated statements – "There was a man in my room last night." "The police are after me." "This isn't my home."	• Looks in mirror and talks to own image, or just talks with self. • Will require max assistance with all ADLs. • Exhibits increased safety concerns. May walk into the street, climb out of bed without asking for help. • May groan, scream or make grunting sounds. • Sleeps more.

Alzheimer disease

General guidelines

1. **Achieve eye contact** to assure that you have the resident's attention. Maintain that eye contact.
2. **Use touch** to gain the resident's attention and then use touch and the persons name during care and conversations to maintain attention.
3. **Be patient!** Give the resident time to respond. If she/he doesn't respond, don't be tempted to talk more. Instead repeat your request and use visual or tactile cues to help get your meaning across.
4. **Tactile or visual cues** may be most helpful with residents who are having difficulty with right vs. left, spatial relations or neglect.
5. If a resident is still unable to follow a direction or perform a task **guide him or her gently** through the task with tactile support.
6. Keep instructions and tasks **simple**. Break down tasks into simple steps and use the same order and process each day. Routine is good.
7. As often as possible **work at the resident's pace**. Rushing can cause frustration and confusing for both you and the resident.
8. If there are signs of **fatigue or strain**, assist the resident to complete part or all of the task.
9. **Provide orientation** all day every day. Time, date, season, location.
10. **Assist** only when needed, encouraging independence.

Creating the best environment

1. When caring for a resident keep the **noise and visual distractions** to a minimum such as **turning off the TV** or radio, **closing the door** to the hall, eating in a quiet place. Reduce **movement and activity.**
2. Use **adequate lighting** to enhance furniture, colors and contrasts.
3. Help keep belongings **neat, organized and uncluttered**.
4. Establish **structure and routine**. Keep the environment constant.
5. Have a **positive attitude**. Residents who have cognitive deficits may have lost awareness. and orientation, but they will maintain awareness of how they are being treated.
6. **Do not treat the resident like a child**. Treat them like **adults**.



Alzheimer disease (continued)

Behavior characteristics

1. **Suspicious –** e.g., “You stole my money.”
2. **Mommy/daddy pattern –** e.g., “Mommy, mommy, mommy.”
3. **Angry/agitated –** e.g., “I hate you. You’re stupid. Get out of here.”
4. **Wandering/pacing –** e.g., Caregiver: “Where are you going?” Resident: “I don’t know. I’m so tired.”

Communication tips

1. Guide a conversation onto specific or **familiar topics** and redirect conversation back to familiar topics when the resident begins to ramble or get off topic.
2. **Be reassuring** and help the residents to find the word they are looking for **without speaking for them**.
3. Use **clear, short sentences**.
4. Be redundant. **Repeat information often,** especially if memory and orientation are impaired.
5. Be **literal and concrete** when communicating. Avoid arguing. Trying to reason or rationalize with someone who is confused or disoriented may just heighten these characteristics.
6. **Allow time** for the resident to respond.
7. **Pictures, gestures or notes** may help you to convey your message.
8. Avoid open-ended questions. **Provide choices**.
9. **Be agreeable** to their thoughts and feelings.

Communication behaviors to *avoid*

1. Do *not* quiz or ask the resident lots of questions. This will only frustrate and confuse them.
2. Do *not* correct or contradict statements the resident has made as fact even if you know that it is wrong.
3. Avoid using sarcasm.
4. Avoid using long, complex statements or instructions. Keep communication and instructions simple.
5. Avoid letting frustration or anger enter into your voice.
6. Do *not* ask them to repeat.

Cueing/compensatory systems

May include (direct and indirect):

1. Daily schedule
2. Identification folder
3. Memory wallet
4. Monthly calendar
5. Safety card checklist
6. Memory journal

Hearing in geriatrics

Hearing loss

1. Conductive (Example: Wax in the ear.)

- Hearing impairment due to the failure of sound waves to reach the inner ear
- Outer ear and middle ear may be affected.
- Will cause decrease in loudness only.
- Can fix the problem quickly and easily.

2. Sensorineural (Example: Nerve damage from listening to loud music.)

- Will cause sound to be fuzzy or distorted.
- Occurs most frequently in elderly, hunters or people working around loud machinery without ear protection.
- High frequency sound less likely to be heard, i.e., *s*, *th*, *f*, *sh*, *ch, t*, *p* (high-pitched sounds.)
- Harder for men to hear the high voice of a woman.

3. Mixed

- Combination of conductive hearing loss and sensorineural hearing loss.
- A combination of any of the following: outer ear, middle ear, peripheral

4. Central (Could be born with this problem)

- Hearing loss resulting from central nervous system, as nerve passes through the brain stem, cerebellum, thalamus and cortex.
- Central nervous system or brain and brain stem.

Hearing aids

- **Behind the ear (BTE) –** Most common type.
- **In the ear (ITE)**
- **Body aid –** Less frequently seen; commonly used in the 1970s for severe hearing loss.
- **Cochlear implants –** A new surgery and not frequently seen in geriatrics yet.

Check/maintain hearing aid

- Use stethoscope to check sound.
- Check batteries with battery checker or use cupped hand method.
- *Never* get wet, clean with alcohol swab.
- *Never* use toothpick, needle, etc. to clean out wax.

Hearing aid tips

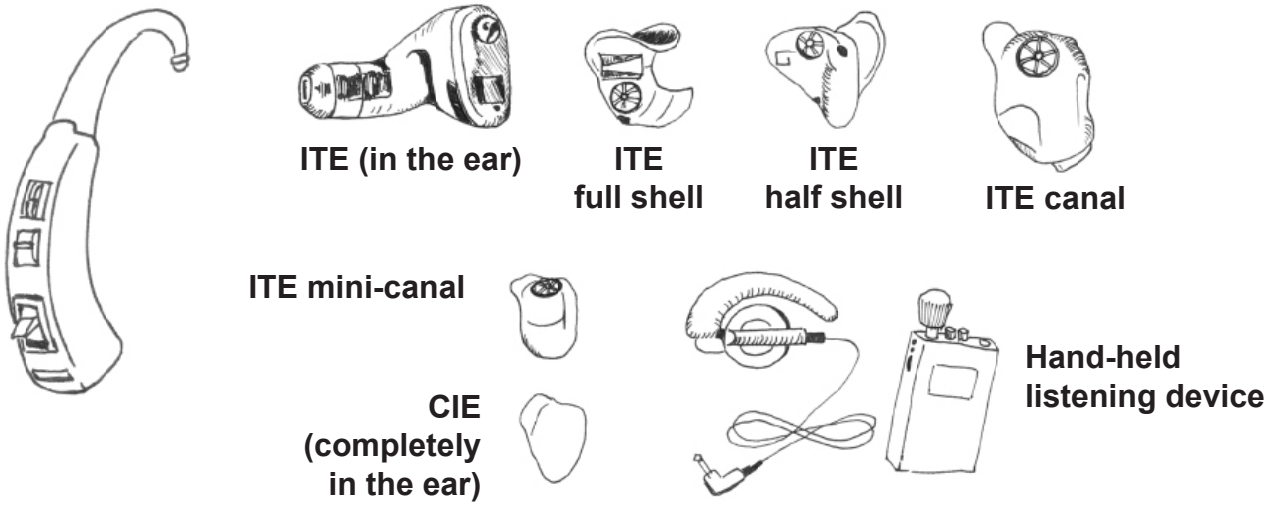
Be sure resident wears his/her hearing aid every day

Morning care

1. Place battery in hearing aid. (Battery should be replaced every 2-3 weeks)
2. Place hearing aid on the resident.
3. Turn on the hearing aid.
4. Turn up volume to a comfortable level for the resident.

Evening care

1. Remove hearing aid from resident before bedtime.
2. Open battery compartment.
3. Check ear mold for wax.



Troubleshooting hearing aid problems

Problem	Cause	Possible solution
Hearing aid has no sound or is weak	• Battery is upside down	– Make sure battery is inserted correctly
	• Battery is low or dead	– Replace battery
	• Hearing aid is not on	– Turn switch to *M* on the *M-T-O* or *M-S-O*
	• Clogged ear mold tube	– Clean with tools or call hearing aid professional
	• Volume turned down	– Turn on volume control
Instrument whistles	• Improper seating of hearing aid or mold in the ear	– Try reinserting the mold or hearing aid until it fits securely
	• Improper ear mold size	– Hearing aid professional should be called
Sound is distorted or intermittent	• Low battery	– Replace battery
	• Battery compartment not completely closed	– Gently close the battery compartment
Buzzing sound	• Low battery	– Replace battery

Suggestions for talking with the hard of hearing

1. Get the attention of the individual. Don't begin without establishing eye contact whenever possible.

2. Place yourself on the side of the bed away from the window in order to let the light shine on your face. Avoid backlighting as this will place your face in the shadows.

3. Take distance into consideration when talking to the resident or individual. Two to five feet seems to be the optimum distance for successful lip reading.

4. Talk naturally, but not too fast, without shouting or elaborately "mouthing" the words. Words spoken a bit more slowly, and not run together too rapidly, are clearer than those that are shouted or exaggerated.

5. Turn down the radio, TV and any other competing noise within the room.

6. Avoid using sentences that are too complex or run on too long. Slow down a little, pause between sentences, and wait to make sure that you have been understood before going on.

7. Emphasize the *key* word in the sentence, regardless of the less important words that come before and after it. Try to avoid speaking in monotone.

8. If, after repeating a word or phrase, the resident continues to have difficulty understanding you, try to find a different way of saying the same thing.

9. Keep your hands, medical chart or clipboard away from your face while talking.

10. Eating, chewing gum or smoking while talking will not only distort the sounds of your speech, but will interfere with visual contact.

11. If you are giving a specific instruction, such as time or place, be sure that it is repeated back to you. Many numbers and words sound alike.

12. Avoid "ah," "um," "well," "er" and coughs, as they are meaningless to the lip reader.

13. Remember that some words are physically invisible to the lip reader, such as "hair" or "egg."

14. Try to remember that abrupt changes of subject on your part can be very confusing.

15. Remember that lip reading is physically fatiguing. Take this into consideration when you have been talking for any length of time.

16. Recognize that nobody, especially the hard of hearing, hears as well and understand as well when tired or ill.

Communication

Gestures

Gestures may be the primary means a resident uses for communication. Gestures can also make it easier for the resident to understand what you are saying to them. Gestures should be encouraged when a resident is having difficulty with talking. Gestures are especially helpful when working with the hearing impaired, aphasic or cognitively impaired. Continue to speak words with gestures and use many facial expressions and body language.

A few common gestures to follow:



Good bye



Hello



Bathroom



Angry

Communication
Gestures (continued)



Sick



Tired



No



Walk



Thank you



Yes



Eat



Drink

Communication

Left CVA

Right side of the body will be affected (right hemiplegia)

1. Resident may be **aphasic**, meaning a *complete* breakdown in any or all methods of communication (expression and understanding).

2. Resident may be **dysphasic**, meaning a *partial* breakdown in any or all methods of communication.

3. Resident may be **anomic**, meaning unable to name objects even though their usage is understood.

4. Resident may **perseverate**, meaning repetition of words, phrases, sentences, or actions inappropriately.

5. Resident may have a **visual deficit**, which may be full or partial field blindness to the right side.

6. Resident may **speak in jargon**, meaning incoherent speech or gibberish, but it may be spoken clearly.

7. Resident may have **deficits** in writing, reading, speech, comprehension, and math.

8. Resident may use **"yes" and "no"** inappropriately.

9. Resident may not be able to **follow directions** or repeat words or actions when demonstrated.

Special communication strategies

Some tips for speaking with *aphasic residents* (left CVA)

1. Get resident's attention before starting to speak.

2. Speak slowly.

3. Watch resident as you speak to him/her.

4. Allow resident ample time to respond if you believe he/she can make a response, but don't let him/her struggle.

5. Don't use long, complex sentences. Break up long sentences into several short ones.

6. Use words that occur frequently in English usage and that are more familiar to resident.

7. Use gestures and facial expressions to accompany what you are saying.

8. Ask yes or no questions for quick response or if the only response a resident can give is yes or no.

9. Avoid requiring resident to communicate in large groups or noisy surroundings if he/she seems bothered by those situations.

10. Be aware that aphasic residents may not be able to attend to tasks for long periods of time.

11. Early during a conversation, provide the resident with a way to anticipate the content of a conversation.

12. Do *not* shout, however, it may be helpful to speak slightly louder than usual.

13. Don't talk to the resident as if he/she was a child.

14. Be aware that aphasic residents often perform poorly right after attempting a task that is difficult.

15. Provide a reassuring and encouraging atmosphere for the resident.

16. Repeat or rephrase a sentence when the resident does not understand the sentence the first time.

17. Get confirmation as to whether or not resident is understanding what you say.

18. Remember that aphasic residents generally attend and understand better when the topic of conversation interests them.

19. Be willing to "give up" when it is clear that the resident is not able to understand you and when you are both becoming frustrated.

20. Get advice from the Speech-Language Pathologist about how to most effectively communicate with the aphasic resident.

Communication

Right CVA

Left side of the body will be affected (left hemiplegia)

1. Resident may be highly distractible with an extremely short attention span.
2. Resident may be disoriented and think he/she is someplace else.
3. Resident may show poor judgment.
4. Resident may misuse objects (e.g., use a comb for a toothbrush).
5. Resident may talk incessantly, repeating the same ideas over and over again.
6. Resident may deny there is anything wrong with him/her.
7. Resident may start to do something then stop as if confused about what he/she is doing.
8. Resident may be confused about time and space concepts (i.e., may not know time of day or year).
9. Resident may have perceptual motor problems such as eye-hand coordination and/or balance problems (i.e., over-reach mouth when eating).
10. Resident may have a left visual field loss and may neglect the left side of his/her body.

Special communication strategies

Suggestions for communicating with *right CVA residents*

1. Have the resident verbalize how to complete a task. Take precautions when he/she performs this task as residents often do not have insight into their deficits.

2. Orient the resident several times daily as you go about your routine by reminding him/her of the day, date, time of day, where he/she is, what plans he/she has that day, etc.

3. These residents may be confused by demonstration. Utilize verbal cues if this is the case.

4. Simplify the environment so there is less to deal with visually (decrease visual distractions).

5. Decrease noise levels.

6. Break tasks into small steps and help the resident sequence these steps if necessary.

7. Provide verbal cues for sequencing tasks as necessary.

8. Provide good lighting.

9. Provide verbal and tactile reminders to the neglected side.

10. Instruct resident from his right, or non-impaired side.

11. Cue resident to wait for all necessary instructions before beginning a task. Cue resident to complete tasks as necessary.

12. Ask short, clear, concrete questions and re-ask or restate the question if the resident gives a vague response.

13. Gently remind resident of the sequence of events he/she is anticipating if he/she gets confused (i.e., resident states, “My daughter will be here in one half hour.” RNA’s response might be, “No, your daughter will be here after lunch. It is just breakfast now.”)

Communication

Motor speech disorders

Motor speech disorders in communication commonly include *dysarthria* and *apraxia*.

Dysarthria (slurred speech) occurs when the muscles used to speak are impaired neurologically, as from a stroke or Parkinson disease.

Apraxia describes residents whose oral muscles are OK, but when they try to use them to speak, the message from the brain does not get through. They may not be able to form the sounds of words at all or they may mispronounce words.

Special communication strategies

Suggestions for communicating with residents who have motor speech disorders

	Dysarthria	Apraxia
1. Encourage the resident to repeat what was said. Sometimes a second attempt is clearer than the first.	x	
2. Encourage the resident to speak slowly and as clearly as possible.	x	
3. Let the resident know when you do not understand.	x	
4. Ask the resident to speak one phrase at a time, in more severe cases, one word at a time.	x	
5. Ask the resident to spell words you can't understand.	x	
6. Ask the resident to write key words.	x	
7. Ask questions that can be answered with a "yes" or "no."	x	
8. Allow the resident plenty of time to speak.	x	x
9. Watch the resident's mouth and face for helpful clues.	x	x
10. Use a communication board with the resident.		x

Communication board

Communication boards are a helpful communication aid to be used with residents who cannot verbally express their needs. Communication boards are used by pointing at simple objects, pictures or words that are resident specific. The resident will point to the desired word or symbol to express functional needs.

At first, your resident may benefit more from actual pictures than printed words. It is less confusing if you limit the number of items on a page to the immediate or personal needs of the resident. You may also add printed words, including vocabulary specific to the resident and her/his situation.

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Module 3

Demonstrating Clinical Competency

CONTINUED

Standard/Objective

Dysphagia and eating

1. Verbalize/write three common diagnoses associated with dysphagia.
2. Identify the three stages of a normal swallow.
3. Verbalize/write five common swallowing problems.
4. Verbalize/write three aspiration precautions.
5. Demonstrate/verbalize/write three aids to facilitating a safe swallow.
6. Identify two liquid consistencies.
7. Demonstrate safe positioning for self-feeding.
8. Demonstrate use of adaptive devices to assist with self-feeding.
9. Identify two anatomical sites of the larynx.

Diagnoses associated with dysphagia

Cerebrovascular accident (CVA)

A stroke or brain attack occurs when a blood clot blocks a blood vessel or artery, or when a blood vessel breaks, interrupting blood flow to an area of the brain. (National Stroke Association definition)

Swallowing problems may result depending on the location and size of the stroke in the brain and can include:

1. Delayed/absent swallow response
2. Disrupted lingual and/or pharyngeal peristalsis
3. Reduced laryngeal closure and/or elevation
4. Cricopharyngeal muscle dysfunction
5. Aspiration before, during or after the swallow

Parkinson disease

Parkinson is a progressive neurological condition affecting movements such as walking, talking and writing. (Parkinson Disease Society definition)

Swallowing problems may include:

1. Delayed swallow response
2. Lingual dysfunction
3. Reduced pharyngeal peristalsis
4. Cricopharyngeal muscle dysfunction
5. Aspiration before, during or after the swallow

Multiple sclerosis (MS) and amyotrophic lateral sclerosis (ALS)

MS is thought to be an autoimmune disease that affects the central nervous system. (National Multiple Sclerosis Society definition)

ALS, often referred to as “Lou Gehrig’s disease,” is a progressive neurodegenerative disease that attacks nerve cells in the brain and spinal cord. (ALS Association definition)

Swallowing problems may include:

1. Problems in oral motor coordination and strength
2. Delayed swallow response
3. Aspiration before, during or after the swallow

Disciplines that are part of the *dysphagia team:*

1. Physician
2. Speech-Language Pathologist
3. Nurse
4. Dietitian
5. Occupational Therapist

Diagnoses associated with dysphagia (continued)

Alzheimer disease

Alzheimer disease is one of several disorders that cause the gradual loss of brain cells. (Alzheimer Association definition)

Swallowing problems may include:

- Decline in cognitive areas with decline in taste and smell but with functional or normal swallowing abilities.

Chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF)

Chronic obstructive pulmonary disease (COPD) includes emphysema and chronic bronchitis, diseases that are characterized by obstruction to air flow. (American Lung Association definition)

CHF is a common form of heart failure that results in retaining excessive fluid, often leading to swelling of the legs and ankles and congestion in the lungs. (American Heart Association definition)

Depending on the severity of the diseases, the eating experience may be altered by changes in taste and smell, physical capacity, breathing ability or other factors.

Cancer

Cancer develops when abnormal cells in a part of the body begin to grow out of control. (American Cancer Society definition)

Depending on the site, severity and treatments, the eating experience may be altered by changes in taste and smell, surgical removal of the larynx (laryngectomy) or other factors.

Changes in personal environment

Changes in taste, smell, physical limitations, taste preferences, ethnic identity, economic resources and/or dining location can all affect swallowing and eating ability with the geriatric resident.

Swallow function and the normal swallow

Swallow function

Oral preparatory/oral stage

The lips, tongue, teeth and cheeks work together to chew and break up food, mixing it with saliva to form a soft ball called a ***bolus*** that can be easily swallowed. With liquids, the tongue uses a great deal of control to form a cup shape around the liquid, holding it ready for swallowing.

Pharyngeal stage and the swallow reflex

When the tongue squeezes food or liquid to the back of the mouth it "triggers" the swallow reflex: the windpipe closes off so that whatever is being swallowed passes through the back of the throat and down to the stomach; the windpipe then opens up again, allowing you to breathe.

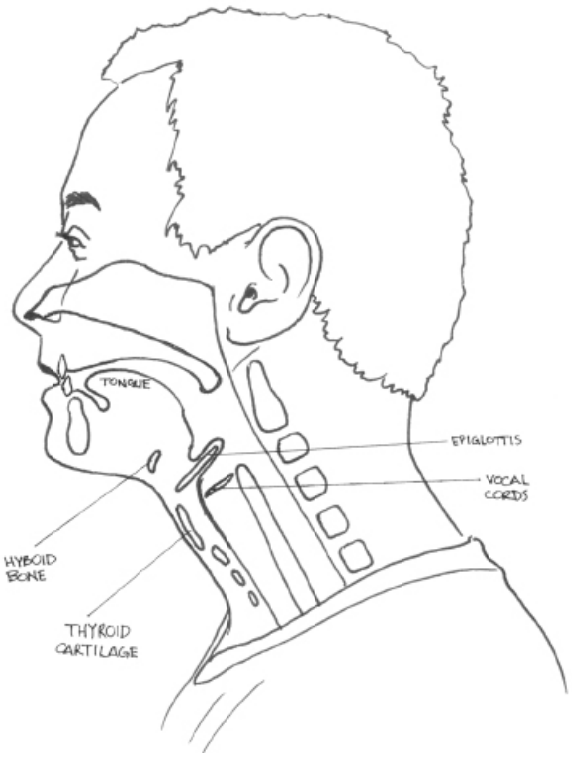
Esophageal stage

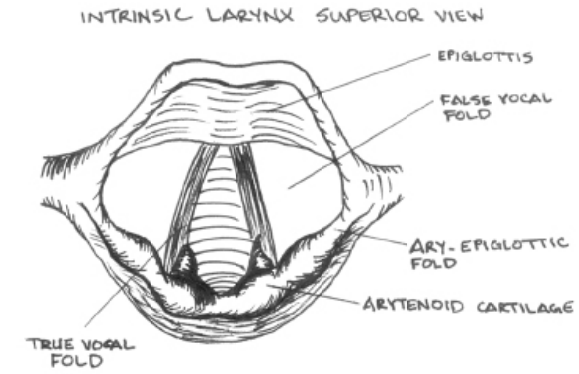
This is the movement of the food from the back of the throat down the tube into the stomach. Food is moved in a constant wave through continuous constricting and releasing of the tube walls called ***peristalsis***.

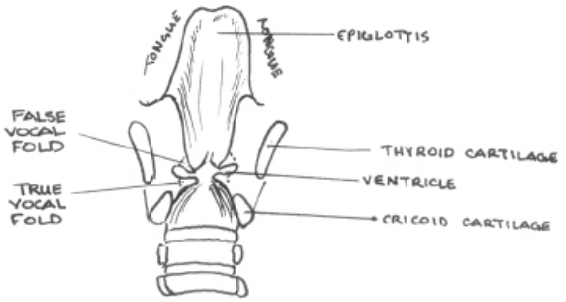
Normal swallow function

1. **Food passed from spoon to mouth:** Food must be cleared from the spoon by the lips.
2. **Food sent from front to back of mouth in a ball (bolus):** Tongue pulls food back for chewed molds into bolus for swallow.
3. **Bolus sent to back of mouth to faucial arch:** Bolus touches faucial arches signaling brain to close epiglottis; in effect, telling brain, "Hey, I'm ready to swallow."
4. **Epiglottis covers trachea:** Simultaneously, vocal cords close to protect lungs and velum pulls back to close nose to mouth.
5. **Food passes into esophagus:** Food is squeezed down toward the stomach.

Normal adult anatomy



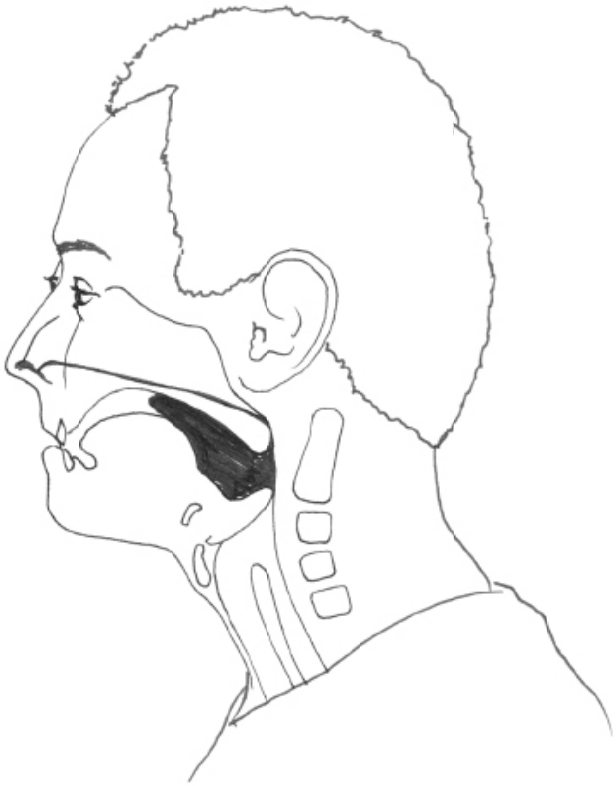




Stages of swallow



Stage 1:
Bolus in oral cavity.



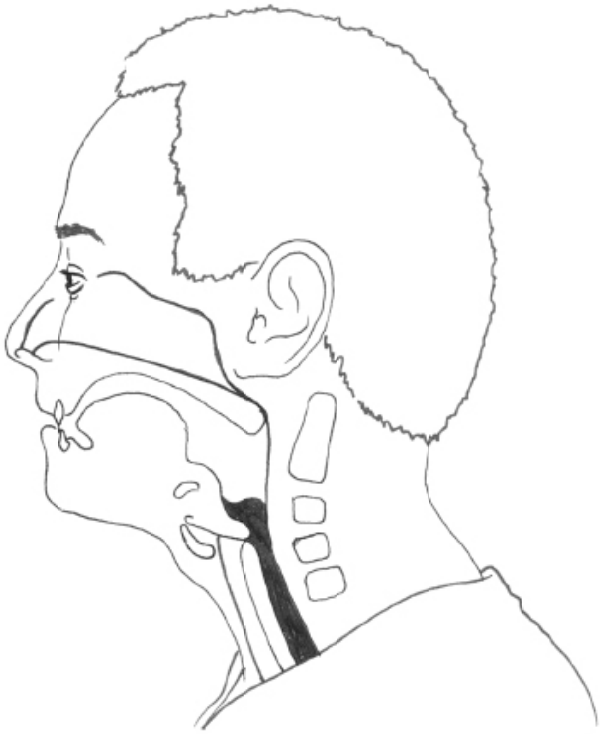
Stage 2:
Bolus conveyed into oropharynx.

Stage 3:
Bolus extends into the laryngopharynx.



Stages of swallow
(continued)

Stage 4:
Bolus penetrates opened pharyngoesophageal segment.





Stage 5:
Bolus nearly transversed the pharynx.



Stage 6:
Pharynx returned to referenced position.

Common problems with swallowing *you* may notice

1. Resident reports difficulty swallowing.
2. Resident is unaware of the food when it arrives.
3. Doing nothing with the food in the mouth — just holding it there.
4. Difficulty chewing food and/or being unable to move food to the back of the mouth.
5. Spitting food out.
6. Putting too much food into the mouth and/or eating too fast.
7. Talking with food in the mouth.
8. Forgetting to swallow.
9. Coughing/choking on food or liquids.
10. Complaining that food is “stuck” in the throat or not going down.
11. A “wet” or “gurgly” voice before or after swallowing.
12. Problems swallowing pills.
13. Food is left over in mouth, particularly between the cheeks and gums.
14. Congestion.
15. Decreased level of arousal.
16. Spiking temperature.
17. Facial drooping.
18. Drooling or difficulty controlling saliva.
19. Spilling food or liquid from the mouth.
20. Frequent throat clearing.
21. Inability to produce a strong cough.
22. Regurgitating food through the nose.
23. Weight loss.
24. Avoiding certain textures.
25. Watery or tearing eyes

Reminder: Any or all of these signs may indicate problems with swallowing or aspiration. In the case of silent aspirations, there may not be anything that you will be able to notice.

Conditions that may necessitate the placement of an NG tube

1. Poor nutritional intake (e.g., averages less than 40 per cent consumption of meals or sudden severe weight loss).
2. At risk for decubitis.
3. Altered mental status, which prohibits normal oral intake.

Swallow function
Eating and safety strategies

Techniques to help improve swallow
The following are some of the more common procedures and important positions that help improve swallow and decrease risk of aspiration and are most often included in the Speech-Language Pathologist's **Swallow Protocol**. See the comprehensive list of "Suggestions and aids to swallowing" in this section.

1. **Chin tuck:** Helps pooling in valleculae.
2. **Head turn:** Helps close off airway on weaker side.
3. **Alternate liquids with solids:** Clears residual in mouth or vallecullae.
4. **Clear oral residual with tongue and finger:** Decreases risk of choking from residual food in mouth.
5. **Use straw:** May help force airway closure; can be contraindicated with slow airway closure.
6. **Always remain upright at 90° angle:** Extremely important with any resident to reduce risk of choking; also helps if resident remains upright for 20 minutes after meals.

Food texture definitions
Special food "textures" (e.g., mechanical soft, puree), avoiding certain foods and/or preparing them differently can assist in assuring swallow safety.

Food textures are defined as:

1. Puree
- Applesauce or pudding
- Doesn't require chewing
- Requires less tongue control to form bolus

2. Ground
- Ground meat
- Requires less chewing and effort to form bolus

3. Mechanical soft
- Lasagna, soft chicken, fruit cocktail
- Requires fairly good chew and tongue control

4. Liquids
- Thick: nectar, honey, pudding consistency
- Thin: water, juice, soda



Foods that may present difficulty for someone with a swallowing problem include:

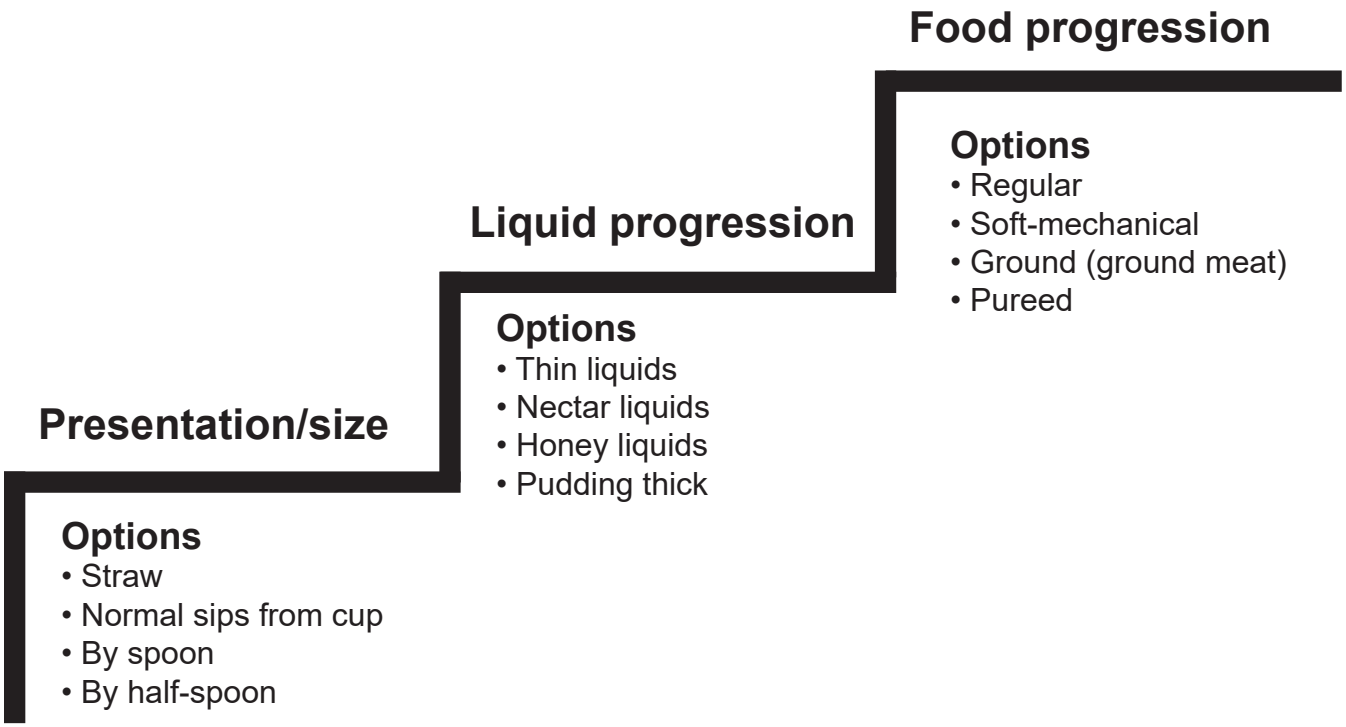
1. **Mixed textures:** Food in liquids such as minestrone soup or cornflakes and milk.
2. **Stringy textures:** Bacon, cabbage, green beans.
3. **Floppy textures:** Lettuce, cucumber.
4. **Small, hard textures:** Peanuts, peas, corn, beans.
5. **Thin liquids:** Water, broth, “clear” liquid drinks.

> **Note:** Fluids may not satisfy the resident’s appetite. Some alternatives to thin liquids include: Gelatin, sherbet, milk shakes, ice chips and Popsicles. Cold or slightly warm temperatures enhance swallowing.

6. **Foods with tough skins:** Fruits such as apples, grapes, peaches.

7. **Foods that fall apart in the mouth:** Seeds, nuts, flaky pastries, popcorn, potato chips, pretzels, rice.

8. **Dry, sticky foods:** Mashed potatoes, fresh white bread, bananas, peanut butter.



Suggestions and aids to swallowing

This is a comprehensive list. *Always work with your Speech-Language Pathologist to identify what resident-specific approaches are most safe and appropriate.*

1. Position upright with head tilted slightly forward.

2. Tilt head slightly forward (chin down) when swallowing.

3. Hold breath during swallow.

4. Take small bites of food, one bite at a time.

5. Take one bite, completely chew, and swallow before taking another bite.

6. Swallow twice after each bite to clear throat.

7. Clear throat frequently (“ahem”).

8. When drinking liquids, take one sip at a time and swallow after each sip.

9. When a swallow has been completed, the “Adam’s apple” moves up and returns to its normal position.

10. Place food on the affected side of the mouth.

11. Foods high in aroma, flavor and texture are most successful in stimulating the swallow reflex.

12. Liquids should be either ice cold or comfortably hot, not lukewarm or room temperature.

13. Dry foods are often difficult to swallow; moisten with butter, gravy, etc.

14. Provide frequent verbal instructions while eating.

15. Resident must give 100% attention to the task of swallowing and should not be engaged in conversation or asked questions while eating.

16. Reduce/eliminate environmental distractions; turn off TV, radio, close door, etc.

17. Follow any precaution signs noted in resident’s care plan or room.

18. Monitor amounts of liquids/foods taken, especially if resident is extremely impulsive.

19. Alternate liquids and solid foods.

20. Be aware of foods or liquids that may be remaining in the mouth during or after the meal.

21. Always let the resident remain in an upright position for 20 minutes or more after a meal.

22. Always remain calm and reassuring; do not rush feeding times.

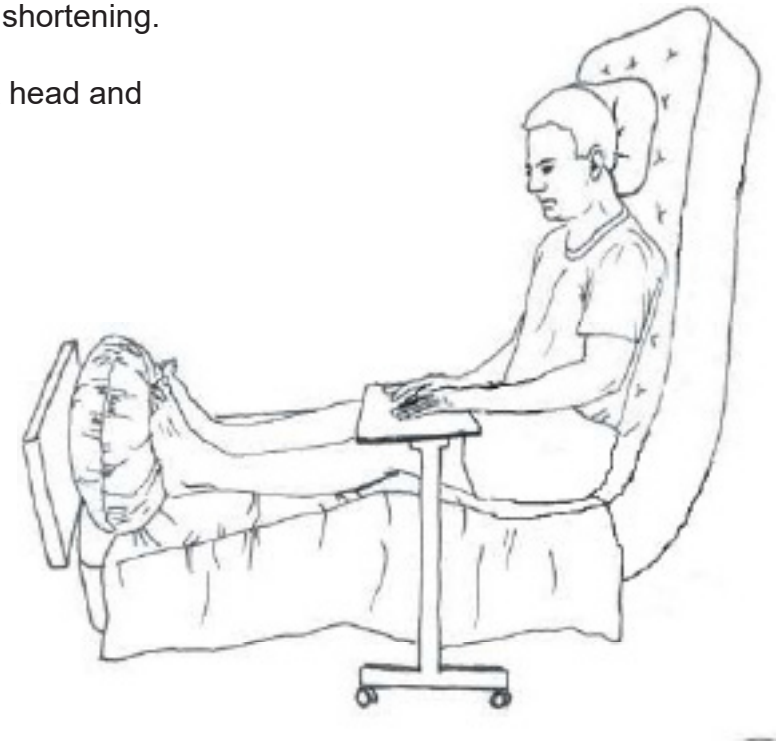
23. Management of impaired swallowing requires patience and discipline.

Proper positioning

Positioning for safe feeding by mouth in bed

Correct positioning for eating

1. Head of the bed at a 90º angle.
2. Knees slightly flexed to take pressure off lower back.
3. Hips flexed 90º.
4. Feet supported to prevent heelcord shortening.
5. Head and trunk at midline.
6. Head tilted slightly forward. Support head and neck with a bed pillow.
7. Table height at bent elbow level.



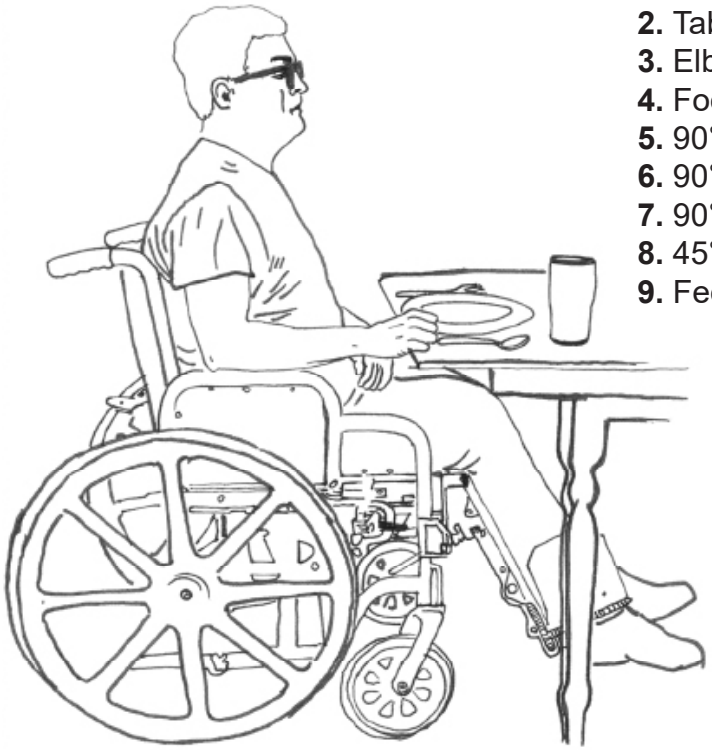
Tube feeders

1. Elevate head of bed 30º-45º in both supine and side lying.
2. Support head and neck.

Incorrect position for eating

1. Resident reclined.
2. Knees not flexed.
3. No neck flexion.
4. Improper bed table height.

Proper positioning (continued)
Sitting in chair or wheelchair



Correct position for eating
1. Shoulders back
2. Table height at waist
3. Elbows supported on chair or table surface
4. Food is within 12-inch reach
5. 90° hip flexion
6. 90° at knees
7. 90° at ankles
8. 45° neck flexion
9. Feet supported on the floor or on foot pedals

Special cushions may need to be added to the seat and back of the wheelchair.

Incorrect position for eating
1. Rounded shoulders
2. Head strained forward
3. Table height too high
4. Elbows unsupported
5. Posterior tilt at hips – angle greater than 90°, sliding out of chair
6. Feet unsupported and dangling

Resident in geri-chair

Correct position for eating
1. Chair upright
2. Food is within 12-inch reach
3. 90° hip flexion
4. 90° knee flexion with feet supported
5. Lap tray at the proper height

Incorrect position for eating
1. Resident reclined
2. Knees not flexed
3. No neck flexion
4. Improper table height
5. Inability to reach food easily

Adaptive equipment for feeding

A variety of different kinds of special or adaptive equipment may be used by the resident to allow him/her to perform self-feeding independently. On the following pages there are examples of different pieces of equipment that may be recommended. The resident's care plan will indicate which kind of equipment the resident will use.

Hints for feeding and use of equipment

1. Explain use of equipment to the resident
2. Consistently place utensil in the same position on tray
3. Resident should use the utensil for at least part of every meal
4. Position resident properly:
  – Not slouched to one side
  – Utensils should be near functioning extremity
  – Tray at appropriate level for easy reach
  – If the resident is in bed, he/she should be seated in a comfortable upright position
5. Be generous with verbal cueing and praise

Indications of need for adaptive feeding equipment

1. Resident spills food or liquid from utensils or cup
2. Resident has trouble holding onto utensil while eating
3. Resident drops utensils or finger foods
4. Resident has difficulty with any one of the feeding steps: scooping, bringing the utensil from the plate to their mouth, drinking
5. Resident expresses frustration during self-feeding

Types of adaptive feeding equipment

1. Utensils: Built-up handles, rocker knives, angled, weighted, swivel, extension, universal cuff
2. Plates: Lip, high-sided with cut out, scoop, partitioned, guards, dycem
3. Cups: Sippie (nosey), two handled, T-handled, glass holders, wheelchair cup holders

Adaptive feeding devices

Device	Function
Dycem Blue, rubbery material	• Provides a non-slip surface • Stabilizes objects for one-hand use
Long straw	• Substitutes for limited range of neck, poor trunk balance, or use of arms/hands
Plate guard	• Prevents food from moving around plate • Aids in food placement on utensils
Partitioned dish	• Allows food to be scooped and kept in divided location
Built-up handle	• Allows for a functional grasp when muscles are weak or joints are contracted
Rocker knife	• Cutting food one-handed • Use rocking motion from center of plate towards outside of plate
Horizontal and vertical handle utensils	• Compensate for loss of wrist and arm movement
Swivel utensil	• Substitutes for lack of rotation of forearm • Allows one to put food on utensil without turning wrist over
Weighted utensil	• May decrease tremorous movement while eating • Ideal for Parkinson residents, and those residents with spasticity and limited hand control since they're easy to grasp
Universal cuff	• Substitutes for poor or absent grip of the hand • Utensils can be interchanged by resident
Feeding cup with long spout	• Facilitates cup-to-mouth placement
T-handle mugs	• Compensates for decreased grip strength
Nosey cups	• Allows safe swallowing with head tipped back • Use with chin tuck

Self feeding

Humans put their fingers in their mouths and suck their thumbs long before birth. Hand-to-mouth movement is instinctive and self-feeding is a skill learned early in life.

Loss of this skill is a devastating blow to self-reliance, so restorative therapy is critical. However, many facilities lack effective programs to re-stimulate this all-important self-feeding capacity among elderly residents.

It cannot be over-emphasized that even limited independent feeding capacity is one of the most important jobs caregivers can perform for elderly people. Because it involves basic physical nourishment, it can even mean life or death.

Example

Mrs. H. stopped feeding herself at lunch. She could not say why. She pushed her food away and even stopped talking with her friends at the table. Nursing aides somewhat aggressively attempted to feed her, but this only made the problem worse.

She was referred to a Restorative Dining Program. Soon, in a quiet and gentle atmosphere and with the skillful touch of a trained Restorative Nurse, Mrs. H. was finally able to communicate that she was becoming very nauseated around midday. Investigation revealed that her medications had been changed to a later hour.

After consultation among all staff, Mrs. H's routine was changed. She returned to her table and happily resumed feeding herself.

Components

1. Physical

- The means by which we feed ourselves.
  - Using only fingers
  - Using utensils
  - Using adaptive equipment
- The positions, area or conditions in which it is most satisfying to consume a meal
  - A well-lighted room or a room with limited light
  - A special friend to eat with
  - The types and presentation of food we most enjoy

2. Social

Interaction with others during a meal: conversation, relationships and celebratory factors. Human societies have historically used food consumption to celebrate holidays, victories, harvests, births and weddings. Every nursing home resident shares such memories.

3. Emotional

The good feelings generated by feeding oneself, including the stimulation of endorphins in the brain, which promote relaxation and self-satisfaction. Rebuilding the ability to nourish, care for and calm oneself is an important reason to help residents recover a skill they enjoyed throughout their lives.

Environmental and social considerations

General considerations in setting up a Restorative Dining Program include:

1. Quiet location.
2. Good lighting without glare.
3. Comfortable temperature.
4. Table color or tablecloth to contrast with tray to make tray stand out from background.
5. Consider attitudes and personalities of residents when arranging seat assignment.
6. Traditionally, mealtime is a social event including conversation, laughter, tasteful food, satisfaction of appetite and enhancement of self-esteem/self-worth.
7. Use regular chairs whenever possible.
8. Use volunteers or staff members to visit with residents during mealtime, especially the residents who require only verbal cueing during mealtimes.

Module 3

Demonstrating Clinical Competency

CONTINUED

Standard/Objective

Joint mobility

1. Identify three purposes for the RNA to perform range of motion.
2. Verbalize and demonstrate passive and active/assisted range of motion for four joints.
3. Identify two contraindications for passive range of motion exercise.
4. Identify three reasons for the RNA to assist in a routine exercise/maintenance program.
5. Verbalize two indications and two contraindications for performance of routine exercise.
6. Identify/verbalize the major muscle groups.
7. Demonstrate one resistive exercise for the upper extremity and one for the lower extremity.
8. Demonstrate method to reduce edema.
9. Demonstrate correct application of a splint.

Joint mobility
Range of motion

Purpose:
1. To maintain or increase the motion of a joint.
2. To prevent contractures or reduce current contractures.
3. To maintain or increase strength.
4. To increase the functional use of the extremity.



General considerations:
1. The resident should be comfortable and relaxed.
2. Explain to the resident what you are doing and why.
3. Only give as much assistance as the resident needs.
4. Hold the body part securely, but gently.
5. Grasp above and below the joint, not directly on the joint.
6. Begin ROM at large joints close to the body and work outward to the smaller, finer joints
7. With painful joints:
- – Watch resident's face for indications of pain.
- – Remain in a pain-free range.
- – Release slowly and carefully.

8. Pre-medicate resident for pain as needed prior to RNP activity.

Contraindications to PROM:
1. Extreme pain upon movement.
2. Bony blockage, fusion or severe crepitus in the joint upon movement.
3. Recent fracture, joint inflammation.
4. Any contraindications noted by MD, Therapist or Nurse in resident's chart.

Terms and definitions:
1. **Range of Motion (ROM)** is the extent of movement within a given joint; each joint has a normal range.
2. **Functional range** is less than normal, however, functional range allows the joint to perform activities of daily living. (Remember that "normal" varies from person to person, especially when dealing with the geriatric population.) If the resident has an obvious affected side, as with a hemiplegic, range the unaffected side first to find out what normal is for that resident.
3. **Passive range of motion (PROM)** consists of exercises done completely by RNA for the resident.
4. **Active/assistive range of motion (AAROM)** consists of exercises done partially by the resident and partially by the RNA.
5. **Active range of motion (AROM)** consists of exercises performed solely by the resident.
6. **Resistive exercise** is active exercise with resistive force applied to make the motion more difficult (with use of weights or equipment.)
7. **Functional exercise** is self-care activity by the resident during bathing, dressing or ADLs.
8. **Self ROM** when the resident uses one arm to assist the other arm with ROM.

Exercise

General rules to keep in mind

1. Active exercises are generally safe for most residents, provided all precautions are observed.

2. All Range of Motion exercises by the RNA should be given only if ordered by the Physician, RN, Physical Therapist or Occupational Therapist.

3. Avoid passive exercises in a *newly* fractured limb unless given specific instructions by the Therapist or Physician.

4. Specific resistive exercises should be given by the RNA only if ordered by the Physician, RN, Physical Therapist or Occupational Therapist.

5. RNAs should never progress a resident in an exercise program without instructions to do so from the Physician, RN, Physical Therapist or Occupational Therapist.

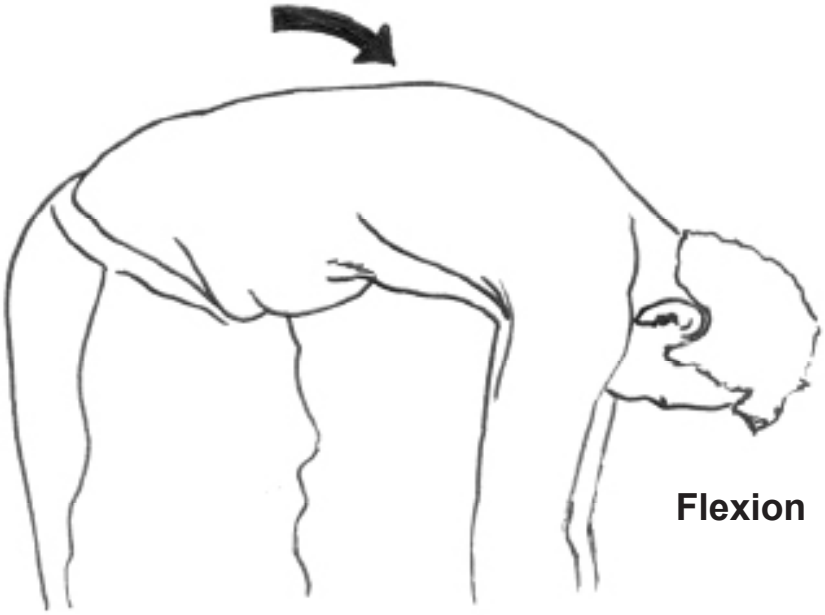
6. Never start an exercise treatment on a resident without full knowledge of the resident's medical history, immediate medical problem, purpose of the exercises and knowledge of your skills and limitations as an RNA.

The basic rules of *body mechanics*

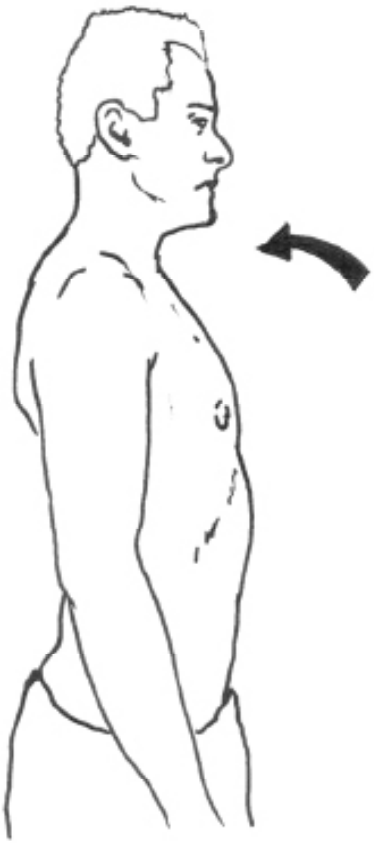
1. Assess the situation before taking action
2. Get close to the object to be moved
3. Bend knees and lift with legs
4. Use a wide base of support
5. Push – *don't* pull
6. Turn – *don't* twist



Motions of the body trunk



Flexion



Extension



Hyperextension

Motions of the body trunk (continued)

Lateral flexion

Bending sideways from the waist



Left lateral flexion

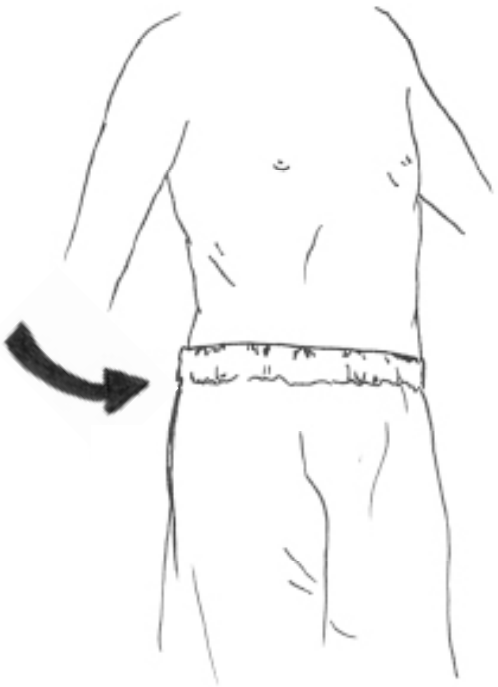


Right lateral flexion

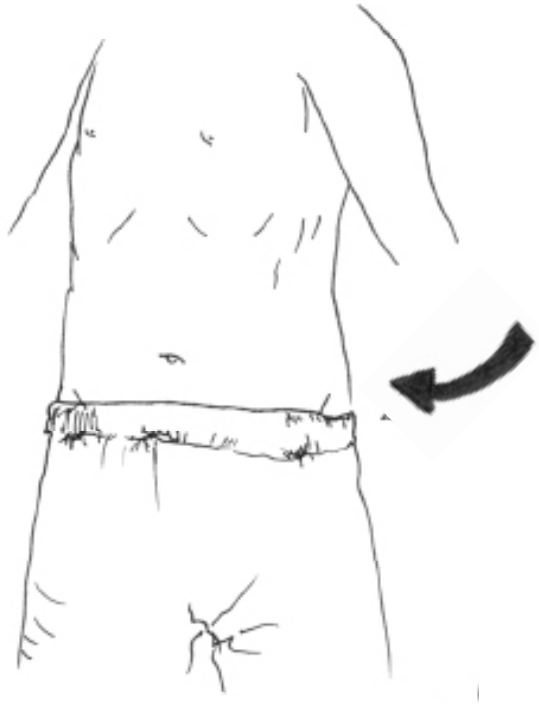
Motions of the body trunk (continued)

Rotation

Turning shoulders while keeping hips stationary
or turning hips while keeping shoulder stationary



Left rotation

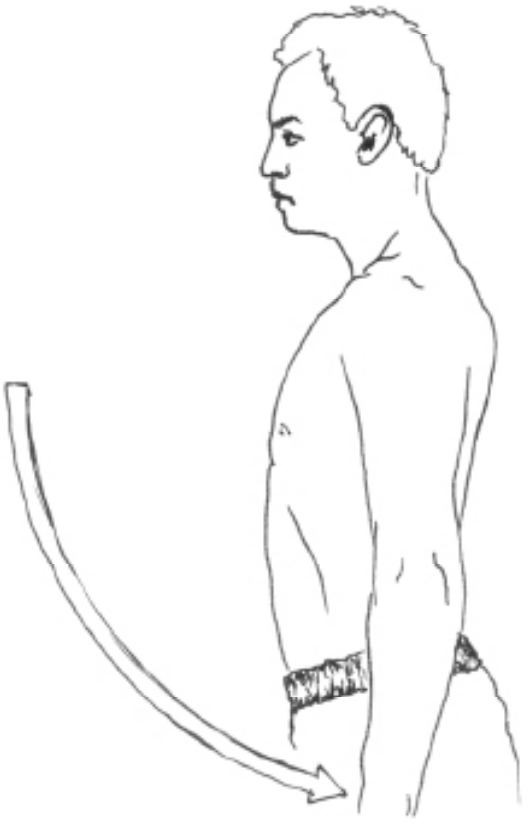


Right rotation

Motions of the shoulder

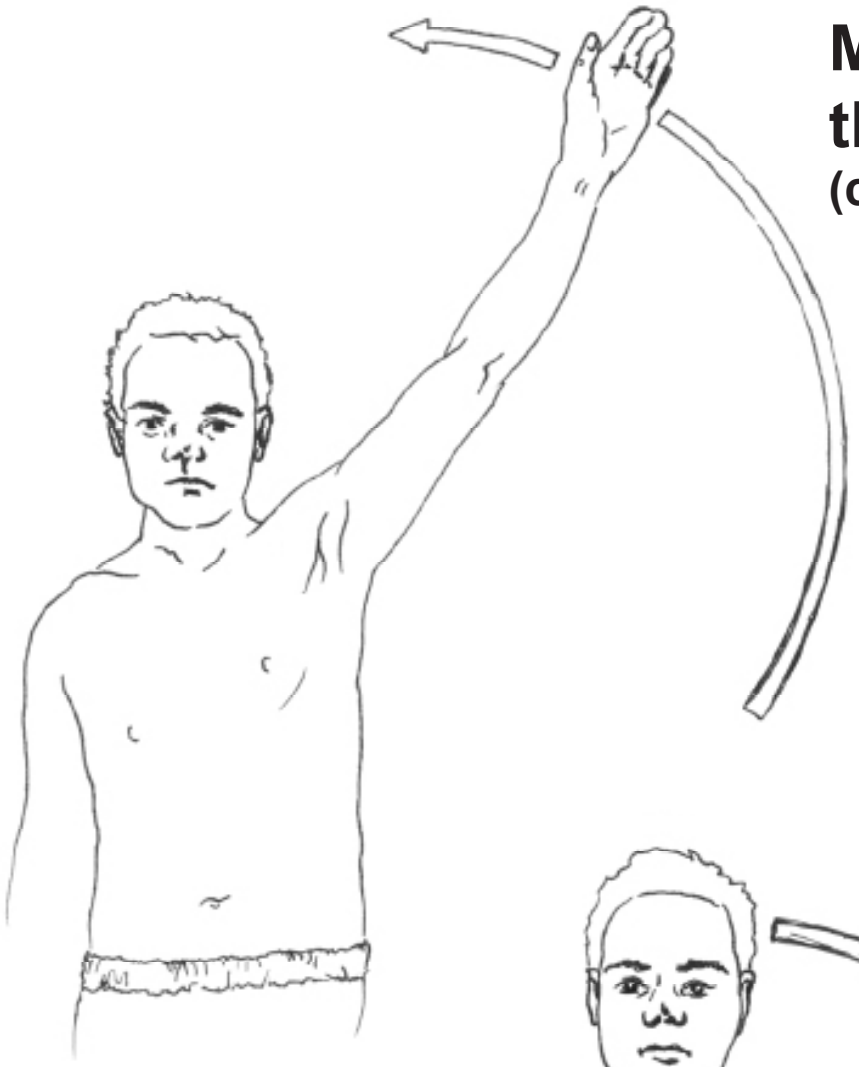


Forward flexion

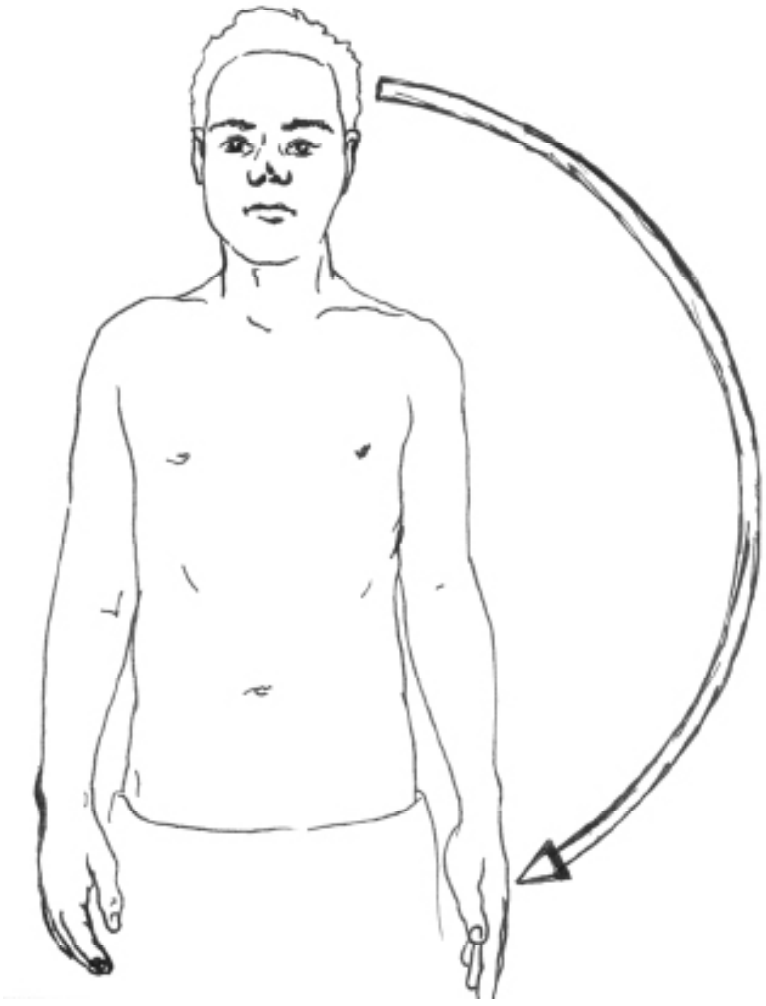


Extension

Motions of the shoulder
(continued)

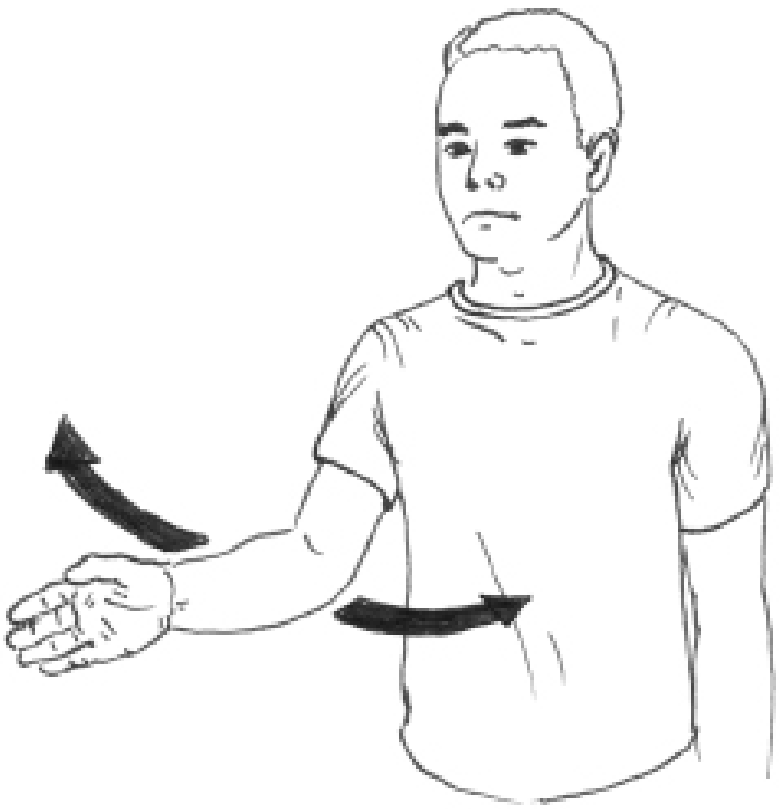


Abduction



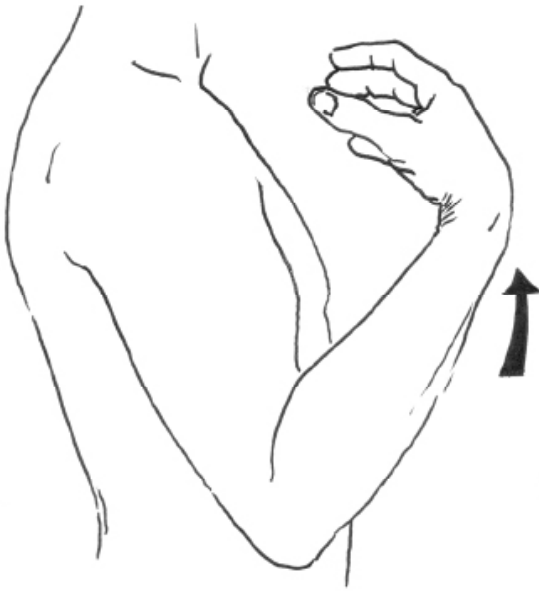
Adduction

Motions of the shoulder (continued)

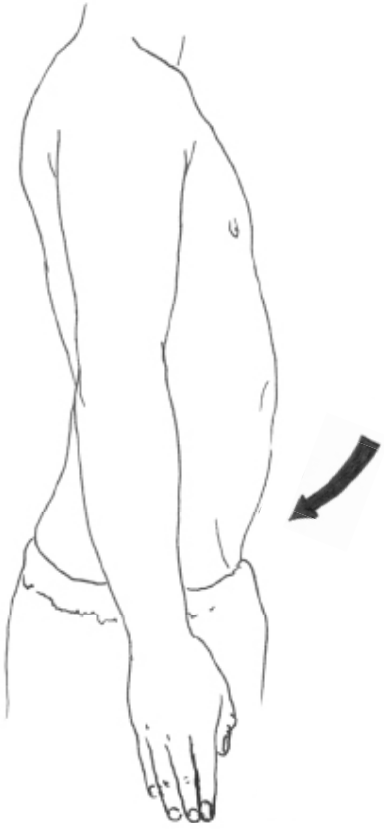


External/internal rotation

Motions of the elbow



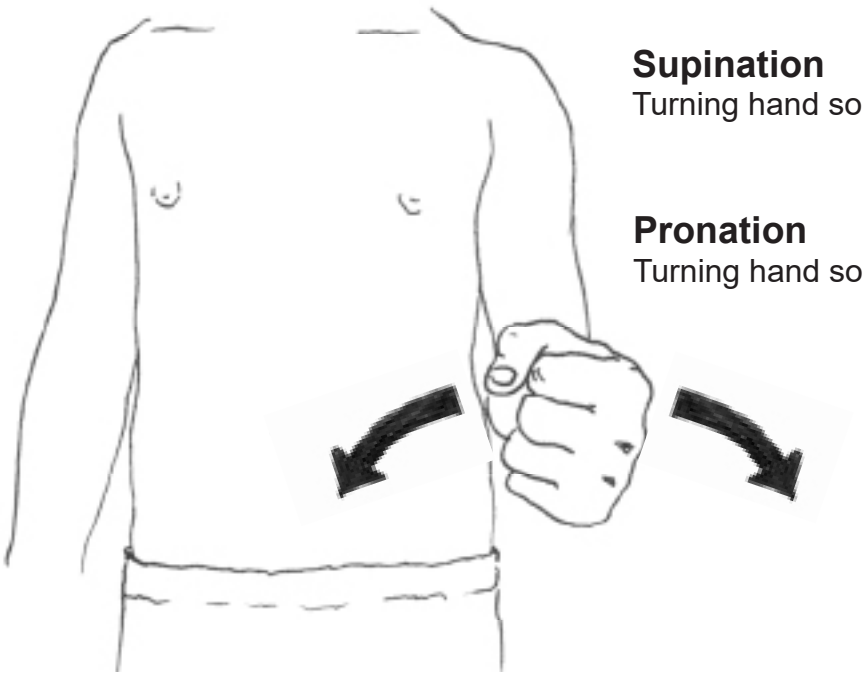
Flexion



Extension

Motions of the forearm

With the resident's elbow bent at 90º at waist height, grasp resident's wrist and hand with both hands



Supination
Turning hand so that palm is facing up

Pronation
Turning hand so that palm is facing down

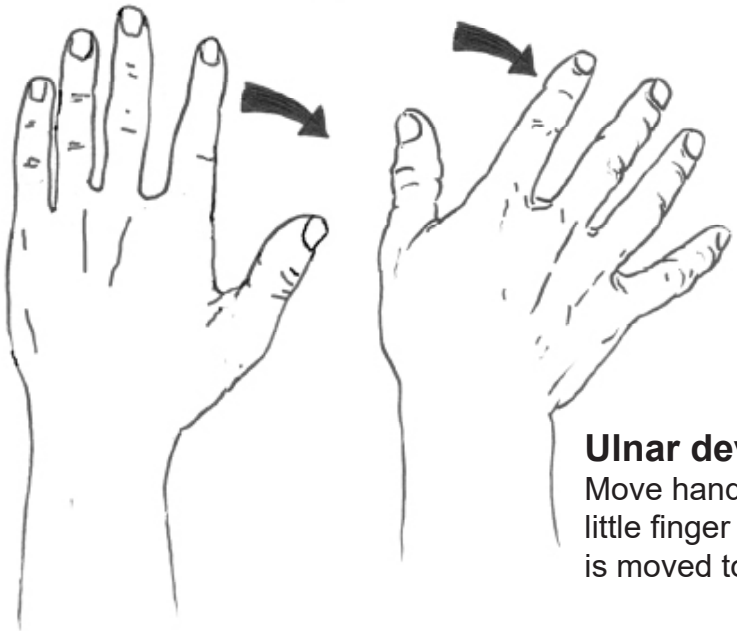
Motions of the wrist



Flexion
Bending wrist so that palm is toward forearm



Extension
Bending wrist so that back of wrist is toward forearm



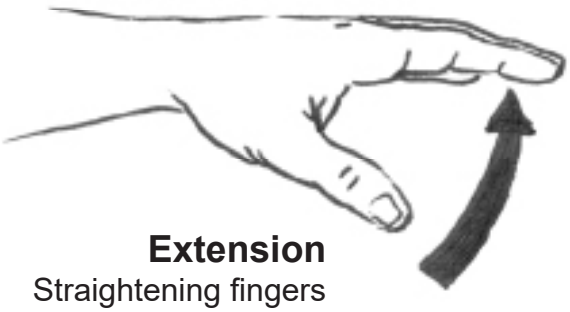
Radial deviation
Move hand sideways so that thumb side of hand is moved toward forearm

Ulnar deviation
Move hand sideways so that little finger side of hand is moved toward forearm

Motions of the fingers



Flexion
Bending the fingers toward the palm, making a fist



Extension
Straightening fingers

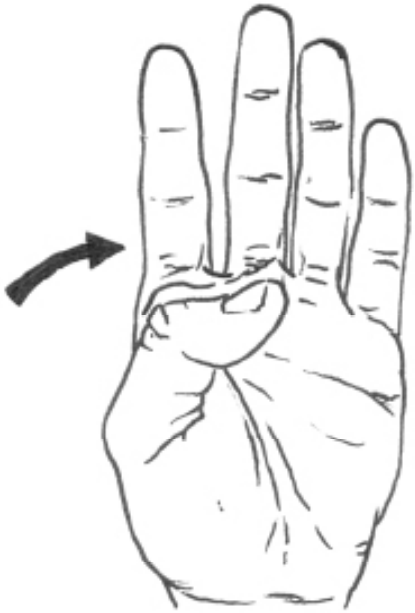


Abduction
Moving fingers apart, spreading fingers



Adduction
Moving fingers together

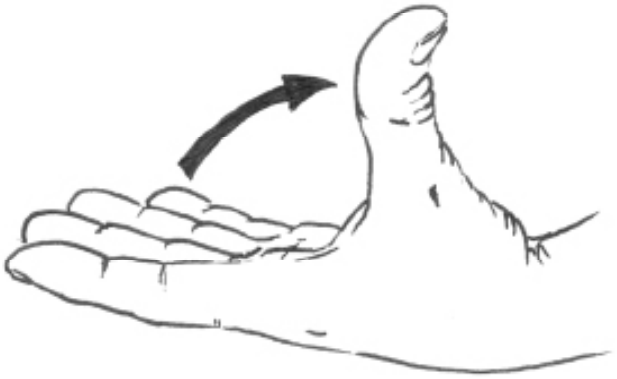
Motions of the thumb



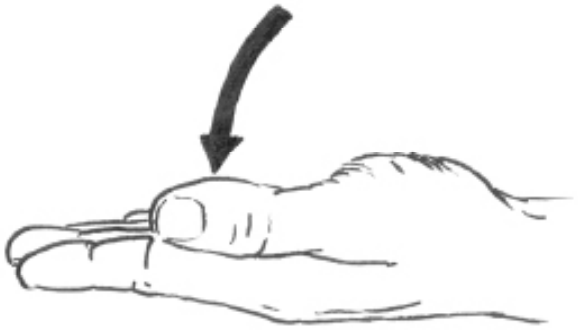
Flexion
Bending thumb at all joints



Extension
Straightening thumb

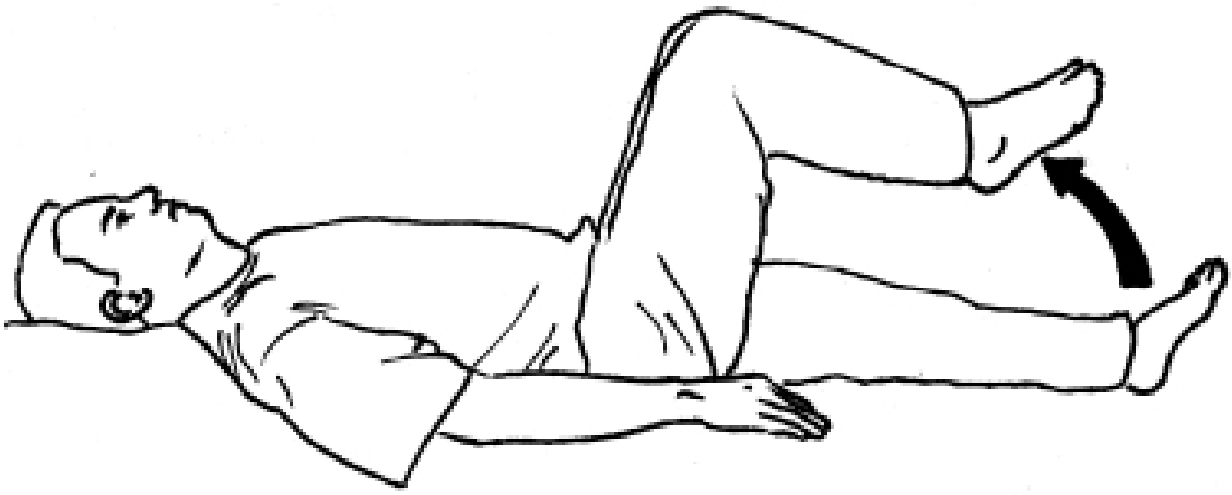


Abduction
Palm up, moving thumb up and away from palm.

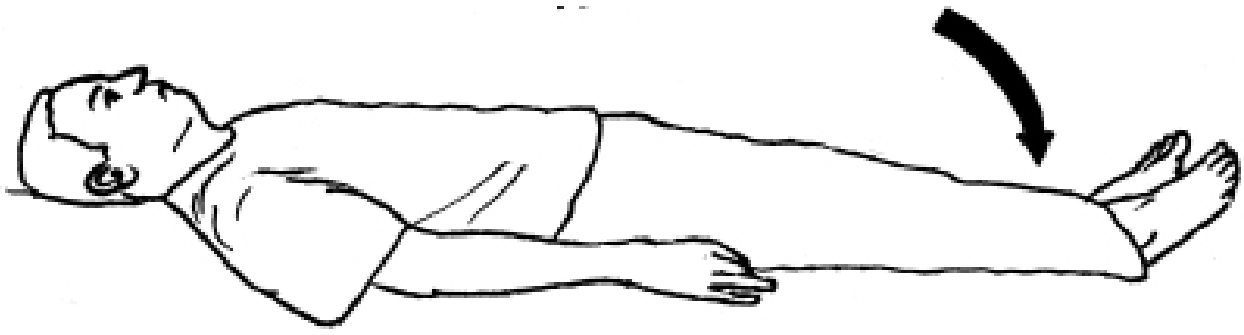


Adduction
Returning thumb to position alongside of first finger.

Motions of the hip and knee



Flexion

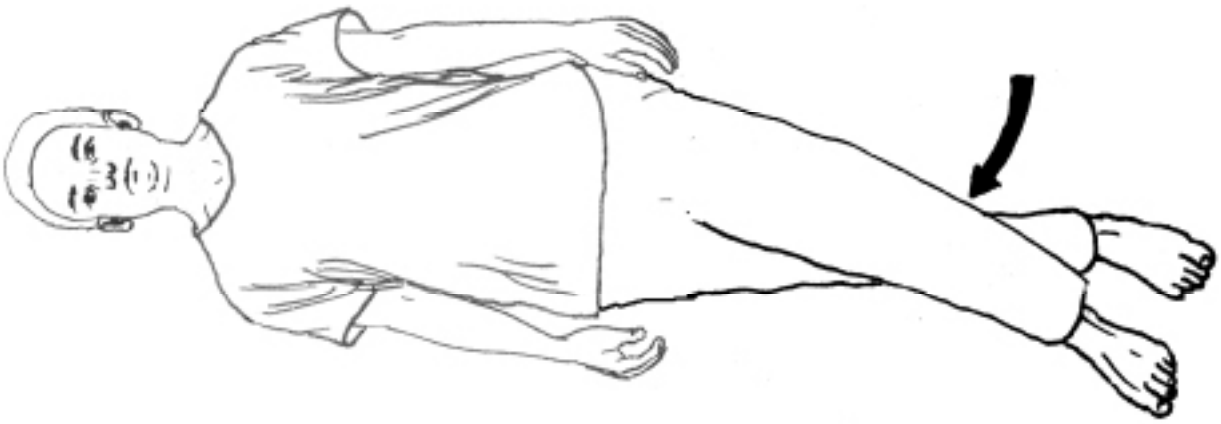


Extension

Motions of the hip

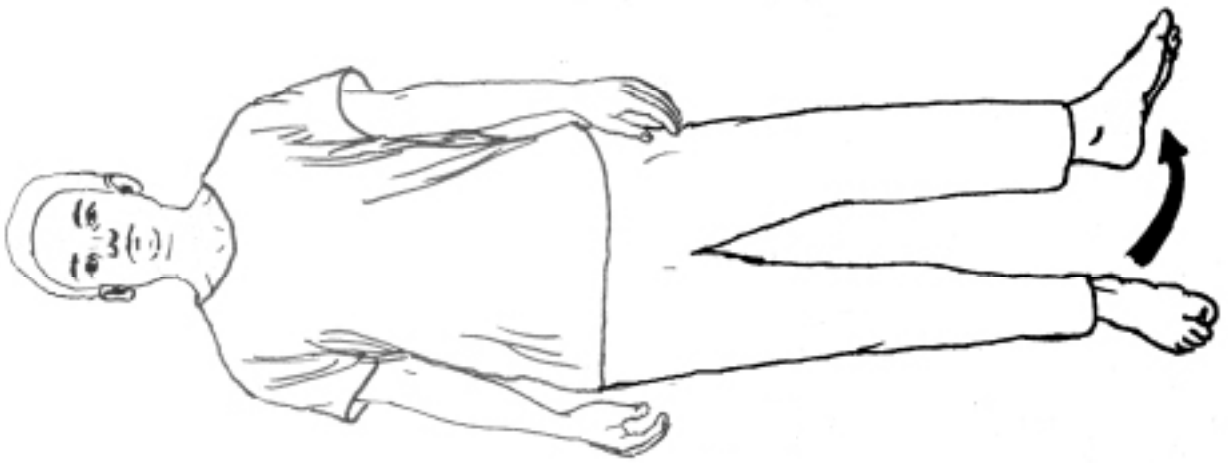


Abduction



Adduction

Motions of the hip (continued)

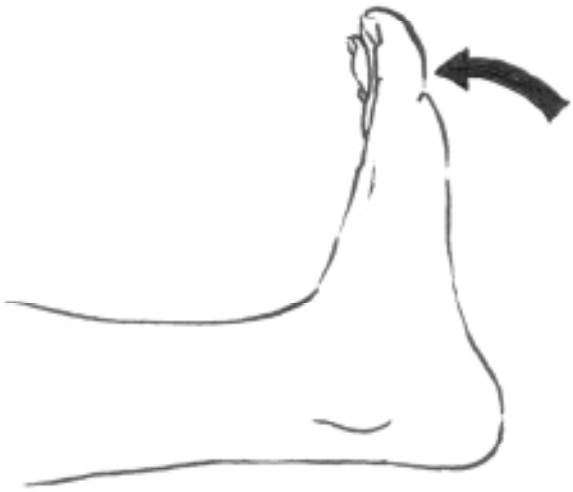


External rotation

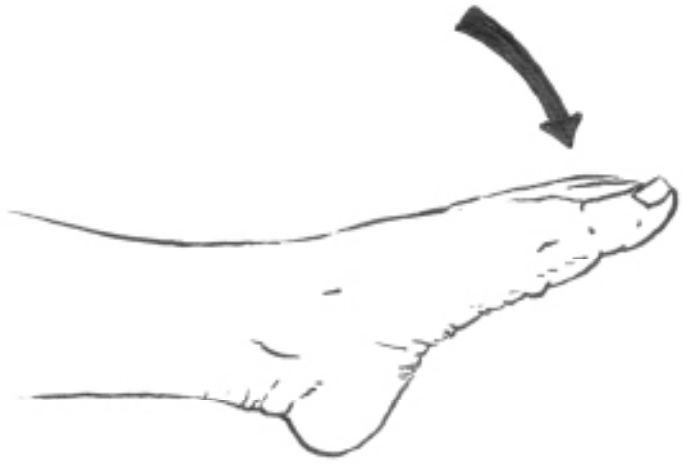


Internal rotation

Motions of the ankle



Dorsal flexion



Plantar flexion



Eversion



Inversion

Assisted exercise

Specific objectives

1. Maintain or improve ROM
2. Decrease pain
3. Maintain/improve strength
4. Improve balance, gait and transfers
5. Improve automatic functional independence and mobility
6. Promote independence, well-being and quality of life

Examples of functional vs. limited strength and activity tolerance

Gait
1. Functional: Ambulation bed to bathroom with supervision
2. Limited: Moderately assisted ambulation 10-foot hallway rail

Range of motion
1. Functional: Able to comb hair
2. Limited: Requires assistance to put arms in sleeves

Strength
1. Functional: Able to perform sit/stand without assistance
2. Limited: Minimal to moderate assistance for sit to stand

Activity tolerance
1. Functional: Five hours sustained OOB
2. Limited: One hour OOB with fatigue

Indications/contraindications for routine exercise/maintenance program

Positive

1. Increased skeletal muscle strength/ROM
2. Increased aerobic capacity
3. Bone density preservation
4. Contributes to mobility and independence
5. Can restore lost physiologic capacity
6. Can reduce risk of CVA, heart problems/disease
7. Appetite stimulation
8. Fall prevention

Negative

1. Heart signs
  – Marked SOB
  – Profuse sweating/pale skin
  – Chest pain
2. Sharp/intense joint pain, sudden onset
3. Change in speech pattern
4. Acute deep vein thrombosis (DVT)

Splinting

Some residents have hand deformities that may require splinting. Splints help protect the skin from breaking down and deformities or contractures from becoming worse. The Therapist can assist in determining if a resident would benefit from splinting or other types of supportive care such as strengthening or positioning.

Indications for splinting

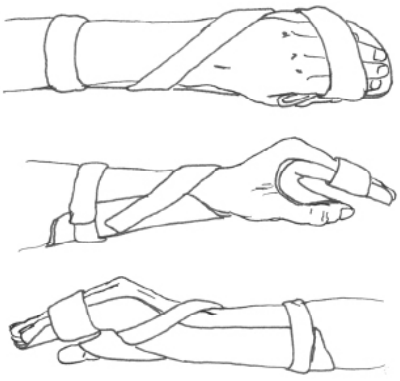
1. The hands have a bad odor.
2. The resident cries or pulls his/her hands away when you try to wash them.
3. Hands are swollen.
4. The resident holds his/her hands with the fingers curled or the wrist bent most of the time.
5. The resident is suddenly unable to lift his/her wrist.
6. The fingers seem stiff or painful when you move them.
7. The resident begins to have problems holding his cup or eating utensils.
8. The bones seem to be lined up in an unusual position.
9. Protect weak muscles and prevent stretching or contractures.

Contraindication for splinting

• Pre-existing draining wound

THOUGHT

Splint application can provide the same therapeutic benefit as medication ordered by the Physician.



Hand care program

Role of Nursing

1. Notify the Occupational Therapist of developing hand problems.
2. Be aware that hand soaks, ranging and splint application are prescribed by the Physician and require orders.
3. Reinforce hand care and splint use with staff.
4. Assess skin care per splint program, notify OT of any problems.

Role of CNA

1. Clean and dry each of resident's hands thoroughly during a.m. and p.m. care. Assure nails are neatly trimmed.
2. Soak hands, range hands and apply splints as directed by splint program when RNA is not available. Remove splints as per program.
3. Notify the OT of hand problems.
4. Notify the OT of problems with splint program and/or repair needs.
5. Keep splints clean as directed by splint program.
6. Do not change splint program without discussing with the OT. All changes need to be documented.

Role of RNA

1. Apply and remove splints as per program.
2. Soak hands, range hands and apply splints as directed by splint program.
3. Assist with instruction for on-call or registry CNAs when they work.
4. Replace straps. Refer repairs to the OT.
5. Notify the OT of problems with splints/programs.
6. Notify the OT of residents with developing hand problems.
7. Look at the skin under the splint for signs or symptoms of redness, swelling (edema), discoloration, etc., reporting all positive findings to Nursing or the OT.

THOUGHT

Involve resident in facility nail-grooming program.

Application of the splint

Before and after

1. Check skin for swelling, skin discoloration or skin irritation.
2. Check to ensure skin surface is clean and dry.
3. Perform ROM or movements to decrease tone to all joints of the extremity (remember that one joint affects the other joints in that arm or leg).
4. Soaking may be indicated for painful and/or stiff joints prior to splint application.
5. Check splint to determine if it needs to be washed.

Applying splint

1. Inform resident you are going to apply splint.
2. Apply and smooth stockinette (a thin cotton material that may be worn under a splint like a glove or sock to absorb perspiration or protect fragile skin) so there are no wrinkles between splint surface and skin.
3. Fit splint over joints.
4. Fasten straps, ensuring that you can slip two fingers between skin and strap.
5. Position so that splinted area is supported.

Care and storage of splint

Wash splint in warm to cold soapy water every other day. If splint is soiled or smells, it will need to be washed each time it is removed (e.g., urine may get on a knee splint).

1. If resident has an infection, check with Nursing for specific instructions.
2. Always store splint in a designated area so the next person who needs to use it can easily locate it.
3. Never lay splint in sunshine or on heater, as higher temperatures will melt the material.
4. Straps will need to be replaced periodically because the pile will not stick to the Velcro. Always replace straps using same length and location as old strap.
5. Wash weekly and replace when it loses its shape.

Areas of high risk for pressure and discomfort with splints

Splint parts

The following parts of a splint may be sources for pressure and/or skin discomfort:

1. Ends of splint
2. Under straps
3. Edges of splint
4. Bony prominences
5. Creases in and around joints

Body parts

The following body parts or areas may demonstrate pressure and/or skin discomfort from splints:

Hand/wrist

1. Finger tips
2. Top of knuckles of fingers and thumb
3. Thumb web space
4. Palm of hand
5. Both sides of wrist (head of ulna and base of thenar eminence)

Elbow – Bony prominence of elbow (medial and lateral epicondyle)

Knee

1. Patella (knee cap)
2. Bony prominences of the sides of knee (lateral condyle)

Leg – Tibia (shin)

Foot

1. Heel
2. Ankle bones (both sides)
3. Under ball of foot
4. Under toe tips
5. Head of fifth toe (midway on outside of foot)
6. Navicular tuberosity (midway on inside of foot)

Parts of a splint

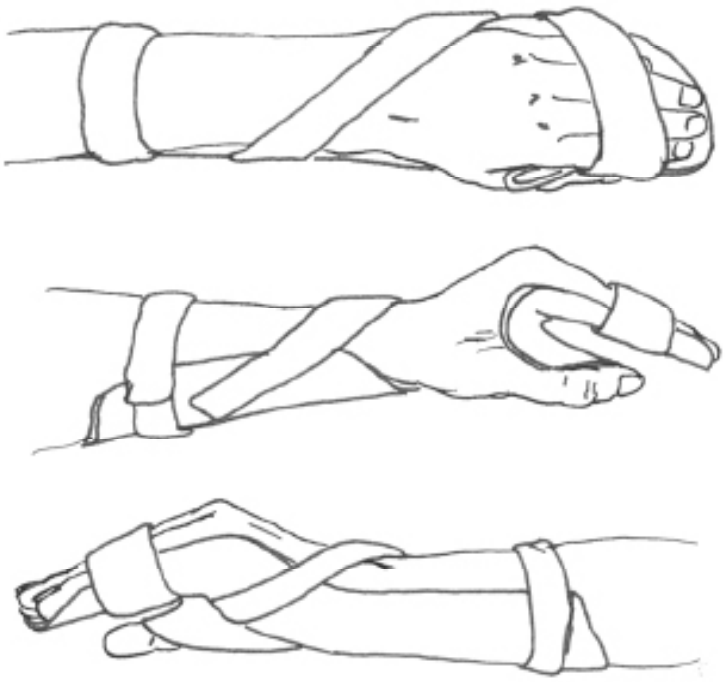
Body of a splint
Some splints have top and bottom parts that surround the joint (example: elbow and knee splints).

Straps
“Hook Velcro” on body of splint. “Pile strap” that attaches to “hook Velcro.”

Stockinette
Applied under splint to absorb perspiration.

D-rings
The ring that a “pile strap” is threaded through and doubled back on itself to fasten to the “hook Velcro.”

Proper splint fit
1. Splint should look as if it was molded to skin surface.
2. Should not dig into skin.
3. Should not move around on skin surface (i.e., loss of weight can result in misfit).
4. Straps properly fastened.
5. Two of your fingers should fit snugly between the strap and the skin.



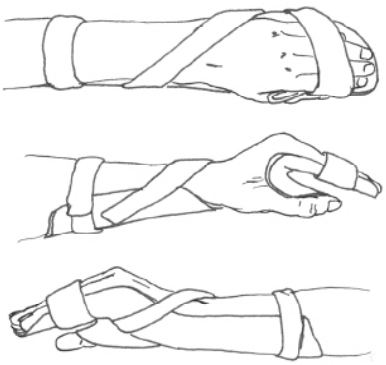
Sample Splint Schedule

NAME:_____ ROOM:_____

DATE:_____

Application:

1. Apply to clean, dry hand.
2. Soak hand as needed for painful and/or stiff joints.
3. Range hand, arm and wrist before and after applying.
4. Powder will help control perspiration.
5. Straps should be snug but not tight enough to cause red marks or swelling; be able to run one finger underneath strap.



Handsplint

Purpose:

• Prevent contractures, decrease tone, protect joint alignment, decrease swelling.

Wearing Schedule:

• Wear 8 hours out of every 24.

Splint Maintenance:

• Wash hard plastic in warm, soapy water. Don't store in warm area, splint will melt.

Precautions:

• Watch for redness, skin irritation or swelling.

Please call _____, OTR

at _____ with any questions.

Thank you

Hand rolls/palm protectors

Purpose:
1. To prevent the development of contractures.
2. To prevent contractures from getting worse.
3. To prevent sores inside the contracted hands.

Procedure:
1. Explain the procedure and the reason for it to the resident.
2. Wash your hands.
3. Wash and dry the resident's hand.
4. Place a clean hand roll in affected hand.
5. Wash your hands.

Putting on ankle-foot orthosis (AFO)

1. Pull tongue of shoe up through laces.

2. Sit and cross affected leg over unaffected leg.

3. Slide AFO under foot and fasten Velcro strap.

4. Uncross affected leg with AFO in place.

5. Slide shoe over toes and push on as far as possible.

6. Place foot on floor and place shoehorn behind heel.

7. Push heel while moving shoehorn into upright position.

8. Work foot into position by pushing downward on knee. Move shoehorn back and forth.

Edema reduction

Elevation



1. Elevate hand above heart level on several pillows.

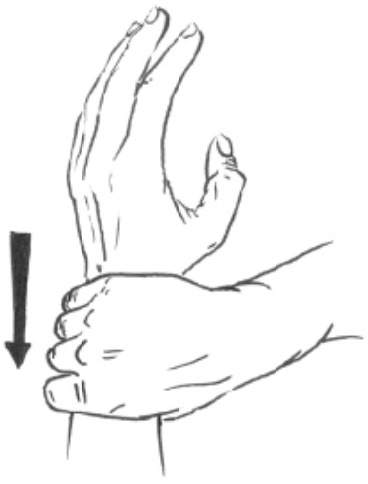


2. Make sure elbow is supported on pillow too.

Retrograde massage

- Massage toward the body in one direction only.
- Start at fingertips and work towards shoulder.
- Use tip of finger and slide towards wrist.





- Keep working all the way up to the shoulder.
- Use a firm pressure, without causing harm to the resident, to move fluid.
- You will need to use lotion so as not to irritate skin.

Self range of motion

Purpose:

1. Increase awareness of the hemiplegic arm.
2. Maintain joint mobility in a pain-free range.



General considerations:

(in addition to all general considerations for ROM)

1. Painful shoulder movement.
2. Edema.
3. Neglect of hemiplegic side.
4. Patient safety awareness.

Technique:

1. Grasp – place the affected wrist in the palm of the unaffected hand so that the unaffected hand is cradling (but not holding) the affected wrist.
2. Movement should be slow and controlled with a pause at the end of range.

Examples:

1. Overhead –
– Can be performed seated or supine.
– Move arms up above the head toward the ceiling and lower back to the lap.
2. Lateral chop –
– Perform in sitting position.
– Bend elbows, reach to the chin and lower to lap.
3. Pronation/supination –
– Best performed in seated position.
– Extend elbows.
– Roll hands so that the affected palm is facing up to the ceiling, then down to the floor.

Note
Self range of motion can be performed with other joints.
Please review with the primary Physical or Occupational Therapist.

Module 3

Demonstrating Clinical Competency

CONTINUED

Standard/Objective

ADL training

1. Demonstrate lower body dressing technique with an orthopedic resident.
2. Demonstrate upper body dressing technique with a hemiplegic resident.

Philosophy of activities of daily living (ADLs)

What are activities of daily living?

Those tasks or activities that promote maximum psychological, physical and social independence of:

1. Bathing	**4.** Hygiene
2. Dressing	**5.** Feeding
3. Grooming	

Why are activities of daily living important?

1. Promote independence	**3.** Social acceptance
2. Build self-esteem	**4.** Improve strength, balance and coordination

The goal of this program is to encourage and allow the resident to do as much for him/herself as possible.

This may be as little as washing his/her face and hands and combing his/her hair or a full morning routine. When the Occupational Therapist discharges the resident to the Restorative Nursing staff, a specific routine will have been established and the resident may be using adaptive equipment.

It is important for the RNA to be familiar with frequently used equipment and common dressing, grooming, bathing and hygiene techniques.



Levels of assist

See "Documentation Crosswalk Language" in Appendix

The following descriptions will be used to describe a resident's ability to perform activities of daily living. These will be used on the *resident's care plan* and in *daily demonstration*.

Total assist: 90% to 100% assist – resident requires continual physical/verbal cueing and/or assistance with/without adaptive equipment; attention span is short; cognitive skills may be poor.

Maximum assist: 75% of effort/instruction or support supplied by caregiver; skills are sloppy and endurance may be poor.

Moderate assist: Physical contact and verbal instruction to make up 50% of the effort/instruction or support required to complete the task. This may be hands on for 50% and hands off for 50% of task time OR caregiver supplying 50% of effort, instruction or support throughout task OR a combination of both (i.e., equal effort and movement between caregiver and resident — 50/50).

Minimal assist: 25% of the effort, instruction or support is provided by the caregiver. This is a combination of physical, gestural and instructional but more gestural and instructional than physical.

Contact guard: Infrequent hands-on contact using light touch to make sure resident is safe and to remind resident of details of task.

Verbal assist: No physical assist, but resident requires instructions to start, pay attention, attend to details and complete the task.

Supervision: Frequent checks on resident's progress while completing task to assist with any new problems (e.g., resident can perform learned activity but has difficulty managing new procedure).

Set-up assist: Caregiver must set up ADL task (e.g., lay out clothes, get utensils, put bath water by bed, etc. Resident can then perform task without assist).

Independent: Resident can perform activity without instruction or assist of caregiver.

Dressing techniques
Post hip fracture

General guidelines
Following hip replacement surgery or a hip fracture, special precautions are to be followed by the resident when dressing or being dressed. The Occupational Therapist will typically teach the resident how to dress using the precautions. These are to be followed 2-3 months after surgery. All body positions that force the head of the femur against surrounding muscles should be avoided.

Some tips to remember:
1. Do *not* bend forward from the waist more than 90º or as instructed.
2. Do *not* lift the knee higher than hip height on the operated side.
3. Do *not* cross the legs at ankles or knees.
4. Do *not* bring the legs together.
5. Do *not* inwardly rotate hips when lying in bed (do not point toes inward).

In general, the following are recommended during the healing process:
1. When seated, the knee (on the operated lower extremity) should be at the same level as or lower than the hip.
2. Always back up to a chair, toilet or bed until the back of the leg hits the edge of chair (toilet or bed). If the edge of the chair is at the same level as the crease of the knee or higher on the leg, the surface will be high enough to safely sit.

When dressing:
1. Dress operated leg first.
2. Sit on the side of the bed or in an armchair using adaptive devices.
3. Put on underwear and pants first.
4. Knee high socks and stockings are recommended with the proper use of a stocking aid.
5. Wear slip-on shoes and/or elastic shoelaces.
6. Shoes should be taken on or off with the appropriate use of a dressing stick or long handled shoehorn.

Dressing techniques (continued)
Total hip replacement (THR)

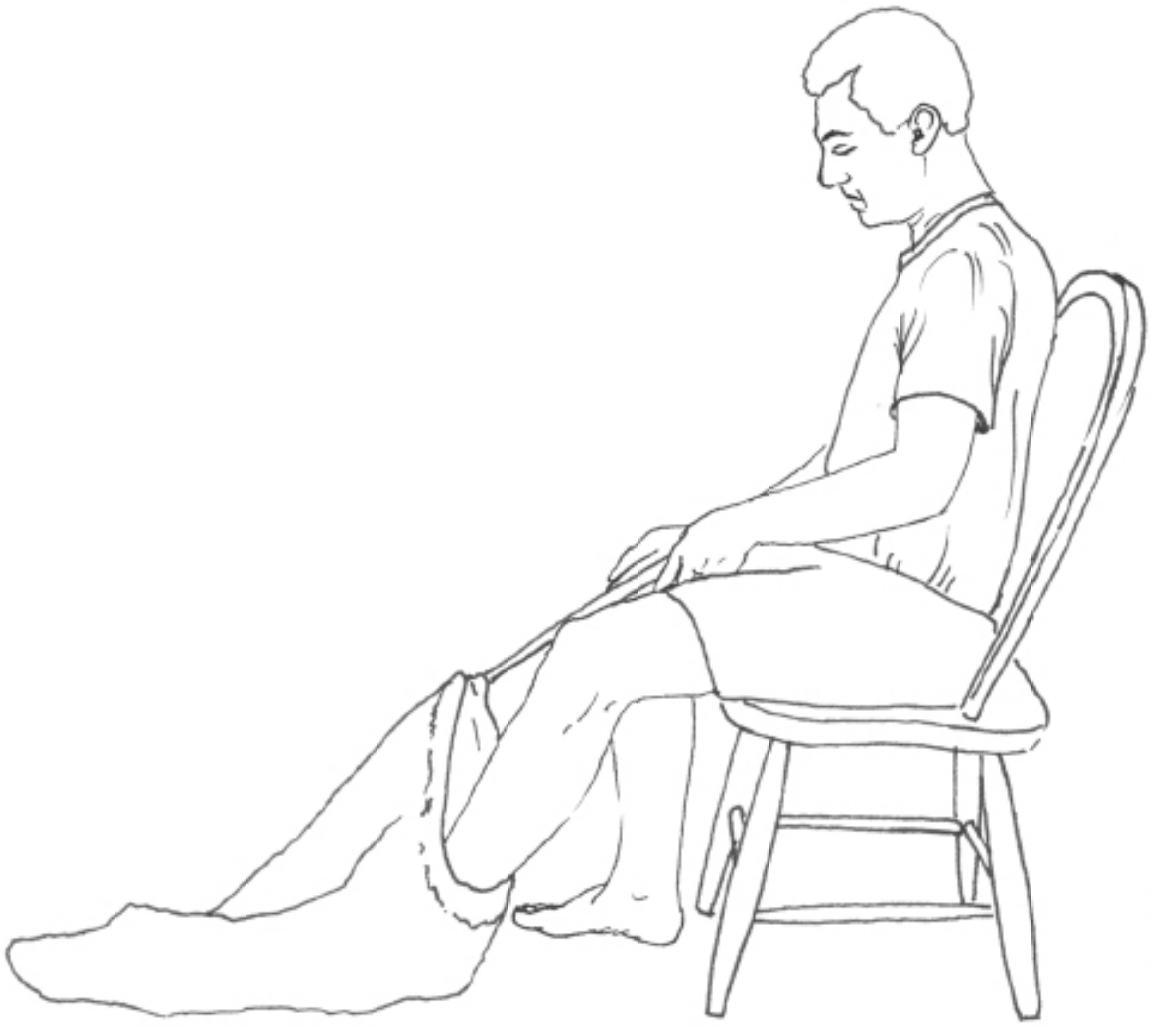
Pants and underwear

1. Sit on the side of the bed or in a chair. Use the adaptive devices provided by your Occupational Therapist.

2. Put on underwear and pants first. Using the dressing stick, catch the waist of the underwear or pants with the hook. Lower the stick to the floor and slip pant leg over your operated leg first. Then do the same for your non-operated leg (See drawing).

3. Pull the pants up over your knees. Stand, with the walker in front of you and pull the pants up.

4. When undressing, take the pants and underwear off your non-operated leg first, reversing Step 3 above.



Dressing techniques (continued)

Hemiplegia

Many residents will present with weakness, paralysis on one side of the body or other physical problems that interfere with their ability to dress themselves. This will require the resident to use specialized techniques and equipment to put on and take off their clothes.

The Occupational Therapist will teach the resident how to do his/her dressing again and the special techniques he/she needs to utilize. When the resident is discharged to the Restorative Nursing ADL Program, the Therapist will indicate on the plan of care the specific techniques to be used.

Remember
- Dress involved side first.
- Undress uninvolved side first.

Putting on/taking off UE garments

Undergarments

1. Use a front-fastening bra, if possible. Put on similar to front-buttoning garment.
2. To hook a back-fastening bra, wrap bra around waist so that hooks are in front.
3. Hold up eyelet side of the bra with affected arm.
4. Hook the bra and turn it around so that hooks are in back.
5. Insert involved arm through strap, insert uninvolved arm. Pull so that straps are adjusted correctly on shoulders.

Dressing techniques (continued)

Adult hemiplegic – putting on/taking off UE garments

Button-front shirt, blouse, sweater or jacket

1. Assure garment is unbuttoned. Place shirt in lap, back facing resident, neck away from resident.





2. Gather up back to expose armhole for involved arm. Place involved arm through sleeve. Pull above elbow up to the shoulder.





3. Reach behind neck, grasp collar and move hand around collar to bring the shirt behind the resident.

Putting on/taking off UE garments

Button-front shirt, blouse, sweater or jacket (continued)



4. Bring collar to shoulder and insert unaffected arm into armhole (sleeve).



5. Button shirt (may use button hook).

Dressing techniques (continued)

Adult hemiplegic – putting on/taking off UE garments

Pullover garment



1. Place shirt in lap, back facing resident, neck away from resident.



2. Gather up back to expose armhole for involved arm.



3. Place uninvolved arm through other sleeve. Expose arm above elbow.

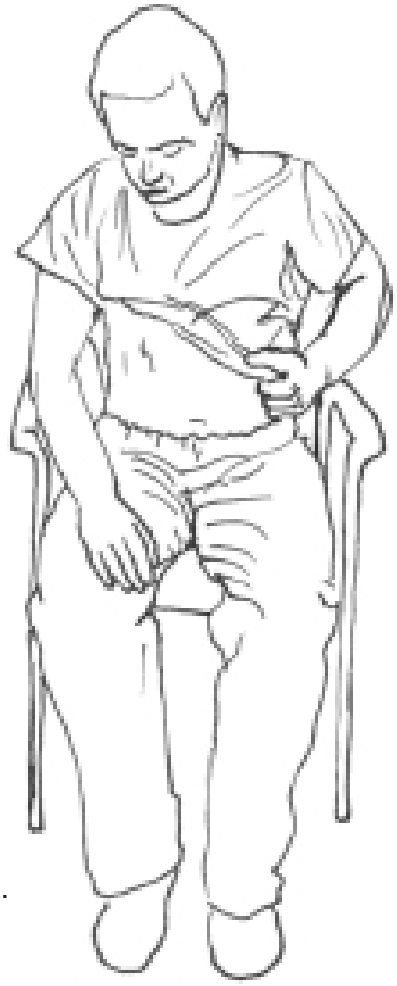
Pullover garment (continued)



4. Pull sleeve on involved arm above elbow to mid-upper arm region.



5. Gather shirt from hemline to collar, duck head, pull shirt over it.



6. Pull shirt down in back and front.

Dressing techniques (continued)

Adult hemiplegic – putting on/taking off LE garments

Putting on pants



1. Bring affected leg and cross over unaffected knee.

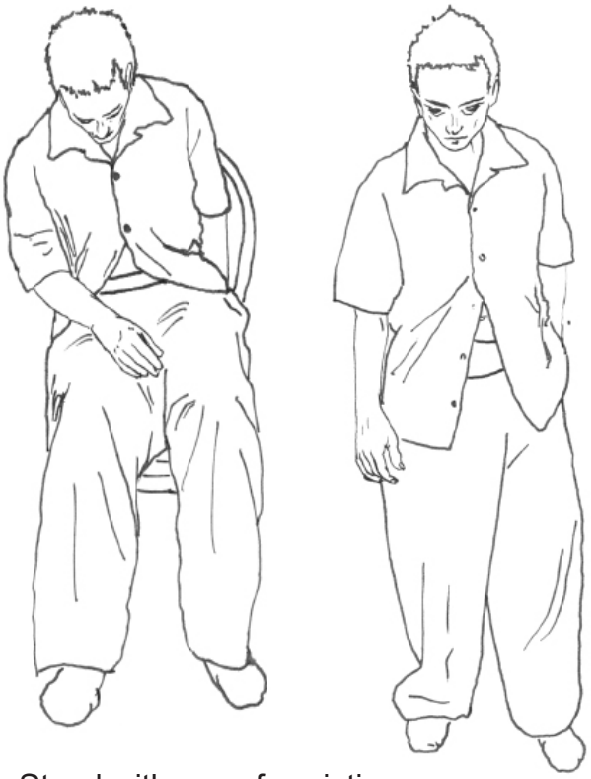
2. Slide pant leg over affected foot and pull up to knee.

Putting on pants (continued)

3. Place unaffected foot into matching pant leg.



4. Pull pants up as far as possible while remaining seated.



5. Stand with use of assistive device or assistance.



6. Fasten pants.

Dressing techniques (continued)

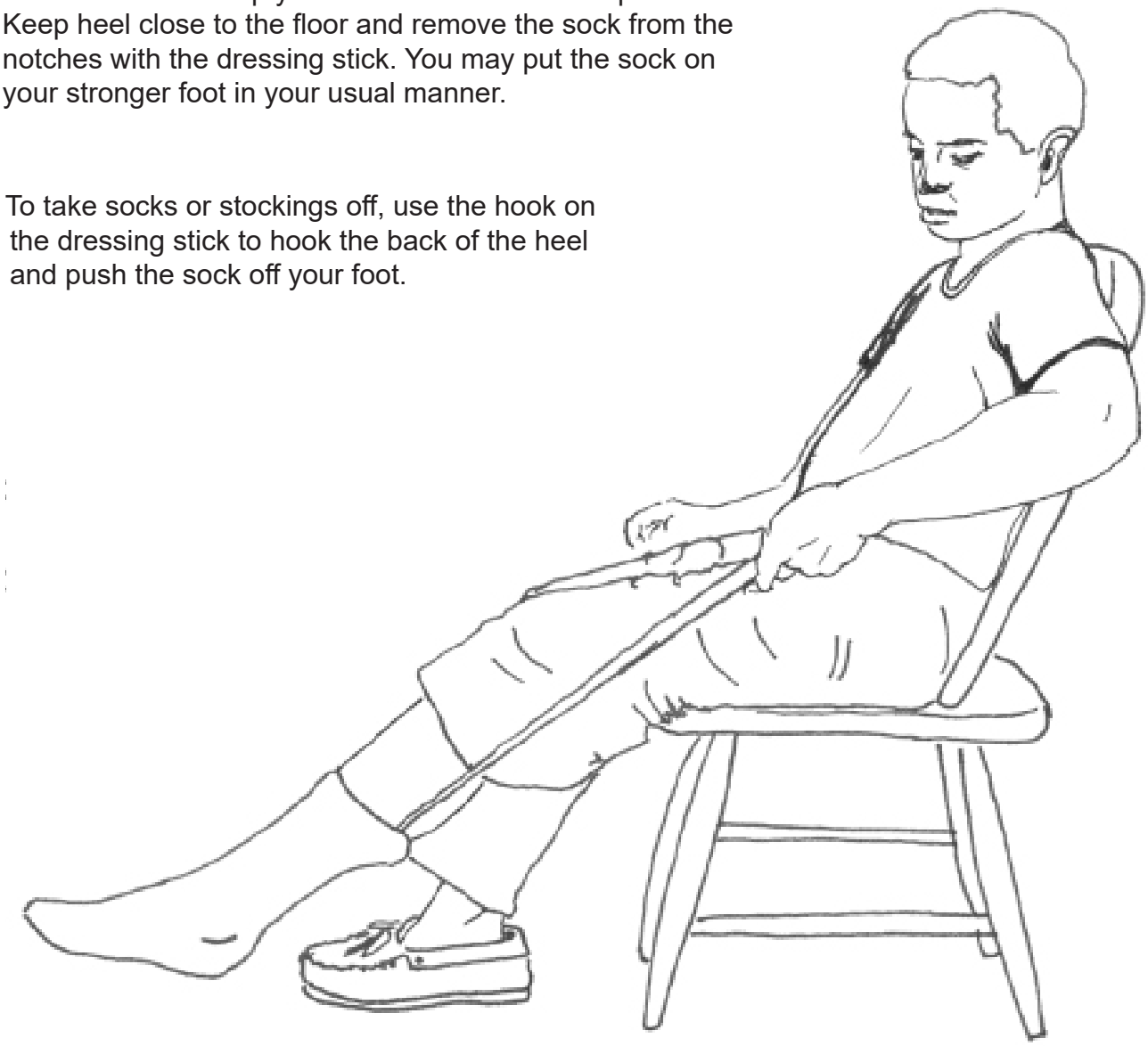
Adult hemiplegic – putting on/taking off LE garments

Socks and stockings

1. Slide the sock or stocking onto the stocking aid. Make sure the heel is at the back of the plastic and the toe is tight against the end. The top of the sock should not come over the top of the plastic piece. Secure the sock in place with notches in the plastic piece.

2. Holding onto the cords, drop the stocking aid out in front of the weak foot. Slip your foot into the sock and pull it on. Keep heel close to the floor and remove the sock from the notches with the dressing stick. You may put the sock on your stronger foot in your usual manner.

3. To take socks or stockings off, use the hook on the dressing stick to hook the back of the heel and push the sock off your foot.



Dressing techniques (continued)

Adult hemiplegic – putting on/taking off LE garments

Shoes





1. Resident should wear slip-on shoes or use elastic shoelaces so he/she won't have to bend over to put the shoes on and tie the laces.

2. Use the dressing stick or a long-handled shoehorn to put on or take off shoes.

3. Place shoe horn in heel of shoe and push down on knee to slide foot into shoe.

Putting on ankle-foot orthosis (AFO)

1. Pull tongue of shoe up through laces.
2. Sit and cross affected leg over unaffected leg.
3. Slide AFO under foot and fasten Velcro strap.
4. Cross affected leg over unaffected leg with AFO in place.
5. Slide shoe over toes and push on as far as possible.
6. Place foot on floor and place shoehorn behind heel.
7. Push heel while moving shoehorn into upright position.
8. Work foot into position by pushing downward on knee. Move shoehorn back and forth.
9. Grasp uprights and pull up until foot slips into place in shoe. Remove shoehorn.
10. Fasten strap, being careful not to snag socks. Fasten shoes.

Pacing the resident with *low endurance*

Many residents will show a decline in their self-care independence after an illness. The illness can vary from pneumonia to urinary tract infection to the flu or a cold. Any medical complication can affect a resident's ability and motivation to complete his/her own self-care.

It is extremely important to treat residents to gradually increase endurance and allow return to prior level of function.

Prior to discharge from Occupational Therapy, the Therapist will train the RNA in resident-specific needs related to tolerance, limitations and signs/symptoms of fatigue. Symptoms of fatigue vary greatly and must be monitored daily.

The key to successfully managing these residents is to assure they stop and rest or complete the task just before or with first signs of fatigue. Studies have documented that the total time required to recover from fatigue is much less when rest is taken frequently and before fatigue than when rest is taken after exhaustion.

Therefore, it is necessary to be able to identify the early signs of fatigue. The Therapist will instruct the RNA in the resident's level of endurance and signs of fatigue; however, the resident changes daily and the RNA must be able to identify the signs. *Any* change in the resident's performance should alert the RNA that something is happening.

Behavior changes that may indicate fatigue

1. Breathing (e.g., shortness of breath. gasping for breath)
2. Cooperation (e.g., refusal to try activity, becomes fearful, angered)
3. Level of function (e.g., impulsiveness, rushing to get finished)
4. Judgment (worsens)
5. Pace (e.g., does things faster or slower)
6. Balance (worsens)
7. Finds fault with your assistance

When these behaviors are noted, an immediate change in the task is necessary

Possible changes include:

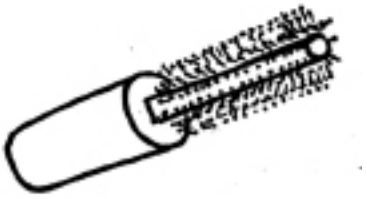
1. Rest break
2. Completing task for resident
3. Increasing assist, but not completing for resident
4. Increasing instructions
5. Shortening the task (e.g., instead of bathing and dressing, change to just completing bathing).
6. Offering encouragement

Always end treatment with something that resident has *successfully completed!*

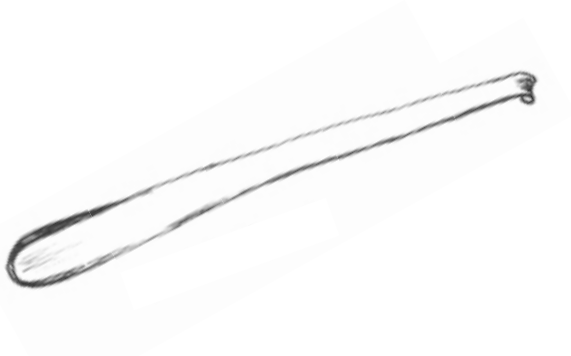
Adaptive equipment for ADLs

Specialized equipment may be required by the resident to perform dressing, grooming and bathing tasks independently. The Occupational Therapist will provide the equipment to the resident and teach him/her how to use it. When the resident is discharged to the Restorative Nursing ADL Program, the Therapist will indicate on the resident care plan what equipment has been provided and how it is utilized.

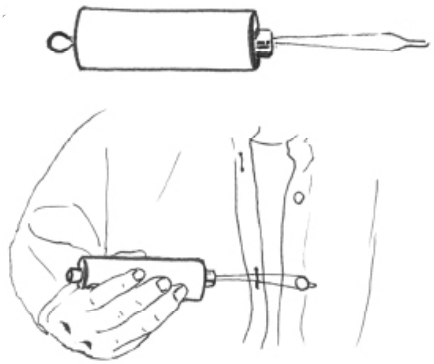
Adaptive dressing and grooming devices



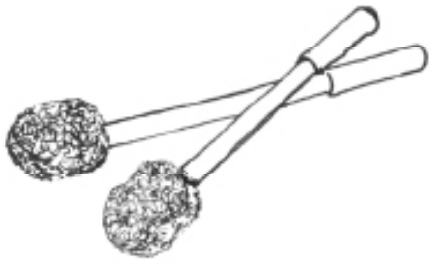
Built-up handled hair brush
- Makes holding brush easier and more comfortable



Long-handled shoehorn
- Substitutes for lack of range in arms and trunk
- Used when resident is unable to bend over safely



Button hook
- Used when fingers are unable to manipulate the button to fasten it



Long-handled sponge
- Substitutes for limited strength and range

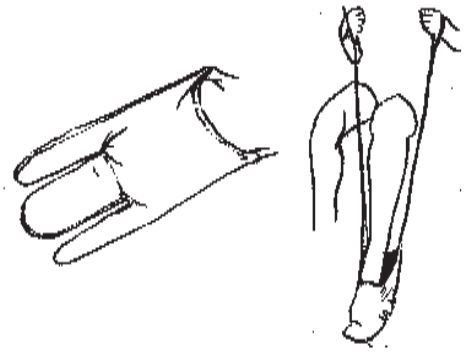
Adaptive dressing and grooming devices (continued)



Reachers
- Compensates for limited reach or muscle weakness
- Used to pull clothing over feet or to reach hangers in the closet



Raised toilet seat
- Permits ease in getting off toilet when legs are weak
- Limits hip flexion
- Eases transfer from a wheelchair



Sock aid
- Used when hip range is limited or arm/hand strength is poor



Suction-cup denture brush
- Allows one-handed cleaning of dentures
- Suctions onto sink



Suction-cup fingernail brush
- Assists resident with loss of use of one hand to maintain cleanliness

NOT PICTURED

Dressing stick
- Compensates for limited reach or muscle weakness
- Used to pull clothing over feet or to reach hanger in the closet

Universal cuff
- Substitutes for hand grasp
- Can be adapted to hold a tooth brush, razor, comb/brush, etc.

Module 3

Demonstrating Clinical Competency

CONTINUED

Standard/Objective

Functional mobility

1. Define therapy assist level terms (MAX, MOD, MIN, CGA, SUP, IND).
2. Define weight bearing status (NWB, TDWB, PWB, WBAT, FWB).
3. Identify, demonstrate and verbalize precautions for the resident with a total hip replacement and ORIF.
4. Demonstrate one safe transfer technique for the resident with total hip replacement.
5. Describe a device to maintain weight-bearing status and the reason for its use.
6. Demonstrate the appropriate use of one assistive device.
7. Demonstrate safe positioning techniques for the resident with hemiplegia in bed and wheelchair.
8. Identify three major pressure risk areas for positioning a hemiplegic resident in bed and in a wheelchair.
9. Demonstrate one bed mobility technique.
10. Demonstrate one safe transfer technique for the resident with hemiplegia.
11. Identify components of a safe partial-assist transfer from bed to wheelchair for a resident with PWB hip fracture.
12. Demonstrate one safe assisted ambulation technique.
13. Demonstrate slide board transfer.
14. Demonstrate the use of the gait belt.
15. Demonstrate wheelchair set-up and safety.

Functional mobility

Levels of assist

See "Documentation Crosswalk Language" in Appendix

The following descriptions will be used to describe a resident's ability to perform activities of daily living. These will be used on the *resident care plan* and in *daily demonstration*.

Total assist: 90% to 100% assist – resident requires continual physical/verbal cueing and/or assistance with/without adaptive equipment; attention span is short; cognitive skills may be poor.

Maximum assist: 75% of effort/instruction or support supplied by caregiver; skills are sloppy and endurance may be poor.

Moderate assist: Physical contact and verbal instruction to make up 50% of the effort/instruction or support required to complete the task. This may be hands on for 50% and hands off for 50% of task time OR caregiver supplying 50% of effort, instruction or support throughout task *or* a combination of both (i.e., equal effort and movement between caregiver and resident — 50/50).

Minimal assist: 25% of the effort, instruction or support is provided by the caregiver. This is a combination of physical, gestural and instructional but more gestural and instructional than physical.

Contact guard: Infrequent hands-on contact using light touch to make sure resident is safe and to remind resident of details of task.

Verbal assist: No physical assist, but resident requires instructions to start, pay attention, attend to details and complete the task.

Supervision: Frequent checks on resident's progress while completing task to assist with any new problems (e.g., resident can perform learned activity but has difficulty managing new procedure).

Set-up assist: Caregiver must set up ADL task (e.g., lay out clothes, get utensils, put bath water by bed, etc. Resident can then perform task without assist).

Independent: Resident can perform activity without instruction or assist of caregiver.

Positioning of residents

Do:

1. Change position at least every two hours
2. Extend joints at regular intervals. Explain what you are doing
3. Encourage resident to assist in position changes
4. Use a friction-reducing draw sheet when available
5. Support the feet to prevent foot drop
6. Grasp extremity below or above sore joint
7. Grasp joint if muscles are sore
8. Support affected side
9. Avoid excess stress on contractures
10. Position tubing to avoid pressure and to drain properly
11. Mimic the basic anatomical position:
    - Head erect
    - Feet forward
    - Arms at sides with hands pronated and thumbs abducted
    - Knees and fingers slightly flexed
12. Consider resident's daily schedule to accommodate various position changes
13. Provide ROM whenever turning and repositioning
14. Encourage AAROM whenever possible
15. Distribute weight equally when up in chair or in bed
16. Support extremities and the head when needed

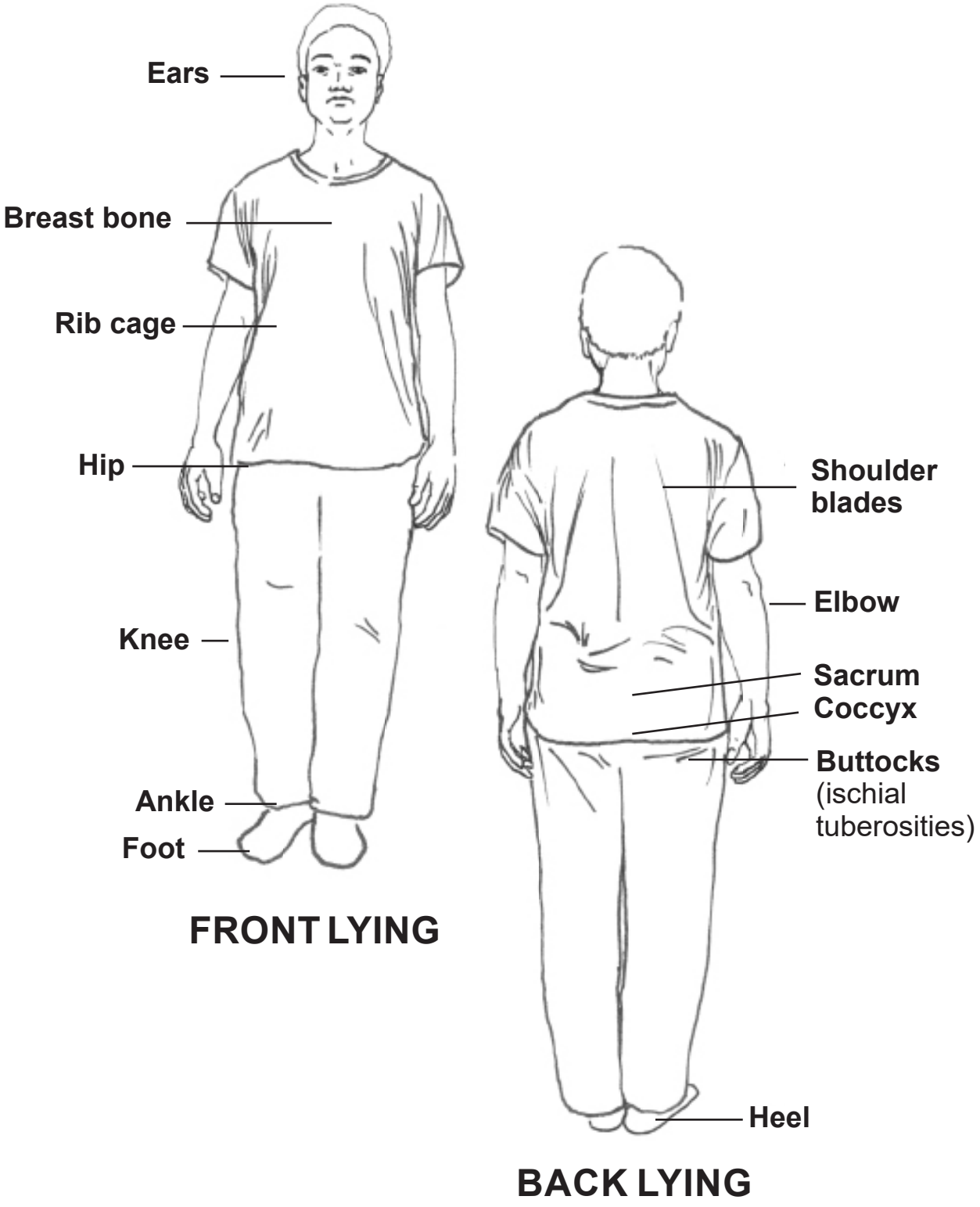
Don't:

1. Don't position resident on open wound areas
2. Don't allow top linen to be weighty or binding (may use bed cradle)
3. Don't allow bottom linen to be wrinkled beneath resident's body
4. Don't grasp sore joints
5. Don't grasp sore muscles
6. Don't place resident on tubing
7. Don't turn or lift resident by pulling on hemiplegic or injured limb or lift by pulling up under hemiplegic shoulder
8. Don't allow slumping or head dropping to side, back or front

The basic rules of *body mechanics*

1. Assess the situation before taking action
2. Get close to the object to be moved
3. Bend knees – let the legs do the work, not your back
4. Use a wide base of support
5. Push – *don't* pull
6. Turn – *don't* twist

Major pressure areas



Positioning devices

1. **Laptray:** A useful surface assists arm positioning and trunk control. *This can be considered a restraint – check with Nursing or Therapist.*

2. **Pommel cushion:** Keeps hip from inwardly rotating. *This can be considered a restraint – check with Nursing or Therapist.*

3. **Seat cushion:** Helps prevent pressure ulcers.

4. **Head support:** Positions head erect. Used in reclining wheelchairs.

5. **Lateral support:** Attaches to the wheelchair to align trunk.

6. **Hemi sling:** Supports affected arm to prevent subluxation.

7. **Arm trough:** Positions the hemiplegic shoulder and arm to prevent injury and a painful shoulder.

8. **Lap buddy:** Soft, padded cushion that fits above resident's knees through arm rests to provide upper body support and prevent sliding. *This can be considered a restraint – check with Nursing or Therapist.*



Positioning

Bed positioning for total hip replacement (THR)



Correct
Keep pillows between the legs when he/she is lying on one side to prevent the hip from rotating inward.



Correct
Do keep a pillow between the legs when lying on his/her back.



Incorrect
When the resident is supine, do *not* permit him/her to rotate the hip inwardly (do *not* point toes inward).

Positioning

Turning in bed with a pillow between knees

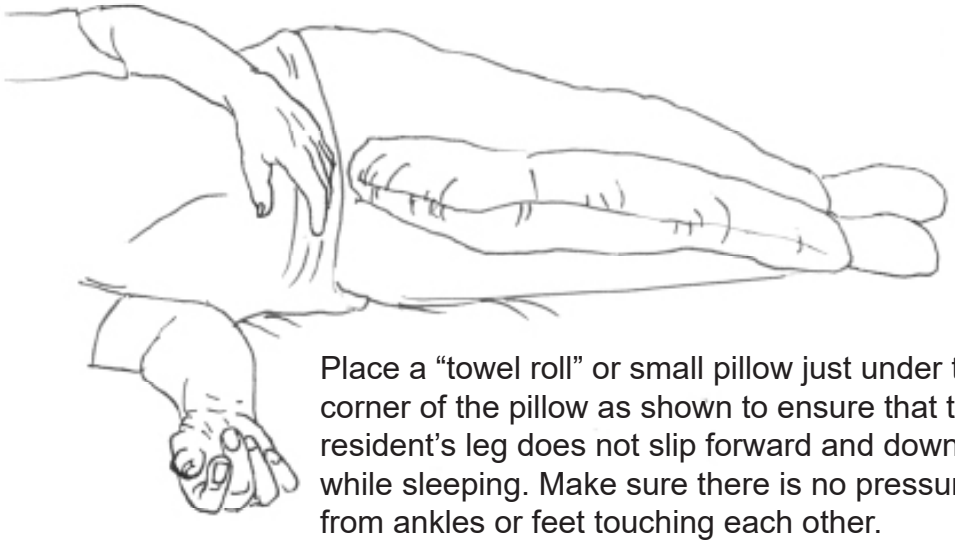
Purpose:
To provide comfort and prevent skin breakdown at pressure areas at ankles and knees.



Move resident toward the center of the bed so he/she is not too close to the edge. Use a friction-reducing draw sheet when available. Position the pillow between the knees as shown above.



Now have resident grasp the nearest corner of the pillow and turn to his/her side.



Place a “towel roll” or small pillow just under the corner of the pillow as shown to ensure that the resident’s leg does not slip forward and down while sleeping. Make sure there is no pressure from ankles or feet touching each other.

Protecting the hemiplegic shoulder

What all members of the team – including family – should *avoid*:

1. *Never* pull on the hemiplegic arm to help change position or sit up.

2. Do *not* hold onto the hemiplegic arm to support the resident in sitting, standing or walking.

3. *Avoid* lifting the resident or repositioning in the wheelchair by placing your arms under the resident's arms.

Positioning

Tone can be increased or decreased by *positioning*

When spasticity is a problem, improper positioning can cause pain or discomfort, which increases spasticity.

***Improper* positioning**	***Proper* positioning**
1. Pain	**1.** Comfort
2. Discomfort	**2.** Increased function
3. Decreased function	**3.** Decreased spasticity
4. Increased spasticity	

Conditions that increase spasticity

1. Emotional upset
2. Pain
3. Discomfort
4. Attempting tasks that are too difficult or that cause straining:
- – Rolling over
- – Moving from sitting to standing
- – Reaching for an object away from the body
- – Picking up small objects
- – Shifting sitting position
- – Bowel movement
- – Poor positioning
- – Loud noises
- – Sneezing, coughing, laughing
- – Illness (cold, flu, urinary tract infection, pneumonia)

Positioning

Adult hemiplegic positioning while lying *supine*

Purpose

To encourage relaxation, prevent (or decrease) pain, and prevent (or decrease) tightness.

Instructions

1. Place a flat pillow under head with the head straight in the middle or turned slightly toward affected side.

2. Body is straight in bed, not bent to either side.

3. Small pillow should be placed completely under affected shoulder blade.

4. Affected arm is supported by pillow out to the side. A small towel roll may be placed in the hand to support wrist (not for squeezing).

5. Small pillow is placed under affected hip.

6. Pillow to support leg in mid-positon and to minimize external rotation.

7. May use pillow under lower leg to float heels.



- **Desired response:**
  Relaxation and control of tightness
- ***Un*desired response:**
  Becoming stiff and uncomfortable

Positioning

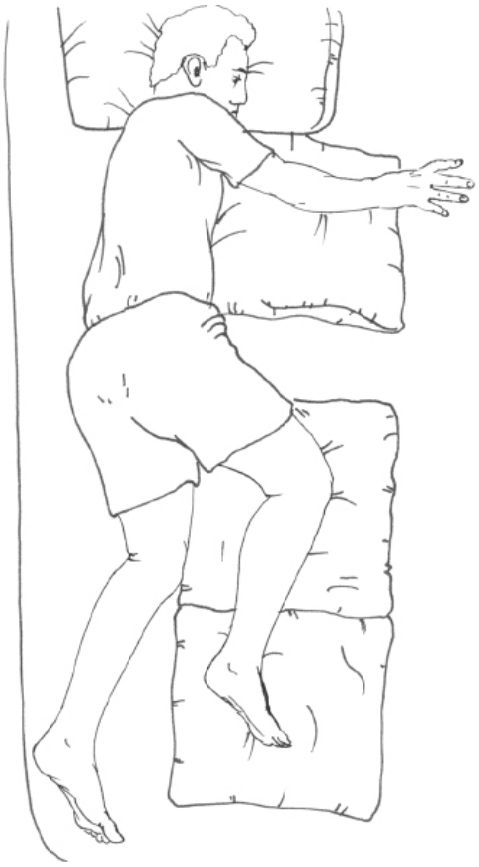
Adult hemiplegic positioning while lying on *unaffected* side

Purpose

To encourage relaxation, prevent (or decrease) pain, and prevent (or decrease) tightness.

Instructions

1. Lie on unaffected side with affected side rolled forward slightly.
2. Place flat pillow under head.
3. Place one or two pillows under affected arm to support it. Affected shoulder is slightly forward and hand is supported.
4. Place a pillow under the affected leg for support, with hip slightly forward, hip and knee bent.
5. A pillow, if necessary, can be placed behind back to prevent rolling backwards.
6. No objects should be placed against the bottom of the foot.



Right hemiplegia

- **Desired response:**
  Relaxation and control of tightness
- ***Un*desired response:**
  Becoming stiff and uncomfortable

Positioning

Adult hemiplegic positioning while lying on *affected* side

Purpose

To encourage relaxation, prevent (or decrease) pain, prevent (or decrease) tightness and increase sensory input.

Instructions

1. Place a flat pillow under head.
2. Lie on affected side with affected shoulder forward.
3. Palm of hand should be turned up with entire arm supported.
4. Affected hip should be straight with knee slightly bent.
5. Pillow should be placed under unaffected leg for support.



Right hemiplegia

Options

- Both hips and knees can be bent with flat pillow in between them.
- Clasp hands with affected thumb on top, pointing to head of bed.

- **Desired response:**
  Relaxation and control of tightness

- ***Un*desired response:**
  Becoming stiff and uncomfortable

Positioning

Adult hemiplegic positioning while *sitting in bed*

Purpose

To encourage relaxation, prevent (or decrease) pain, and prevent (or decrease) tightness.

Instructions

1. Make sure resident is positioned toward the top of the bed so that bending occurs in the correct places. Use trapeze or friction-reducing draw sheet to re-position.
2. Sit in bed as upright as possible, with head and body in line.
3. Body weight should be even on both buttocks. Do not lean to either side.
4. Affected arm is slightly forward and supported at side by pillows and from behind at shoulder blade.
5. Hand should be flat on pillow.
6. Small towel roll should be under affected knee.
7. Heels can be floated as necessary.



- **Desired response:**
  Relaxation and control of tightness
- ***Un*desired response:**
  Becoming stiff and uncomfortable

Positioning

Adult hemiplegic positioning while *sitting in a chair/wheelchair*

Purpose

To encourage relaxation, prevent or decrease pain and/or tightness and provide pressure relief.

Instructions

1. Sit with buttocks completely back in the chair. Hips and knees are at right angles, feet flat on floor or footrests.
2. Head and body are in line, weight distributed evenly on both buttocks. Do not lean to either side.
3. Affected arm is supported by table, lap tray, trough or pillows (per Therapist instructions).
4. Wrist and hand may be supported by hand roll or splint (per Therapist instructions).
5. Chair cushion should be used as recommended (per Therapist instructions).
6. Use a positioning device as needed to prevent slipping or sliding out of the chair seat (e.g., dycem or one-way glide sheet).



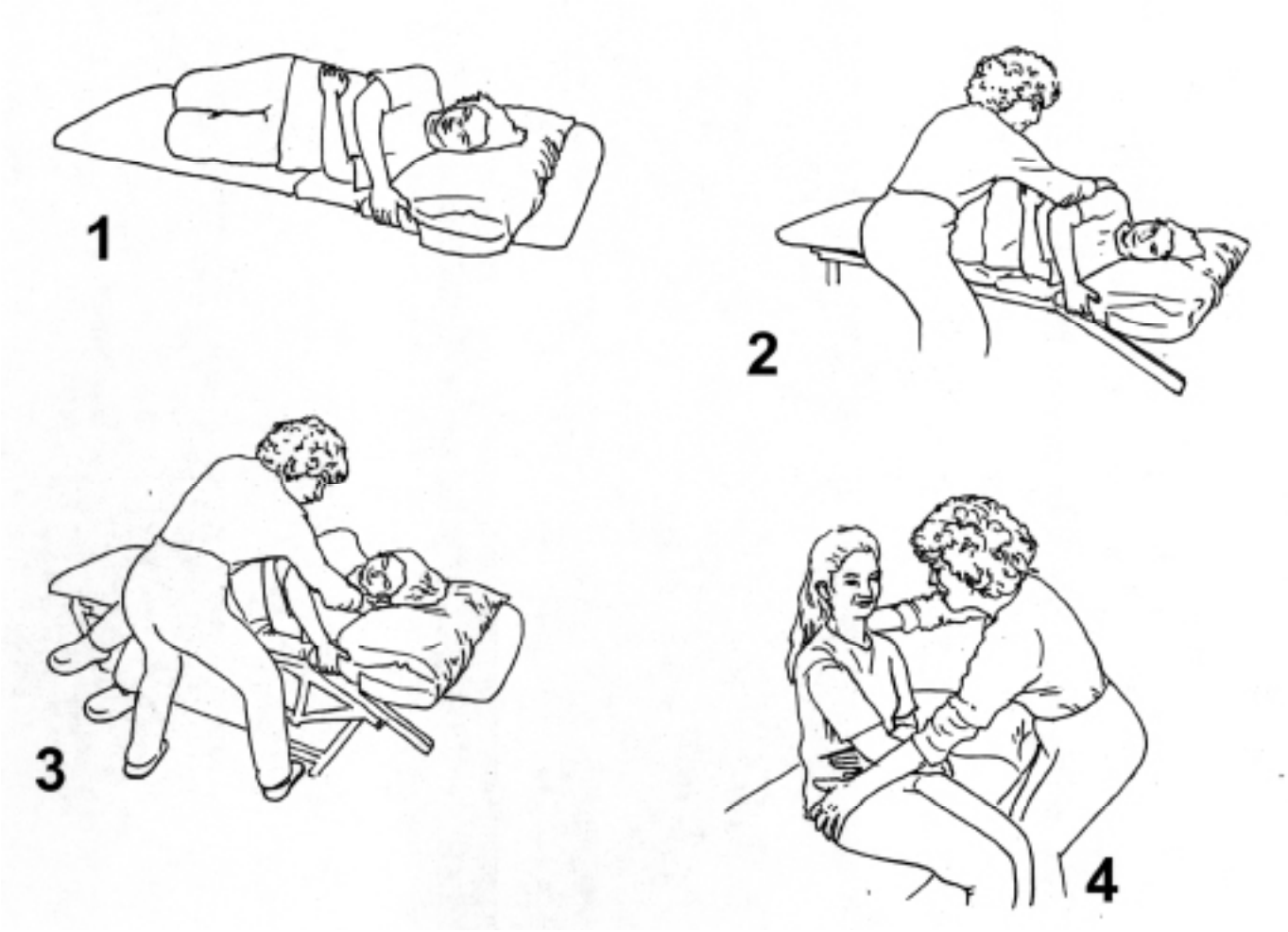
- **Desired response:**
  Relaxation and control of tightness
- ***Un*desired response:**
  Becoming stiff and uncomfortable

Bed mobility

From supine to side-lying to sitting

To get a resident to the edge of a bed

1. Brake or brace bed and prepare wheelchair for transfer.
2. Log-roll resident onto his/her side. Use a friction-reducing draw sheet as needed.
3. Be sure your spine is in normal alignment. Watch your body mechanics.



The Certified RNA *always* observes

The basic rules of *body mechanics*
1. Assess the situation before taking action
2. Get close to the object to be moved
3. Bend knees – let the legs do the work, not your back
4. Use a wide base of support
5. Push – *don't* pull
6. Turn – *don't* twist

When to use a gait belt –
– with a resident who requires *hands-on* assistance to transfer or ambulate.

How to put a gait belt on a resident:

1. Put the belt around the resident's waist.
2. Tighten the belt enough so it will not slip *up* on the resident.
3. Keep the belt buckle away from the bony areas of the trunk.

Purpose

1. To ensure resident safety during transfer from one place to another.
2. To avoid grabbing the resident by the arms during transfer.
3. To give a mechanical advantage by providing something to hold on to, thus allowing for better control.
4. To prevent injury to resident or employee.
5. To help residents feel more secure.

Contraindications

Do *not* use with any resident who has any of the following conditions:
1. Abdominal aortic aneurysm.
2. Severe heart or breathing problems.

Precautions

Use caution with placement on residents with any of the following conditions:
1. PEG or feeding tube in their stomach.
2. Colostomy bags.
3. Recent abdominal surgery .
4. Recent back surgery or back injury.
5. Recent rib fracture.
6. Heart or breathing problems.

Transfers

A pattern of movements to move from one surface to another

The basic rules of *body mechanics*

1. Assess the situation before taking action
2. Get close to the object to be moved
3. Bend knees – let the legs do the work, not your back
4. Use a wide base of support
5. Push – *don't* pull
6. Turn – *don't* twist

Remember:
A transfer is
a ***shift***,
not a ***lift***!

Red – yellow – green

Red: *Think* a minute and *plan* your transfer.

Yellow: *Be prepared*: position catheters, IVs, slippers, wheelchair, bed, etc.

Green: *Discuss* ways resident can assist, then inform resident what the two of you will do together during the transfer.

The keys to safe transfers

1. Remember your body mechanics; they apply to you and the resident.
2. Use a second person to assist you when indicated.
3. Use appropriate equipment. A transfer belt gives you control of the resident without restricting the resident from assisting you.
4. When possible, allow the resident to maintain integrity through independence by providing only as much assistance as necessary.
5. Make sure restraints are untied and any tubes (feeding, catheter) are protected.
6. Adjust equipment to suit your needs: raise or lower bed, use draw sheet or friction-reducing draw sheet.
7. Position equipment to transfer the shortest distance possible.
8. When possible, transfer toward resident's strong side. Protect the weaker side unless otherwise indicated by the Therapist.
9. Keep resident informed of what you are doing. Give short, simple commands.
10. Know resident's limitations (e.g., fractured right hip with no weight bearing allowed).
11. Use the safest technique as indicated by the Therapist.

OSHA recommends that manual lifting of residents be minimized in all cases and eliminated when feasible.

Transfers
General techniques

Remember:
A transfer is
a ***shift***,
not a ***lift***!

Basic guidelines

Take time to set up the best possible circumstances

1. Prepare the wheelchair.
2. Assure that the resident wears supportive footwear.
3. Protect feeding and drainage tubes.
4. Decrease the distance between the transfer areas.
5. Place the transfer belt snugly around the resident.

Communicate with the resident

1. Tell the resident what you are doing.
2. Use short, simple instructions.
3. Encourage the resident to do as much as she/he can.

Use the principles of good body mechanics for yourself and the resident.

Precautions

1. Always assess the situation before starting the transfer.
2. If you need extra help from one or more staff, ask for it.
3. Let your legs do the work, not your back.
4. *Never* let the resident grasp you around the neck or waist during a transfer.
  – Around the neck can cause you and the resident injury.
  – Around the waist is near your center of gravity, and the resident could easily throw you off balance.
5. If the resident must hold onto you during the transfer, have him/her hold onto your forearms.
6. Use transfer belt unless the resident is independent.
7. Avoid excessive strain on the resident's shoulders by *not* pulling on the arms to move the resident.
  – You can easily dislocate the shoulder.
  – You can cause a flare of tendinitis or bursitis to the resident's shoulder.
  – You can cause permanent damage to the shoulder.
  – You can drop the resident because the arm is *not* structurally designed to hold all the body's weight.
8. If a resident is a "grabber," put both of the resident's hands in his/her lap and secure the resident's arms by putting your arms on the outside of the resident's arms.

Transfers

General techniques (continued)

If you have trouble completing the transfer, don't try to go on. Just pivot back to the starting place.

Remember:
A transfer is
a ***shift***,
not a ***lift***!

Types of transfers – bed to wheelchair

One-man partial assist

1. Resident scoots to the edge of the bed or chair.
2. Resident's feet flat on the floor.
3. Support resident's weak arm.
4. Caregiver assists resident to stand by guiding up with gait belt.
5. Resident should assist by pushing up from the bed if possible.
6. Caregiver stands in front of the resident and slightly to her/his weaker side, blocking the resident's weaker knee with the caregiver's knee.
7. Using the hand closest to the chair, the resident reaches for the chair armrest farthest away.
8. Resident pivots or steps toward the chair, places hand on the armrest and is assisted to sitting by the caregiver.

Key points

- Stronger side is allowed to do the work.
- Resident can work on balance during the transfer.
- Caregiver doesn't lose contact with resident's weak knee.
- No pulling on the arms – thus no shoulder injury to the resident.
- Both caregiver and resident squat together as resident sits.

Two-man full assist (bed to wheelchair)

1. Follow Steps 1-8 for the one-man partial assist.
2. Second caregiver stands between the back of the chair and the bed (may place one knee on the bed if necessary) and assists with transfer by guiding the resident's hips to the chair. *Or* second caregiver stands to the front and on the other side of the resident and performs "mirror-image" positioning assistance.

Slide board transfer (one-man and two-man assists)

A slide board transfer may be used when the resident has enough arm strength to assist with shifting his/her buttocks and adequate trunk control not to lose balance when moving in a sitting position – *can only be used with wheelchairs with removable armrests.*

1. Assist resident to sitting position in bed using techniques described above.
2. Position wheelchair at a slight angle to bed, with brakes locked. Remove armrest nearest bed.
3. The resident's feet should be placed on the floor.
4. Place one end of the slide board securely under the resident's thigh. The other end of the board should form a bridge to the wheelchair (one-fourth of the opposite end of the board should rest on the seat of the wheelchair.)
5. Guard the resident by standing in front and blocking the knees if necessary.
6. Place gait belt securely around the resident's waist.
7. Have the resident lean forward (nose over toes), push away from the sideboard with her/his arms and slide the buttocks across the board while moving laterally toward the wheelchair.
8. Guide the resident to the chair. If necessary, you may provide assistance by guiding at gait-belt level. If resident needs assistance for balance, place your hands on his/her shoulders.

Hip precautions for total hip replacement (THR)

These precautions are offered to help *prevent dislocation and/or injury* to operated hip and typically are prescribed by the Physician for at least 6-8 weeks post-op.

1. Weight bearing



- Limit weight bearing as indicated by Physician
- Non-weight bearing
- Touch down (10%)
- Partial (25%-75%, or as determined by Physician)
- As tolerated
- Full

2. Walking

- Use walker/crutches as instructed by Physician and/or Therapist
- Do *not* walk with toes pointing inwards (e.g., “pigeon-toed”)

3. Lying down – sidelying

- Keep a pillow between legs from hips to feet or use abductor wedge

4. Bending

- Do *not* bend hip past 60° to 90° as specified by Physician/Therapist
- Do *not* bend forward, reach toes, tie shoes, or pull up socks
- Do *not* bring knee up higher than hip
- When getting into/out of chair/bed, keep hip from bending beyond allowable range

5. Crossing legs

- Do *not* cross legs, ankles or knees when sitting or lying

6. Rolling/twisting

- Do *not* let operated leg roll or twist inward
- Do *not* twist or look behind yourself
- Use pillow to help position if needed in bed

7. Squatting – Do *not* squat

8. Pivoting – Do *not* pivot on operated leg

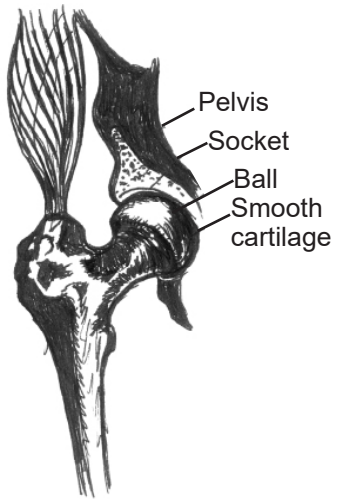
9. Sitting

- Do *not* sit at more than a 60°-90° angle
- Do *not* sit on low chairs or toilet seats; use raised toilet seats and chair cushions as recommended by Therapist
- Always sit in a slouched position in chair
- Place a pillow between knees when sitting
- Slide foot of involved leg in front of you when getting in or out of a chair

Understanding hip replacement

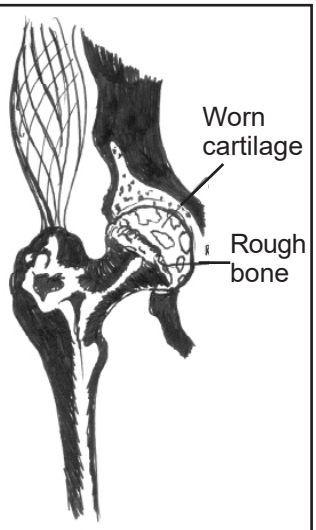
By understanding the anatomy of the hip, you can better understand how the recovery process works. The hip is a ball-and-socket joint where the thighbone meets the pelvis. This joint is surrounded by cartilage, muscles and ligaments, which allow it to move smoothly. When a natural hip must be replaced, an Orthopedic Surgeon uses a prosthesis (artificial hip joint). Like the natural hip, the prosthesis is made of a ball and socket that fit together to form a smooth joint so the resident can walk easily and without pain.

Healthy hip



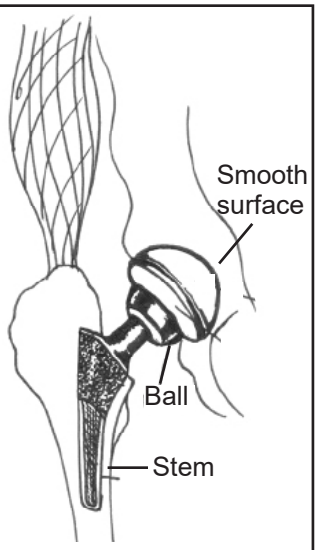
In a healthy hip, **smooth cartilage** covers the **thighbone** and pelvis. This allows the **ball** to glide easily inside the **socket**. When the surrounding **muscles** support the weight and the joint moves smoothly, the resident can walk painlessly.

Problem hip



In a problem hip, the **worn cartilage** no longer serves as a “cushion.” As the **roughened bones** rub together, they become irregular, with a surface like sandpaper. The ball grinds in the socket when resident moves his/her leg, causing pain and stiffness.

Prosthesis



A **ball**, often metal, replaces the head of the thighbone, and a **cup**, often plastic, replaces the worn socket. A **stem** is inserted into the bone for stability. All parts have **smooth surfaces** for comfortable movement once the resident has healed.

Transfers
Total hip replacement (THR)

Remember:
A transfer is
a ***shift***,
not a ***lift***!

Supine to sitting to standing

1. Approach resident and clearly explain the procedure.
2. One caregiver cradles the post-operative leg, being sure it is kept in good position (avoiding adduction and internal rotation.)
3. Tell the resident to flex unoperated leg, placing foot on the bed to help move buttocks to the side of the bed. Lower unaffected leg off the bed.
4. Resident can either hold on to overhead trapeze or support himself/herself on elbows to lift head and shift trunk while pivoting.
5. The second caregiver assists the resident to a semi-sitting position, supporting the back as the resident releases the trapeze and places hands or elbows on the bed next to his/her hips.
6. Resident is instructed to push with hands or elbows to propel hips forward toward the edge of the bed.
7. The caregiver, holding post-operative leg, slowly lowers leg to the floor as resident pushes hip forward to the edge of the bed, keeping the knee extended to avoid too much flexion at hip.
8. A walker is placed in front of the resident, and a caregiver stands on either side.
9. Resident is instructed to keep unoperated leg flexed and post-operative leg extended.
10. Resident is instructed to place one hand on the walker and the other on the bed to push up to standing.



Standing to sitting to supine

1. The resident and the walker should be square with bed and slightly toward the head of bed with unoperated leg touching bed.
2. Resident is told to slide the post-operative leg forward.
3. To avoid internal rotation, the resident reaches for the bed with one or both hands and slowly sits on the bed.
4. The resident's post-operative leg is supported by a caregiver who makes sure it stays in proper position.
5. The resident is told to lean back on his/her elbows as he/she pivots, bringing the unoperated leg up on the bed. Resident flexes unoperated leg, placing foot on bed to help lift buttocks.
6. Resident reaches up for the trapeze, using it and the good leg to position himself/herself in bed.

Bed to wheelchair (reclined 45º to 60º)

1. If possible, the footrest closest to the bed is removed or swung out of the way.
2. The resident is assisted to stand, using a walker.
3. The resident steps around until he or she is in a position to sit and the unaffected leg touches the wheelchair or bed.
4. Resident slides the post-operative leg forward.
5. The resident reaches for the arm of the wheelchair with one or both hands and sits down while sliding the post-operative leg forward to keep the knee extended.
6. The resident helps to push himself/herself back into the chair with both arms and the unaffected leg.
7. The footrest is replaced, and the post-operative leg is kept in proper alignment.

Transfers

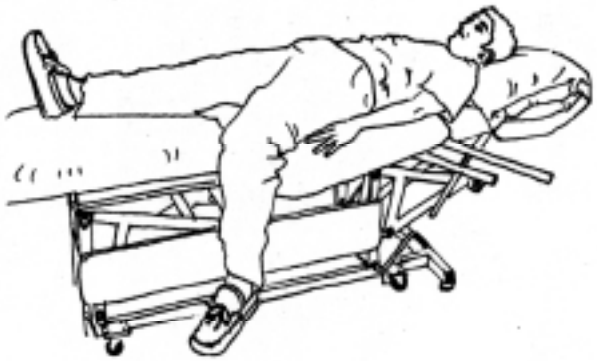
Total hip replacement (THR)

Bed to chair with walker

Remember:
A transfer is
a ***shift***,
not a ***lift***!



1. Resident has bridged to the edge of the bed.



2. Unaffected leg can be lowered off the bed.



3. Assist with cradling of surgical leg as resident pivots around.



4. Block unaffected knee and assist resident to sitting position at the edge of the bed.

Transfers

Total hip replacement (THR)

Bed to chair with walker (continued)

Remember:
A transfer is
a ***shift***,
not a ***lift***!



5. Position walker and assist while resident pushes up off bed to stand.



6. Resident reaches for walker in standing position.



7. Resident steps with walker around to chair, then touches chair with unaffected leg as surgical leg steps out and resident's hand reaches back to chair.



8. Resident carefully sits in chair while following total hip precautions.

Transfers

Hemiplegic partial-assist transfer

Remember:
A transfer is
a ***shift***,
not a ***lift***!

- Position wheelchair for transfer.
- Once resident is sitting, put gait belt *snugly* around resident's waist.
- Position resident at edge of bed with his/her feet on the floor.

1. Caregiver grasps resident's weak hand (palm to palm) and the front of the gait belt while the caregiver's other hand grasps the gait belt in back. Block the resident's weak knee with the caregiver's knee.





2. Assist the resident to stand and reach for the surface she or he is transferring to.



3. Assist the resident to sit down with control.

Remember:
A transfer is
a ***shift***,
not a ***lift***!

Transfers
Max assist or dependent transfers

This is a transfer done with a rehab resident in a “no-lift” facility. You will most likely use a mechanical lift that allows for weight bearing for non-rehab residents.

Start with both your knees bracing resident’s weaker knee. Your knees should be in front of and to the sides of resident’s knee to block. When possible you will want to transfer to the resident’s stronger side.

Basic transfer rules

1. Always take your time. Accidents happen when you hurry.
2. Plan your move:
- Position your feet
- Position your knees
- Position your hands
- Face the surface you are transferring to

3. Always explain the procedure to the resident as you progress.
4. Always get assistance if you are not sure you can safely perform the transfer alone.
5. Use your weight; let your legs do the work, not your back.



Do *not* attempt this transfer
until you have had thorough
one-on-one instruction by,
and practice with,
a Therapist or Nurse.

Blocking the knee is a *must!*

Brace the resident’s weaker knee with your knees. Keep your spine in normal alignment as you assist the resident to stand. This allows the resident to bear weight through a weakened leg during the transfer.

When the resident stands on his/her leg with a caregiver blocking at the knee, the resident is supporting his/her body weight instead of the caregiver supporting the body weight of the resident.

Transfers

Hemiplegic one-person dependent transfer

This is a transfer done with a rehab resident in a “no-lift” facility.

Remember:
A transfer is
a ***shift***,
not a ***lift***!



1. Block both of the resident’s knees with the caregiver’s knees. Cross the resident’s arms in front of the body. Closely hug the resident, grasp the back of the gait belt with both hands and look toward the surface you are transferring to.



2. Assist the resident to stand and to bear as much weight as possible on his/her legs.

Blocking the knee is a *must!*

- Brace the resident’s weaker knee with your knees.
- Keep your spine in normal alignment as you assist the resident to stand.

This allows the resident to bear weight through a weakened leg during the transfer.



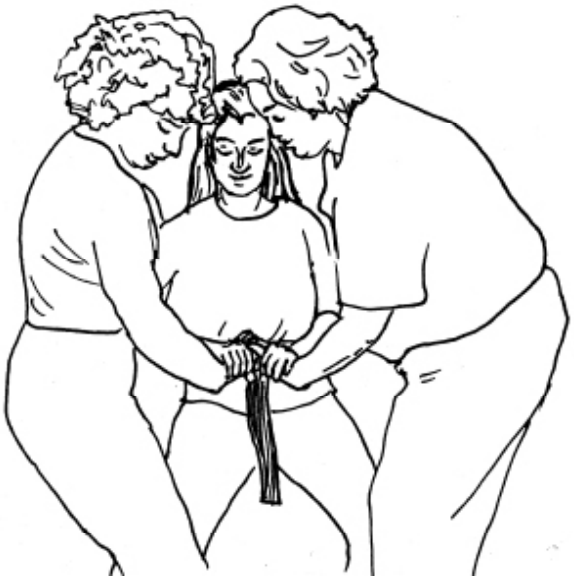
3. Step/pivot to the chair or other surface you are transferring to. Avoid twisting and lower the resident to the seated position.

Remember:
A transfer is
a ***shift***,
not a ***lift***!

Transfers

Two-person dependent transfer

This is a technique for a rehab resident in a “no-lift” facility.



1. Both caregivers grasp the resident’s hands (palm to palm) and the gait belt in front, as well as grasping the gait belt at the resident’s back. Both caregivers block the resident’s knees (“mirror-image” of caregivers).



2. Assist the resident to stand and to bear as much weight as possible on his/her legs.



3. Step/pivot toward the surface you are transferring to and lower the resident into a seated position.

Transfers

Slide board transfers

This is a technique that can be used with some residents rather than the non-weight-bearing sling mechanical lift transfer.

Remember:
A transfer is
a ***shift***,
not a ***lift***!

Purpose

To promote safety with transfers of residents who are unable to bear weight functionally.
Examples are:

1. Non-compliance with weight-bearing restrictions
2. Amputees above and below knee
3. Morbidly obese residents

Residents must be able to demonstrate good upper body strength, follow simple commands, have good trunk balance and intact skin (on buttocks and sacral areas.)

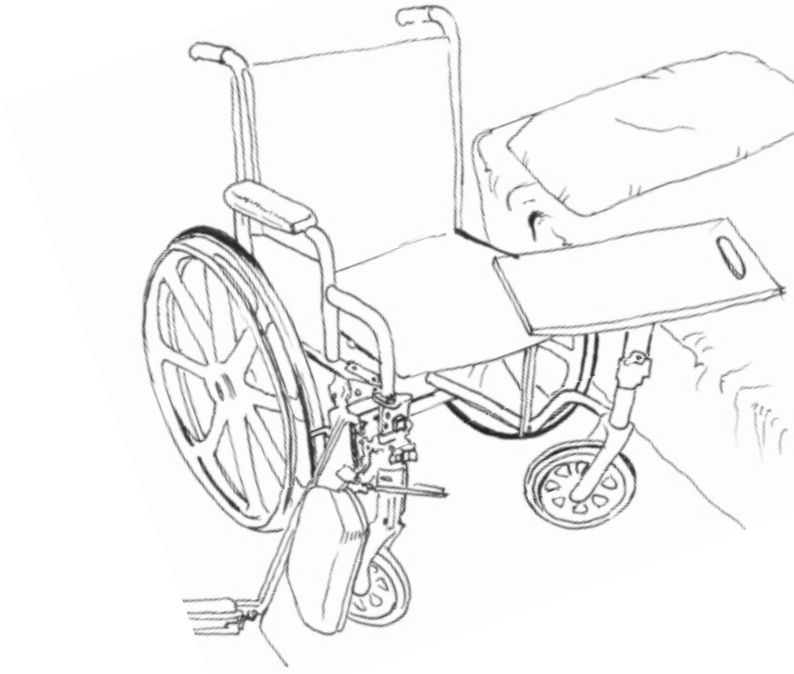
The specific technique for each resident should be determined by a Physical or Occupational Therapist after evaluation.



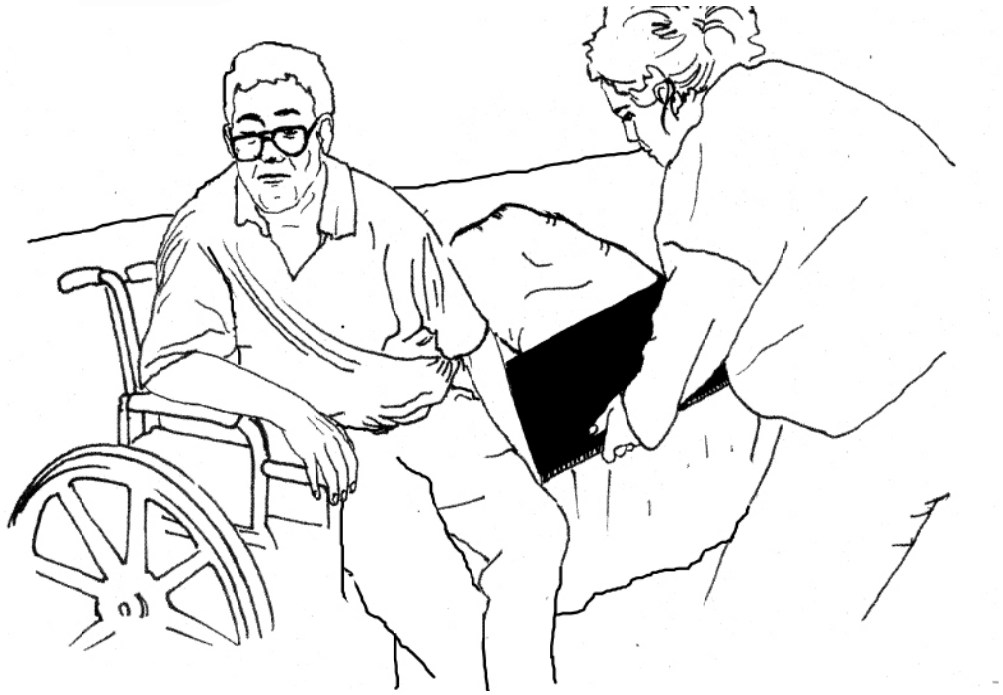
Transfers

Slide board transfer (continued)
Assisted to bed

Remember:
A transfer is
a ***shift***,
not a ***lift***!



Step 1:
Be sure the brakes are locked! Remove the wheelchair armrest closest to the bed. Tell resident to lean away from side under which you are trying to put the slide board.



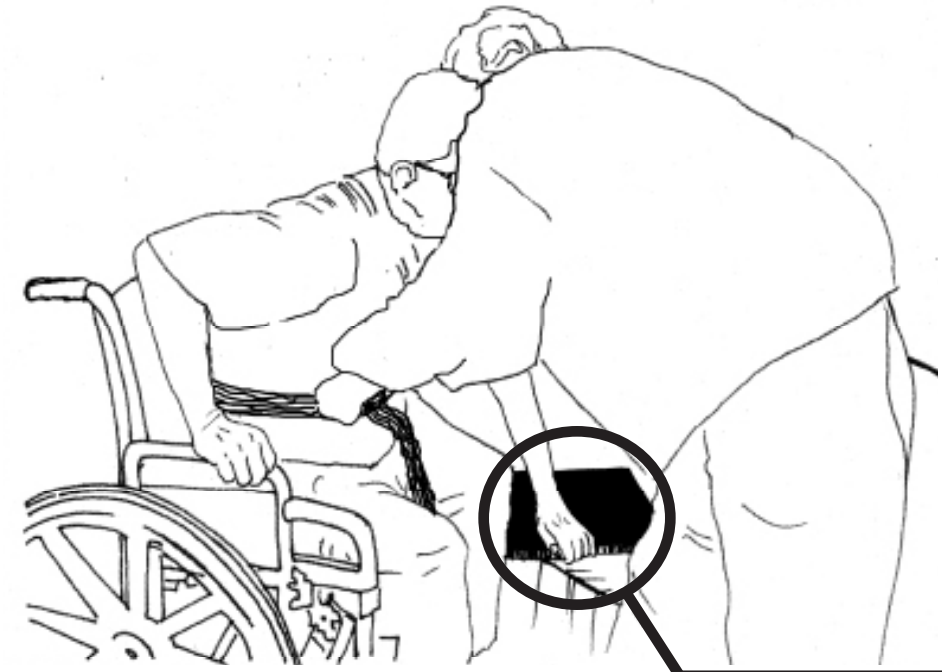
Step 2:
Assist resident in leaning away from the side of the bed and push slide board under resident's buttocks.

Transfers

Slide board transfer – assisted to bed (continued)

Step 3:
If resident is able, have him/her grasp the slide board and insert it under buttocks. You may need to steady resident during this procedure.





Step 4:
Once slide board is under resident, have resident (if able) reach out and place one hand on the board and position the other hand on the remaining wheelchair arm.

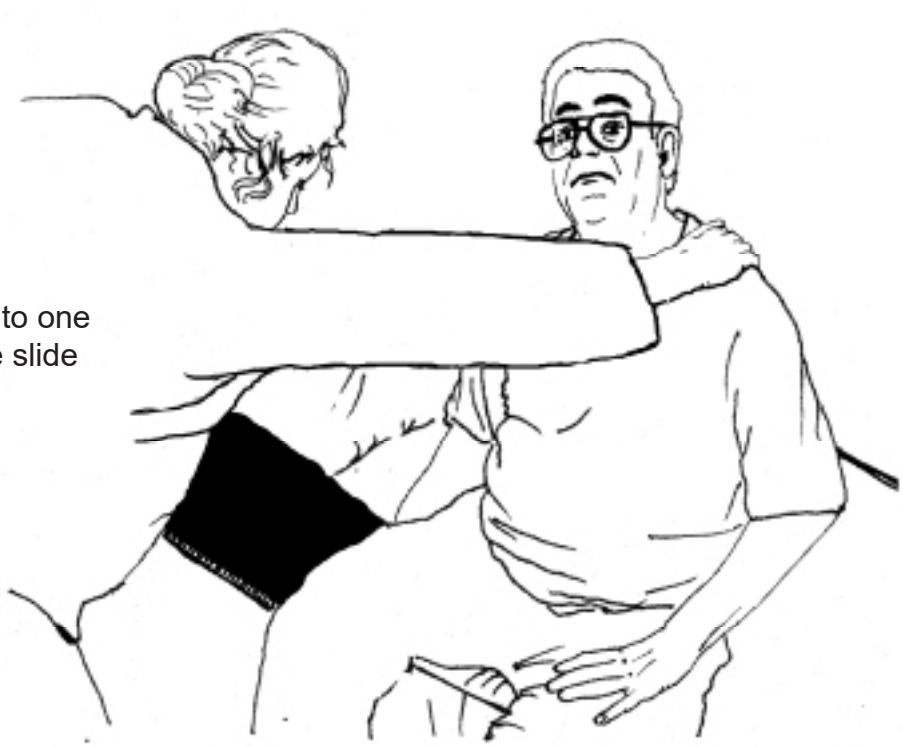
Note:
Do ***not*** allow resident's fingers to curl under slide board.

Transfers
Slide board transfer – assisted to bed (continued)

Step 5:
Instruct the resident to assist with the slide transfer to the bed.



Remember:
A transfer is
a ***shift***,
not a ***lift***!



Step 6:
Instruct resident to lean to one side while you grasp the slide board and remove it.

Transfers

Toilet transfer

Remember:
A transfer is
a ***shift***,
not a ***lift***!

Use a toilet commode or other equipment, if recommended by your Therapist. Prepare wheelchair. The specific technique for each resident should be determined by a Physical or Occupational Therapist after evaluation.

Stand pivot transfers





Step 1:

Lower clothing in stance *after* pivoting towards the toilet. Tell the resident to back up to the toilet until she/he feels the back of the knees touching it.

Step 2:

Resident should reach back for the armrests (if using toilet commode) and slowly lower her/himself onto the toilet, keeping the operated leg out in front. Tell the resident to bend the knee and hip on the non-operated side as she/he lower her/himself onto the seat.

Reverse the procedure for getting up, using the armrests to push up.
Be sure resident is balanced before grasping the walker.

Transfers

Tub transfer

Caution
1. Guard for loss of balance when lifting legs.
2. Dry completely before returning to wheelchair.
3. Dry floor before returning to wheelchair.





1. Provide non-slip surface in the tub/ shower. Prepare wheelchair and equipment in tub/shower.

2. Using the walker, step to the side of the tub. Stop next to the chair and turn so that you are facing away from the tub.

3. Reach back with one hand for the back of the chair. The other hand should remain on the walker.

4. Sit down on the chair, keeping operated leg straight out.

5. Lift legs over the side of the tub and turn to sit facing the faucet.

6. To transfer out of the tub, turn in your chair while lifting legs over the side of the tub. Stand up outside of tub, pushing off from the chair.

Use a long-handled sponge and shower hose to wash.

The specific technique for each resident should be determined by a Physical or Occupational Therapist after evaluation.

Remember:
A transfer is
a ***shift***,
not a ***lift***!

Transfers
Car transfer

Remember:
A transfer is
a ***shift***,
not a ***lift***!

Preparation
1. Open car door fully.
2. Move front seat back as far as possible.
3. Roll down window if needed as a stable surface to hold onto for balance.
4. Choose most appropriate transfer method.
5. Modify technique for transfer in this tight space.

Tips
- Stand slightly to side.
- Remove both footrests.
- Use wheelchair seat for a supporting surface.
- Assist from over, rather than around, the resident. Protect head when getting in and out of car.
- Remember to pick up all wheelchair accessories (arm and footrests, etc.).
- Follow the Therapist's recommendations for ease of positioning on the car seat as necessary.

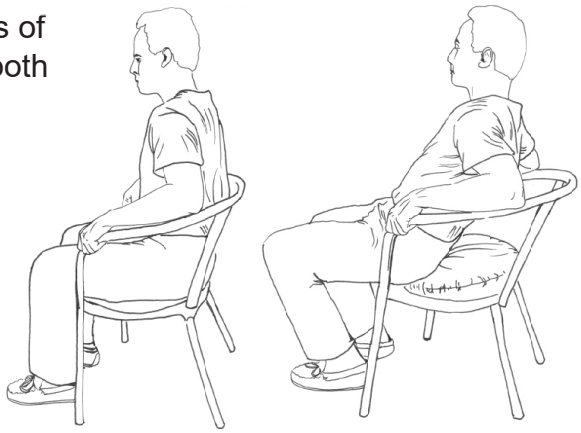




Remember
The specific technique for each resident should be determined by a Physical or Occupational Therapist after evaluation.

Getting up and down from a chair
General techniques

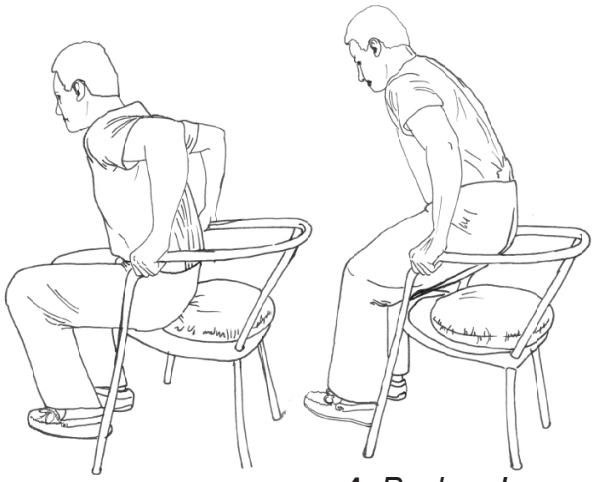
1. Grasp the arms of the chair with both hands.



2. Push down with the elbows, arch the back and scoot the bottom forward.

3. Lean forward so that *the nose is over the toes*.

Total hip and partial hip residents:
Don't bend beyond 90º



4. *Push up!*



5. Reach for walker one hand at a time.



6. Stand for a moment and balance before moving.

Reversing the procedure – sitting down

- Be sure to turn around and back up until the legs touch the chair.
- Reach back for the chair one hand at a time.
- Sit down slowly.
- Sit all the way back in the chair.

Getting up and down from a chair

Total or partial hip replacement or with limited weight bearing

Step 1:
Grasp the arms of the chair with both hands.



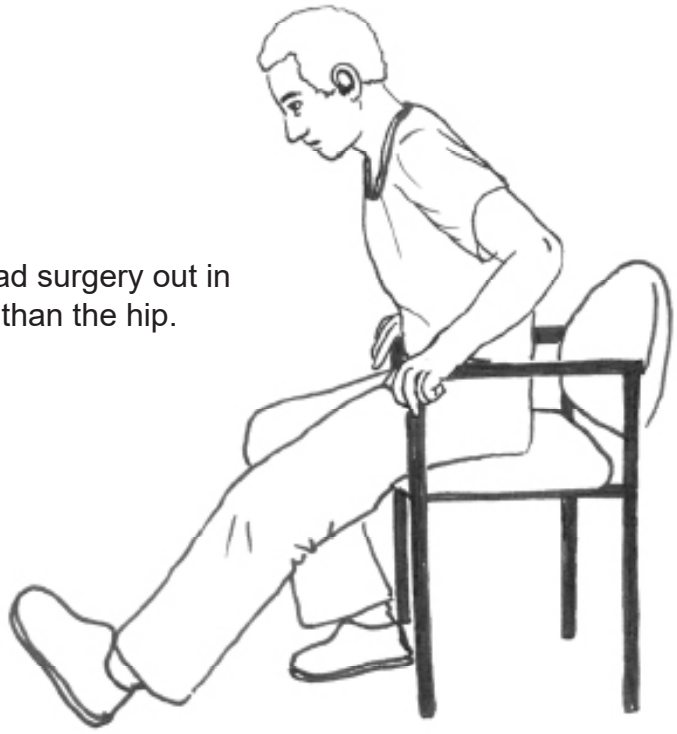
Step 2:
Push down with the elbows, arch the back and scoot the bottom forward.



Getting up and down from a chair

Total or partial hip replacement or with limited weight bearing (continued)

Step 3:
Put the foot of the leg which had surgery out in front so the knee will be lower than the hip.



Step 4:
Don't bend hip beyond 90º. Push up!

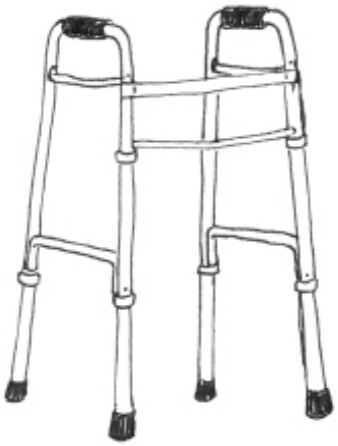


More tips:

1. Reach for walker one hand at a time.
2. Stand for a moment and make sure of balance before moving.
3. Back up to the chair until both legs touch the chair.
4. Reach back and grasp the chair arms one at a time.
5. Don't bend hip beyond 90º.
6. Sit down slowly.
7. Put the foot of the leg which had surgery out in front so the knee will be lower than the hip.

Ambulation

Definition: Ambulation is walking or moving about in an upright position.



Observe for

1. Chest pains
2. Shortness of breath (SOB)
3. Dizziness or faintness
4. Unusual weakness
5. Rapid increase or decrease in heart rate
6. Change in skin color (pallor)
7. Sudden onset of heavy sweating

Precautions

1. Make sure all equipment is safe to use
2. Check rubber tips of ambulation devices for wear
3. Check walkers for loose hardware
4. Check gait belt for wear, sharp edges on buckles, etc.
5. Make sure the resident is wearing appropriate shoes, clothing, glasses and hearing aid

Weight bearing status

1. **FWB** – full weight bearing
2. **WBAT** – weight bearing as tolerated
3. **PWB** – partial weight bearing – 25% to 75% or as determined by Physician
4. **TDWB** – touch down weight bearing – light weight on leg, mainly for balance, under 10%
5. **NWB** – non weight bearing

Levels of assistance terminology

1. **MAX – maximum assistance** – resident not assisting, requires 75% or more assist
2. **MOD – moderate assistance** – resident assisting some, requires 25-75% assist
3. **MIN – minimal assistance** – light assistance needed, requires 25% or less assist
4. **CGA – contact guard assistance** – hand contact on resident and verbal cues
5. **SBA/S – stand-by assistance/supervision** – resident only needs someone to standby or supervise and give verbal cues
6. **I – independent** – no assistance needed and observes safety precautions

Ambulation (continued)

Possible reasons for assisted ambulation

1. Risk of falls due to:
- Limited weight bearing status
- Lower extremity weakness
- Poor vision
- Impaired balance
- Decreased safety awareness

2. Generalized weakness due to:
- Inactivity
- Recent illness
- Chronic disease

3. Potential for increased functional activity level on an RNP
- Resident's discharge from Skilled Therapy
- Resident's slow progress with Skilled-Therapy Program
- New admissions not appropriate for skilled intervention

4. Change of condition due to:
- New illness/injury
- Resolution of illness
- Progression of chronic disorder

General procedures

Before assisting the resident to ambulate, know the following:

1. Level of activity permitted and/or need for monitoring pulse and blood pressure pre/post walking.
2. Transfer ability and level of assist needed
3. Mental status and ability to follow directions
4. Vision status
5. Use and type of assistive devices for ambulating
6. Weight-bearing status
7. Lower extremity precautions (e.g., edema, foot drop, etc.)
8. Type of ambulation and plan for distance, pace, etc
9. Resident's tolerance level for walking and preferred shoes and clothing
10. Balance ability

Ambulation equipment

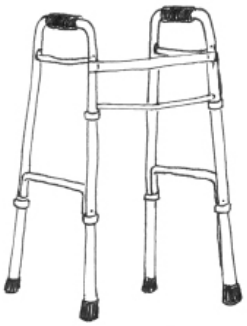
Walkers

1. Pick-up walker
- One step at a time
- Involved leg first
- Used with limited weight bearing or for poor balance

2. Front-wheeled walker
- Rolling front wheels
- Allows for a more fluid gait pattern while still providing support

3. Four-wheeled walker
- For a resident who has good balance, good safety and a fluid gait pattern

4. Merry walker
- For a resident who can sit, stand and ambulate independently but has poor to no safety judgment



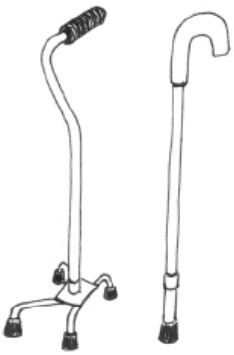


Canes

1. Straight
- Hold cane in hand opposite involved leg
- Offers the least balance support

2. Quad Cane
- Four-point base of support (comes small base and large base)
- Provides more support than a straight cane

3. Hemi-walker
- Four-point base of support
- Wider base of support than quad cane
- Offers the greatest balance support



Crutches

1. Standard (axillary)
- Keep a triangle base of support at all times
- The weight is on the hands maintaining a 2-3 finger space from top support and axilla

2. Platform
- Forearm support
- Used to limit weight bearing on hands and wrists

3. Lofstrand
- Forearm cuff
- Without axillary support

Caregiver tip

With all assistive devices (ADs), advance the AD first, then the involved leg and then non-involved leg.

Gait patterns

1. Step-to Gait (three-point gait)
- NWB
- TDWB
- PWB
- WBAT
- FWB
- Devices: cane, crutches or walker

2. Step Through (three-point gait)
- PWB
- WBAT
- FWB
- Same devices

3. Altered gait patterns

Rationale for weight bearing

1. Prolonged weight bearing for functional toileting and functional ambulation
2. Cardiovascular maintenance
- Maintain cardiac output
- Prevent orthostatic hypotension

3. Long bone load to prevent osteoporosis
4. Maintain muscle length

Devices

1. Tilt table
2. Standing frame
3. Handrail
4. Walkers

Indications/contraindications for routine ambulation/maintenance program

Positive

1. Increased skeletal muscle strength/ROM
2. Increased aerobic capacity
3. Bone density preservation
4. Contributes to mobility and independence
5. Can restore physiologic capacity once lost
6. Can reduce risk of CVA, heart problems/disease
7. Appetite stimulation
8. Fall prevention

Negative

1. Heart signs:
- Marked SOB
- Profuse sweating/pale skin
- Chest pain
- Sharp/intense joint pain, sudden onset

2. Change in speech pattern
3. Acute DVT

Criteria for continuing or discharging from RNP ambulation program

Continuing program

Continued functional progress as indicated by:

1. Increased activity tolerance
- – Increased ambulation distance
- – Decreased time to ambulate a specified distance

2. Decreased level of assistance required

3. Improved gait pattern
- – Improved balance
- – Stride/step length
- – Path
- – Foot clearance

4. Resident skill levels require RNA supervision or specialized training

Discharging program

Decline in functional progress as indicated by:

1. Increased c/o pain and/or fatigue

2. Change in medical condition

3. Change in cognition/mental status

4. Deteriorating gait/transfer skills

5. Falls – requiring assistance by Nursing or Therapy

6. Plateau of skills – someone who can be assisted by the CNA during routine ADL care



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GLOSSARY

Terminology for swallowing disorders

Aspiration: The entrance of food, liquid, or other substance into the airway.

Aspiration pneumonia: Inflammation and/or infection of the lungs caused by inhaling food, liquid, or other substance.

Dysphagia: Difficulty in swallowing.

Esophagus: A portion of the digestive system. A flexible tube or canal that carries food from the throat to the stomach.

Larynx: The organ of the voice. Sound is produced by the vibration of the vocal folds located in the larynx or voice box.

Modified barium swallow: Technique used to trace the passage of substances during a swallow.

Nasogastric tube (NG tube): A feeding tube inserted into the nose and running down the throat into the stomach. Used to feed a person who is unable to take food by mouth.

Percutaneous endoscopic gastronomy tube (PEG): A feeding tube inserted directly into the abdomen leading into the stomach. Used to feed a person who is unable to take food by mouth.

Pharynx: A tube often referred to as the throat, extending from the back of the nasal cavity (nose) down to the level of the voice box. The pharynx is used in breathing and in swallowing.

Reflux: The return of food or liquid to the throat from the stomach.

Silent aspiration: Food or liquid entering the airway or lungs without producing any symptoms of disturbance such as coughing or struggling behavior

Videofluoroscopy: Moving X-ray studies recorded on videotape.



GLOSSARY

Abbreviations for physical rehabilitation

• *Evaluation terms*

WNL – Within normal limits
WFL – Within functional limits
N/T – Not tested
OOB – Out of bed
BTB – Back to bed
Xfer – Transfer
ROM – Range of motion
AROM – Active range of motion
AAROM – Active assist range of motion

PROM – Passive range of motion
Abd – Abduction
Add – Adduction
ER – External rotation
IR – Internal rotation
/ – Extension
✓ – Flexion

• *Treatment terms*

PRE – Progressive resistive exercise
SAQ – Short arc quads
SLR – Straight leg raise
ADL – Activity of daily living [mobility,self care, communication]
IADL – Instrumental activities of daily living – home management, shopping, meal planning, community living skills, money and finances, public transportation, health management handling medication, understanding risks, appointments, safety management (e.g., 911, fire)
CPM – Continual passive motion
THA – Total hip arthroplasty
THP – Total hip precautions (see handout)
THR – Total hip replacement
HEP – Home exercise program
ORIF – Open reduction internal fixation

• *Weight bearing terms*

FWB – Full weight bearing
NWB – Non weight bearing
WBAT– Weight bearing as tolerated
PWB – Partial weight bearing (specify percent or weight in pounds)
TTWB – Toe touch weight bearing
TDWB – Touch down weight bearing

• *Adaptive devices and regularly used orthosis*

AFO – Ankle foot orthosis
PRAFO – Pressure relieving ankle foot orthosis
WBQC – Wide based quad cane
NBQC – Narrow based quad cane
FWW – Front wheeled walker
4WW – Four wheeled walker
PUW – Pick up walker
PFW – Platform walker – specify *L* (left), *R* (right) or *B* (bilateral)
SPC – Single point cane
W/C – Wheelchair
// or **P Bars** – Parallel bars
HHA – Hand Hold assist
Sl bd – Sliding board
WHO – Wrist hand orthosis
TENS – Transcutaneous electrical nerve stimulation

• *Other*

Jt – Joint
Fx – Fracture
UE – Upper extremity
LE – Lower extremity
A&O – Alert and oriented

GLOSSARY

Terminology for activities of daily living (ADLs)

Activities of daily living – Those tasks that are required to function in the home or work environment on a day-to-day basis.

Adaptive equipment – Assistive devices designed to aid in independent performance of self-care skills

Adaptive technique – A method of performing tasks using a modified process.

Grooming – Combing/brushing hair, shaving, applying make-up.

Hygiene – Washing face, brushing teeth/dentures, applying deodorant, toilet hygiene.

Judgment – Knowing limitations and understanding what you must do to safely perform tasks.

Precautions – May include one or more of the following: visual deficits, poor safety awareness, poor judgment, lack of proper safety techniques, medical problems that will impact ADLs (hip replacement, stroke, diabetes, contractures, etc.)

Safety awareness – Understanding own limitations and deficits in relation to ADLs and mobility.

Visual deficits – Difficulty with sight and perception such as: blurred vision, double vision, neglect or limited awareness of one side of visual area, improper perception of things seen, poor eyesight or blindness.

More definitions

1. **Affected** side is the *weaker* side.
2. **Contraindicated** means *advised against*.
3. **Contracture** – Within 24 hours, a joint that has not been moved can begin to stiffen and eventually become inflexible. With longer periods of immobility, the tendons and muscles pull tight, which may result in a fixed position called a contracture.
4. Joint **crepitus** are *noises* in the joint.
5. **Subluxation** is a partial or incomplete *dislocation* of a joint.
6. **Flexion** is *bending* of a joint so that the angle of the joint diminishes.
7. **Extension** is the *return movement* from flexion; the joint angle is increased.
8. **Abduction** is *movement away* from the midline of the body.
9. **Adduction** is *movement toward* the midline of the body.
10. **Internal** is *turning inward* toward the center.
11. **External** is *turning outward* away from the center.
12. **Supination** is *rotating* the forearm so that the palm of the hand is *up*.
13. **Pronation** is *rotating* the forearm so that the palm of the hand is *down*.
14. **Rotation** is turning or movement of a part *around its axis*.
15. **Dorsiflexion** is flexing or bending the *foot toward the face*.
16. **Plantar flexion** is flexing or bending the foot in the *direction of the sole*.
17. **Inversion** is the movement that turns the sole of the foot *inward*.
18. **Eversion** is the movement that turns the sole of the foot *outward*.

GLOSSARY

Terminology for splinting program

Arch – A curved or bowlike shape in the palm of the hand and the bottom of the foot.

Bony prominence – Areas on the body that have little or no fat between the bone and the skin.

Contracture – Joint condition of fixed resistance to movement.

Creases – A longitudinal line or straight depression in the fold of a joint or palm of hand or bottom of foot.

D ring – Rectangle or D-shaped device used in the fastening process of a splint on an arm or leg.

Joint alignment – Proper positioning during rest and movement that allows proper coordination of the flexor and extensor tendons.

Prehension – The act of grasping objects with the fingers.

Range of motion – The movement of a joint through space.

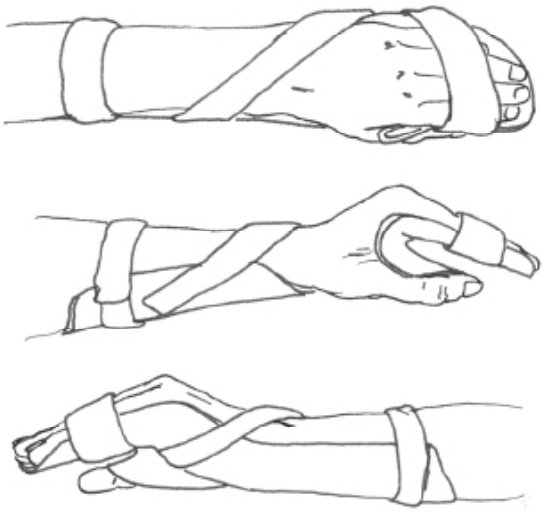
Spasticity – An increase of tone of a muscle resulting in a difficulty with movement.

Splint – An appliance used to support a joint in the arm or leg.

Stockinette – Thin stretchy cotton material used under splints to absorb moisture.

Web space – The space between the knuckle of the pointer finger and the thumb.

Velcro – Fastening material made of two pieces, hook and loop or pile, used to keep splint on arm or leg.



Adaptive walking devices

Canes

Ortho cane
1. Places weight under resident's hand
2. Greater balance and control
3. Can use ortho-grip

Quad cane
1. Adjustable length
2. Four leg-contacts with floor
3. Gives more support as long as all tips contact floor

Single-point cane
1. Telescoping feature allows for adjustment
2. Curved handle for better grip

Walk cane
• Combination of walker and cane

Crutches

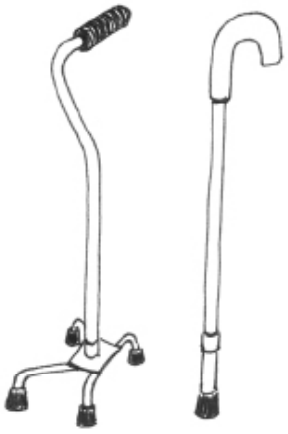
Axillary crutch
• Adjustable

Forearm trough crutch
1. Adjustable handle on trough
2. Used with residents who cannot put weight on wrist and hand

Forearm crutch (Lofstrand)
1. Adjustable aluminum tube attached to curved steel shank
2. Rubber covered hand bar
3. Metal forearm cuff
4. Used when resident needs more support than a cane, but not two crutches
5. Used with some polio, neuro injury or CP residents

Walkers

Pick-up walker
Front wheel walker
Four-wheeled walker



RNA HIRING INTERVIEW GRID

Name: Date of interview:

Interview panel members:

		Possible score	Score
Current license/clearance:	☐ Yes ☐ No		
Years of experience as CNA with floor experience	• 1-2 years • >2-3 years • >3-5 years • >5 years	1 2 3 4	
Years of experience as RNA	• 1-2 years • >2-3 years • >3-5 years • >5 years	1 2 3 4	
Seniority/years of experience at facility	• 1-2 years • >2-3 years • >3-5 years • >5 years	1 2 3 4	
Last performance appraisal	• Below standard • Standard • Above standard	0 1 2	
Attendance at mandatory in-services	• <50% • 50-75% • >75%	0 1 2	
Attendance records	• >10 days absent • 6-9 days absent • 3-5 days absent • 0-2 days absent	0 1 2 3	
Certification from the Restorative Nursing Program course or other documented competency skills review	Competency exam • Passed 100% • Failed <100% Post-test exam • Passed >80% • Failed <80%	4 0 4 0	
Interview skills *(Present a scenario for discussion and judge the response on problem-solving skills, communication skills, initiative and knowledge.Use the same scenario for each applicant)* Document strengths and weaknesses.		1 2 3 4	
	Score	25	

– *SAMPLE* –

Restorative Nursing Program (RNP)
Policy and Procedure

Purpose
The purpose of the RNP is to assist each resident in achieving the highest level of self-care possible.

The concept of self-care is an integral part of daily nursing care and includes at least the following:

1. Active range of motion exercises
2. Passive range of motion exercises
3. Splint or brace assistance
4. Bed mobility training and skill practice
5. Transfer training and skill practice
6. Walking training and skill practice
7. Dressing or grooming training and skill practice
8. Eating and swallowing training and skill practice
9. Amputation and prosthetic care training and skill practice
10. Communication training and skill practice

Policy – This facility should follow the policy as outlined below.

References
This applies to all Skilled Nursing Facilities. References: OBRA F-Tags 676, 677, 685, 686, 688, 690 and 692, California Title 22, Section 72315, and HCFA RAI Version 3.0 Manual.

Procedure (See “Flow Chart” on page 14)

A. Each new resident admitted is assessed per Minimum Data Set (MDS) schedule. At this time, restorative needs and self-care deficits can be identified.
B. A resident can be referred to the RNP from a Skilled Therapy Program, by Nursing, the Interdisciplinary Team (IDT), family, caregivers or self-referred.
C. When the resident need is identified, a referral to rehab for screening is recommended. The Therapist completes the screen, trains the RNA in resident-specific program needs and initiates the resident care plan.
D. Typically, a resident is referred to the RNP near the end of his or her Skilled Therapy Program. Prior to discharge, the Therapist determines resident-specific Restorative Program needs, trains the RNA in appropriate techniques and initiates the resident care plan.
E. A written RNP referral (which includes problems, goals and approaches) is completed by the responsible discipline(s) and given to the RNPC for implementation by the RNA.
F. Obtain Physician orders and discharge order per facility policies and procedures.

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– *SAMPLE* –

Restorative Dining Program protocol

Purpose and goals

To provide each resident with the ability to become an independent eater by learning new techniques or by learning to use adaptive equipment; to increase the ability to effectively and safely take in food and fluids; to improve nutritional status and to prevent dehydration.

Criteria

Entrance/admission

Indicators may include one or more of the following:

1. Weight loss of over 5 percent of body weight
2. Impaired swallowing
3. Poor nutritional intake
4. Wandering
5. Excessive pacing
6. Unable to get food from the plate to the mouth due to:
- Shaking hands
- Decreased ROM for grasping utensil or cup
- Weakness in hands
- Awkward use of non-dominant hand

Exit/discharge

Indicators may include one or more of the following:

1. Weight gain
2. Stable swallowing
3. Desirable nutritional intake
4. Stable behaviors that support intake goals
5. Ability to get food from plate to their mouth
6. Independent eating skills

Process

1. Assessed and referred by Therapy
2. Therapist trains RNA in Restorative Dining techniques per resident
3. RNPC provides oversight to program
4. Dietary provides adaptive equipment with each meal tray
5. RNA orients resident to tray and instructs resident in specific techniques

– SAMPLE –

Restorative Dining Program protocol (continued)

Place and frequency
Quiet, non-distracting environment; three meals per day.

Ratio
Recommend 2-to-1 ratio of residents to RNAs with RNPC or licensed nursing supervision.

Documentation
1. Physician Orders
2. Resident Care Plan
3. Restorative Dining Program Referral Form
4. Restorative Dining Program Record and Progress Notes
5. Licensed Nursing Weekly Summary
6. No Physician Orders required

Team review
Team includes RNA, RNPC, Charge Nurse for resident and OT and SLP Therapists as needed and available; regularly scheduled meetings (at least one time per month) and with resident changes in status.

Review agenda
1. Status and progress of resident
2. Resident response to experience
3. Review of plan and changes as needed

RESTORATIVE NURSING PROGRAM REFERRAL FORM

CURRENT STATUS ▶	SELF-PERFORMANCE ASSIST LEVEL					
ACTIVITY ▼	**INDEPEND.**	**SUPERV.**	**LIMITED ASSIST**	**EXTENSV. ASSIST**	**TOTAL DEPEND.**	**ACTVTY. DID NOT OCCUR**
RANGE OF MOTION -- PASSIVE/ACTIVE						
SPLINT OR BRACE ASSISTANCE						
BED MOBILITY						
TRANSFERS						
WALKING						
DRESSING OR GROOMING						
EATING OR SWALLOWING						
AMPUTATION AND PROSTHETIC CARE						
COMMUNICATION						
EXERCISE						
WHEELCHAIR MOBILITY						
POSITIONING						
OTHER						

COMMUNICATION STATUS	ABLE	UNABLE	WITH VERBAL CUES	WITH GESTURES	ADDITIONAL COMMENTS
ABILITY TO UNDERSTAND					
ABILITY TO SEE/READ					
ABILITY TO SPEAK					
ABILITY TO MAKE DECISIONS					

STRENGTH: (FAIR, POOR ABSENT) **ROM**: SPECIFY EXTREMITY/JOINT & ASSIST LEVEL (WFL, LIMITED -- SEVERE, MODERATE, MINIMAL)	**COMMENTS**: (PRECAUTIONS, BEHAVIOR, COGNITION, POSITIONING NEEDS, BOWEL & BLADDER, EQUIPMENT NEEDS)

PROBLEMS	**GOALS**	**APPROACHES**
		FREQUENCY: DURATION:

INITIAL ASSESSMENT COMPLETED BY (NURSE/ THERAPIST):_____ DATE: _____

RECOMMENDED START DATE: _____

PROGRAM REVIEWED WITH RNA and TRAINING COMPLETED:_____ RNA SIGN and DATE

DATE OF DISCHARGE: _____

LAST NAME	FIRST NAME	INITIAL	PHYSICIAN	ROOM NO.	RES. NUMBER

RESTORATIVE DINING PROGRAM REFERRAL FORM

CURRENT STATUS	
REASON FOR REFERRAL	EXPLAIN: _____
DIET	SOLIDS: ☐ Puree ☐ Mechanical Soft ☐ Regular LIQUIDS: ☐ Thick ☐ Semi-Thick ☐ Thin
WEIGHT	IBW: _____ PRESENT WEIGHT: _____ ADMISSION WEIGHT: _____ DATE: _____ DATE: _____ DATE: _____
CURRENT FEEDING ABILITY	☐ Takes adequate amounts of food and fluids ☐ Feeds self with minimal assistance ☐ Feeds self with prompting ☐ Chewing problem ☐ Swallowing problem ☐ Currently tube fed ☐ Able to cut food ☐ Other _____
PHYSICAL LIMITATIONS	☐ Contractures of hands ☐ Trembling ☐ Dentures: Full ___ Upper ___ Lower___ ☐ Has hand control ☐ Able to hold utensils ☐ Other _____
COGNITION	☐ Alert -- will follow directions ☐ Alert -- will NOT follow directions ☐ Is aware to bring food to mouth ☐ Nonresponsive ☐ Other _____
COMMUNICATION	☐ Able to speak ☐ Able to read ☐ Other _____
VISION	☐ Blind ☐ Right ☐ Left ☐ Partial ☐ Sight good ☐ Other _____
HEARING	☐ Hears without difficulty ☐ Hard of hearing ☐ Right ☐ Left ☐ Hearing aid ☐ Other _____
BEHAVIOR/MOTIVATION	☐ Cooperative ☐ Likes to be independent ☐ Wants to feed self ☐ Does not respond when spoken to ☐ Will not stay seated ☐ Other _____
NEATNESS and TABLE MANNERS	☐ Spills ☐ Misses mouth ☐ Dribbles food and liquids ☐ Neat, eats with appropriate utensils ☐ Food left in mouth ☐ Other _____

SPECIAL NEEDS	
POSITIONING NEEDS	☐ Needs pillow positioning on right _____, left _____, both sides _____ to maintain upright position for meals ☐ Other _____
ADAPTIVE EQUIPMENT NEEDS	☐ Adaptive spoon ☐ Adaptive fork ☐ Adaptive knife ☐ Plate guard ☐ Adaptive cup ☐ Other _____
PRECAUTIONS:	☐ Other _____

PROBLEMS	GOALS	APPROACHES
		FREQUENCY: DURATION:

INITIAL ASSESSMENT COMPLETED BY (NURSE/ THERAPIST):_____ DATE: _____

RECOMMENDED START DATE: _____

PROGRAM REVIEWED WITH RNA and TRAINING COMPLETED:_____ RNA SIGN and DATE

DATE OF DISCHARGE: _____

LAST NAME	FIRST NAME	INITIAL	PHYSICIAN	ROOM NO.	RES. NUMBER

RESTORATIVE NURSING PROGRAM ACTIVITY RECORD

Month/Year _____

Record number of minutes (required for specific Medicare PPS RUG-III levels only) and assist level for each activity in the boxes below.
If the activity is not provided, note the following in the boxes: S = Res. Sick; R = Res. Refused; U = Res. Unavailable; D = Res. Discharged; X = RNA Unavailable.

A. **SELF-PERFORMANCE *(SELF)*** CODE FOR RESIDENT'S PERFORMANCE (NOT INCLUDING SET-UP) (Note: Scoring key from MDS Section G)

O. INDEPENDENT - No help or oversight
1. SUPERVISION - Oversight, encouragement or cueing
2. LIMITED ASSISTANCE - Res. highly involved, provided physical help in maneuvering of limbs or other non-weight bearing assist
3. EXTENSIVE ASSISTANCE - Res. performed part of activity, but help was provided for weight-bearing support or staff provided full assist in some task
4. TOTAL DEPENDENCE - Full staff performance of activity
8. ACTIVITY DID NOT OCCUR DURING THIS PERIOD

B. **SUPPORT (*SUPP*) PROVIDED (CODE REGARDLESS OF RESIDENT'S SELF-PERFORMANCE ACTIVITY**

O. NO SET-UP OR PHYSICAL HELP FROM STAFF
1. SET-UP HELP ONLY
2. ONE PERSON PHYSICAL ASSIST
3. TWO OR MORE PERSONS PHYSICAL ASSIST
8. ACTIVITY ITSELF DID NOT OCCUR

ACTIVITY		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	MIN.																															
	SELF																															
	SUPP																															
	MIN.																															
	SELF																															
	SUPP																															
	MIN.																															
	SELF																															
	SUPP																															
RECORD INITIALS DAILY																																

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE

DATE	**RESTORATIVE NURSING PROGRAM PROGRESS NOTES** *Write DAILY narrative of special occurrences and WEEKLY summary of resident's progress, which may include the following information: (1) Describe resident's specific behavior for each activity; (2) Document the average self-performance and support assistance needed during activity; (3) Describe improvements, declines or maintenance in resident's activities; (4) Describe resident's pain (where, when, and how much (0=none;1-3=mild; 4-7=moderate; 8-10=severe); (5) Note recommendations for continuing and or changing the resident's plan.* **SIGNATURE of Restorative Assistant** *and/or Licensed Nurse*

Resident Name _____ **Room #** _____

RESTORATIVE DINING PROGRAM RECORD

Month/Year _____

Record number of minutes (required for specific Medicare PPS RUG-III levels only), assist level and percentage of intake for each meal.
If the activity is not provided, note the following in the boxes: S = Res. Sick; R = Res. Refused; U = Res. Unavailable; D = Res. Discharged; X = RNA Unavailable.

C. **SELF-PERFORMANCE *(SELF)*** CODE FOR RESIDENT'S PERFORMANCE (NOT INCLUDING SET-UP) (Note: Scoring key from MDS Section G)

O. INDEPENDENT - No help or oversight
1. SUPERVISION - Oversight, encouragement or cueing
2. LIMITED ASSISTANCE - Res. highly involved, provided physical help in maneuvering of limbs or other non-weight bearing assist
3. EXTENSIVE ASSISTANCE - Res. performed part of activity, but help was provided for weight-bearing support or staff provided full assist in some task
4. TOTAL DEPENDENCE - Full staff performance of activity
8. ACTIVITY DID NOT OCCUR DURING THIS PERIOD

D. **SUPPORT (*SUPP*) PROVIDED (CODE REGARDLESS OF RESIDENT'S SELF-PERFORMANCE ACTIVITY**

O. NO SET-UP OR PHYSICAL HELP FROM STAFF
1. SET-UP HELP ONLY
2. ONE PERSON PHYSICAL ASSIST
3. TWO OR MORE PERSONS PHYSICAL ASSIST
8. ACTIVITY ITSELF DID NOT OCCUR

ACTIVITY		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
BREAKFAST	MIN.																															
	SELF																															
	SUPP																															
	%																															
LUNCH	MIN.																															
	SELF																															
	SUPP																															
	%																															
DINNER	MIN.																															
	SELF																															
	SUPP																															
	%																															
RECORD INITIALS DAILY																																

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE

Resident Name _____ **Room #** _____

DATE	**RESTORATIVE DINING PROGRAM PROGRESS NOTES** *Write DAILY narrative of special occurrences and WEEKLY summary of resident's progress, which may include the following information: (1) Describe resident's specific behavior for each activity; (2) Document the average self-performance and support assistance needed during activity; (3) Describe improvements, declines or maintenance in resident's activities; (4) Describe resident's pain (where, when, and how much (0=none;1-3=mild; 4-7=moderate; 8-10=severe); (5) Note recommendations for continuing and or changing the resident's plan.* **SIGNATURE of Restorative Assistant** *and/or Licensed Nurse*

Resident Name _____ **Room #** _____

Case study samples

The following pages contain filled-out case study forms for the following fictional residents:

• **"Cora Connelly" (see Page 32 for case study)** **182-184**
Restorative Nursing Program Referral Form 182
Restorative Nursing Program Activity Record 183
Restorative Nursing Program Progress Notes 184

• **"William Lowe" (see Page 34 for case study)** **185-190**
Restorative Nursing Program Referral Form 185
Restorative Nursing Program Activity Record 186
Restorative Nursing Program Progress Notes 187
Restorative Dining Program Referral Form 188
Restorative Dining Program Record 189
Restorative Dining Program Progress Notes 190

• **"Ava Wave" (see Page 35 for case study)** **191-196**
Restorative Nursing Program Referral Form 191
Restorative Nursing Program Activity Record 192
Restorative Nursing Program Progress Notes 193
Restorative Dining Program Referral Form 194
Restorative Dining Program Record 195
Restorative Dining Program Progress Notes 196

For blank copies of these forms, suitable for photocopying, see Pages **175-180**

RESTORATIVE NURSING PROGRAM REFERRAL FORM

CURRENT STATUS ▶	SELF-PERFORMANCE ASSIST LEVEL					
ACTIVITY ▼	**INDEPEND.**	**SUPERV.**	**LIMITED ASSIST**	**EXTENSV. ASSIST**	**TOTAL DEPEND.**	**ACTVTY. DID NOT OCCUR**
RANGE OF MOTION -- PASSIVE/ACTIVE						
SPLINT OR BRACE ASSISTANCE			X			
BED MOBILITY			X			
TRANSFERS			X			
WALKING			X			
DRESSING OR GROOMING	X Upper Body					
EATING OR SWALLOWING						
AMPUTATION AND PROSTHETIC CARE						
COMMUNICATION	X					
EXERCISE			X			
WHEELCHAIR MOBILITY						
POSITIONING						
OTHER						

COMMUNICATION STATUS	ABLE	UNABLE	WITH VERBAL CUES	WITH GESTURES	ADDITIONAL COMMENTS
ABILITY TO UNDERSTAND	X				
ABILITY TO SEE/READ	X				
ABILITY TO SPEAK	X				
ABILITY TO MAKE DECISIONS	X				Fearful, requires verbal cues

STRENGTH: (FAIR, POOR ABSENT)

ROM: SPECIFY EXTREMITY/JOINT & ASSIST LEVEL (WFL, LIMITED -- SEVERE, MODERATE, MINIMAL)

COMMENTS: (PRECAUTIONS, BEHAVIOR, COGNITION, POSITIONING NEEDS, BOWEL & BLADDER, EQUIPMENT NEEDS)

Requires encouragement & hands on assist due to expressed fear of falls

PROBLEMS	GOALS	APPROACHES
Limited assist ambulation with platform walker 40-50 feet.	Supervised ambulation with FWW room to dining room (125')	Ambulate to tolerance, progress from platform to FWW by week 2.
Right L. E. weakness, requires limited assist to clear edge of bed for transfers bed to wheelchair	Supervised transfers in and OOB, supervised bed mobility, without c/o pain.	ROM / Strengthening BLEs, monitor pain level after exercise. Bed to W/C transfers. FREQUENCY: 5x/wk DURATION: 8 weeks

INITIAL ASSESSMENT COMPLETED BY (NURSE/ **THERAPIST**): Noah Pain, PT DATE: 01/02/03

RECOMMENDED START DATE: 01/03/03

PROGRAM REVIEWED WITH RNA and TRAINING COMPLETED: Ivy Walker, RNA 1/2/03

DATE OF DISCHARGE: _____

LAST NAME	FIRST NAME	INITIAL	PHYSICIAN	ROOM NO.	RES. NUMBER
Connelly	Cora	C.	Dr. Bones	321	0123

RESTORATIVE NURSING PROGRAM ACTIVITY RECORD

Month/Year January 2003

Record number of minutes (required for specific Medicare PPS RUG-III levels only) and assist level for each activity in the boxes below.
If the activity is not provided, note the following in the boxes: S = Res. Sick; R = Res. Refused; U = Res. Unavailable; D = Res. Discharged; X = RNA Unavailable.

A. **SELF-PERFORMANCE *(SELF)*** CODE FOR RESIDENT'S PERFORMANCE (NOT INCLUDING SET-UP) (Note: Scoring key from MDS Section G)
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1. SUPERVISION - Oversight, encouragement or cueing
2. LIMITED ASSISTANCE - Res. highly involved, provided physical help in maneuvering of limbs or other non-weight bearing assist
3. EXTENSIVE ASSISTANCE - Res. performed part of activity, but help was provided for weight-bearing support or staff provided full assist in some task
4. TOTAL DEPENDENCE - Full staff performance of activity
8. ACTIVITY DID NOT OCCUR DURING THIS PERIOD

B. **SUPPORT (*SUPP*) PROVIDED (CODE REGARDLESS OF RESIDENT'S SELF-PERFORMANCE ACTIVITY**
O. NO SET-UP OR PHYSICAL HELP FROM STAFF
1. SET-UP HELP ONLY
2. ONE PERSON PHYSICAL ASSIST
3. TWO OR MORE PERSONS PHYSICAL ASSIST
8. ACTIVITY ITSELF DID NOT OCCUR

ACTIVITY		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
	MIN.		10	5	10	10	10			10	W	W	5	5			R	15	15	15	15			R	15	15	10	10			10	10
Walking	**SELF**		2	2	2	2	2			2			2	2				2	2	2	2				1	1	1	1			1	1
Amb. to tol.	**SUPP**		2	2	2	2	2			2			2	2				1	1	1	1				1	1	1	1			1	1
	MIN.		10	15	15	10	10			10	10	10	15	10			R	10	R	15	15			15	10	15	15	15			15	15
Exercise	**SELF**		3	3	3	3	3			3	3	3	2	2				2		2	1			1	1	1	1	1			1	1
ROM / strength BLE	**SUPP**		2	2	2	2	2			2	2	2	2	2				2		2	1			1	1	1	1	1			1	1
	MIN.		5	5	5	5	5			5	W	W	5	5			R	5	5	5	5			R	5	5	5	5			5	5
Transfers	**SELF**		2	2	2	2	2			2			1	2				2	1	1	1				1	1	1	1			2	1
Bed to W/C	**SUPP**		2	2	2	2	2			2			1	2				2	1	1	1				1	1	1	1			2	1
RECORD INITIALS DAILY			iw	iw	iw	iw	iw			iw	iw	iw	iw	iw			hm	iw	iw	iw	iw			iw	iw	iw	hm	iw			iw	iw

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE
IW	Ivy Walker	HN	Hugo Now				

Resident Name: Connelly, Cora C. **Room** #321

DATE	**RESTORATIVE NURSING PROGRAM PROGRESS NOTES** *Write DAILY narrative of special occurrences and WEEKLY summary of resident's progress, which may include the following information: (1) Describe resident's specific behavior for each activity; (2) Document the average self-performance and support assistance needed during activity; (3) Describe improvements, declines or maintenance in resident's activities; (4) Describe resident's pain (where, when, and how much (0=none;1-3=mild; 4-7=moderate; 8-10=severe); (5) Note recommendations for continuing and or changing the resident's plan.* **SIGNATURE of Restorative Assistant** *and/or Licensed Nurse*
1/06/03	Weekly Summary: Mrs. Connelly cooperates with RNA program. She needs one person assist to get in and out of bed but she is able to lift both
	legs over the edge of the bed when she gets back in bed. She is walking 60' with her platform walker and needs help to guide it. Her walking is
	slow and she needs to stop to rest every 20' to 30'. Leg exercises require some encouragement and she does each exercise 10 times.
	Plan: Ask PT to observe if Mrs. Connelly can use a regular walker instead of platform walker. I. Walker RNA
1/09/03	PT instructed to keep using platform walker one more week, then re-check. I. Walker RNA
1/11/03	Ambulation and transfers held per nursing instruction yesterday and today due to high blood pressure. Exercises done in bed. I. Walker RNA
1/13/03	Weekly Summary: Still cooperative. Ambulation only completed three times this week due to resident's blood pressure. Mrs. Connelly can get in
	and out of bed with much less help but hands on guidance is provided for safety. Physical Therapy ok'd use of the regular walker
	and Mrs. Connelly does not need help guiding it. She walks 100' x 2 with no rests. She can do all her exercises with 3 lb. weights,
	2 sets of 10 each. She says she is getting stronger. Plan: Continue RNA program. I. Walker RNA
1/16/03	Mrs. Connelly refused walking, transfers and exercises because her legs were tired and sore from walking with her family yesterday. Charge
	nurse notified. H. Now, RNA
1/20/03	Weekly Summary: No more complaints of pain or tiredness. Walking from bed room to dining room and back without rest but still wants help
	because of fears of falling. She is able to get in and out of bed by herself, supervision provided for safety. Plan: Continue
	with program. I. Walker RNA.
1/23/03	Mrs. Connelly refused to get out of bed for her exercises today, but would do exercises in bed. She complained that she was tired, but did not
	complain of any pain. Leg exercises with 2# resistance were used while she lay in bed. Nursing notified. I. Walker RNA
1/27/03	Weekly Summary: Mrs. Connelly walked with RNA four times this week, requiring only set up and supervision. She talks while walking and shows
	no signs of fatigue or pain. Transfers only require supervision with set up of her wheelchair or walker. Mrs. Connelly seems to be getting stronger
	and motivated to walk more. Continue with plan. I. Walker RNA

RESTORATIVE NURSING PROGRAM REFERRAL FORM

CURRENT STATUS ▶	SELF-PERFORMANCE ASSIST LEVEL					
ACTIVITY ▼	**INDEPEND.**	**SUPERV.**	**LIMITED ASSIST**	**EXTENSV. ASSIST**	**TOTAL DEPEND.**	**ACTVTY. DID NOT OCCUR**
RANGE OF MOTION -- PASSIVE/ACTIVE					X	
SPLINT OR BRACE ASSISTANCE					X	
BED MOBILITY				X		
TRANSFERS				X		
WALKING						X
DRESSING OR GROOMING				X		
EATING OR SWALLOWING					X	
AMPUTATION AND PROSTHETIC CARE						X
COMMUNICATION			X			
EXERCISE				X		
WHEELCHAIR MOBILITY				X		
POSITIONING				X		
OTHER						

COMMUNICATION STATUS	ABLE	UNABLE	WITH VERBAL CUES	WITH GESTURES	ADDITIONAL COMMENTS
ABILITY TO UNDERSTAND				X	Speaks slowly
ABILITY TO SEE/READ	X				Reading unknown
ABILITY TO SPEAK	X				Minimal talking
ABILITY TO MAKE DECISIONS		X			

STRENGTH: (FAIR, POOR ABSENT)

LUE poor strength, No active movement

ROM: SPECIFY EXTREMITY/JOINT & ASSIST LEVEL (WFL, LIMITED -- SEVERE, MODERATE, MINIMAL)

LUE ROM at all joints. Cue resident to watch exercise to increase her awareness of left side.

COMMENTS: (PRECAUTIONS, BEHAVIOR, COGNITION, POSITIONING NEEDS, BOWEL & BLADDER, EQUIPMENT NEEDS)

Left shoulder pain due to subluxation. Position LUE to prevent pain. Left hand splint with Velcro straps and moleskin lining.

PROBLEMS	GOALS	APPROACHES
Non-functional LUE Diminished sensation LUE Poor awareness of left side of body	Maintain functional ROM LUE without pain and contractures	1. Passive ROM LUE 2. Passive ROM left hand/wrist before and after applying splint to left hand. 3. Wash / dry / inspect left hand before / after splint. FREQUENCY: 7day/wk DURATION: 3 months

INITIAL ASSESSMENT COMPLETED BY (NURSE/ **THERAPIST**): Tina Touch, OTR DATE: 3/21/05

RECOMMENDED START DATE: 3/22/05

PROGRAM REVIEWED WITH RNA and TRAINING COMPLETED: S. Feelgood, RNA 3/22/06

DATE OF DISCHARGE: _____

LAST NAME	FIRST NAME	INITIAL	PHYSICIAN	ROOM NO.	RES. NUMBER
Lowe	William	M.	Dr. Bones	210-1	4879

RESTORATIVE NURSING PROGRAM ACTIVITY RECORD

Month/Year April 2005

Record number of minutes (required for specific Medicare PPS RUG-III levels only) and assist level for each activity in the boxes below.
If the activity is not provided, note the following in the boxes: S = Res. Sick; R = Res. Refused; U = Res. Unavailable; D = Res. Discharged; X = RNA Unavailable.

C. **SELF-PERFORMANCE** ***(SELF)*** CODE FOR RESIDENT'S PERFORMANCE (NOT INCLUDING SET-UP) (Note: Scoring key from MDS Section G)
- O. INDEPENDENT - No help or oversight
- 1. SUPERVISION - Oversight, encouragement or cueing
- 2. LIMITED ASSISTANCE - Res. highly involved, provided physical help in maneuvering of limbs or other non-weight bearing assist
- 3. EXTENSIVE ASSISTANCE - Res. performed part of activity, but help was provided for weight-bearing support or staff provided full assist in some task
- 4. TOTAL DEPENDENCE - Full staff performance of activity
- 8. ACTIVITY DID NOT OCCUR DURING THIS PERIOD

D. **SUPPORT (*SUPP*) PROVIDED (CODE REGARDLESS OF RESIDENT'S SELF-PERFORMANCE ACTIVITY**
- O. NO SET-UP OR PHYSICAL HELP FROM STAFF
- 1. SET-UP HELP ONLY
- 2. ONE PERSON PHYSICAL ASSIST
- 3. TWO OR MORE PERSONS PHYSICAL ASSIST
- 8. ACTIVITY ITSELF DID NOT OCCUR

ACTIVITY		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Passive ROM LUE	**MIN.**	15	15	15	15	15	10	15	15	10	R	15	15	15	10	10	10	R	R	5	15	15	15	15	10	10	5	10	10	15	15	
	SELF	4	4	4	4	4	4	4	4	4		4	4	4	4	4	4			4	4	4	4	4	4	4	4	4	4	4	4	
	SUPP	2	2	2	2	2	2	2	2	2		2	2	2	2	2	2			2	2	2	2	2	2	2	2	2	2	2	2	
Apply Splint after Breakfast / off after Dinner, inspect hand	**MIN.**	10	10	10	10	R	R	10	10	10	R	R	10	10	10	10	10	R	R	10	10	10	10	10	10	10	10	10	10	10	10	
	SELF	4	4	4	4			4	4	4			4	4	4	4	4			4	4	4	4	4	4	4	4	4	4	4	4	
	SUPP	2	2	2	2			2	2	2			2	2	2	2	2			2	2	2	2	2	2	2	2	2	2	2	2	
Warm hand soaks before applying splint	**MIN.**												15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	
	SELF												4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	
	SUPP												2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	
RECORD INITIALS DAILY		sf	sf	sf	sf	sf	kh	kh	sf	sf	sf	sf	sf	kh	kh	sf	sf	sf	sf	sf	kh	kh	sf	sf	sf	sf	sf	kh	kh	sf	sf	

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE
SF	S. Feelgood	KH	Karey Hands				

Resident Name: Lowe, William M.

Room: # 210-1

DATE	**RESTORATIVE NURSING PROGRAM PROGRESS NOTES** *Write DAILY narrative of special occurrences and WEEKLY summary of resident's progress, which may include the following information: (1) Describe resident's specific behavior for each activity; (2) Document the average self-performance and support assistance needed during activity; (3) Describe improvements, declines or maintenance in resident's activities; (4) Describe resident's pain (where, when, and how much (0=none;1-3=mild; 4-7=moderate; 8-10=severe); (5) Note recommendations for continuing and or changing the resident's plan.* **SIGNATURE of Restorative Assistant** *and/or Licensed Nurse*
4/6/05	Mr. Lowe refused ROM and splint yesterday and today complaining of pain to the touch. Nursing notified. S. Feelgood RNA
4/7/05	Weekly Summary: Mr. Lowe tolerated his ROM exercises this week with some complaints of pain. His grimaces required gentle ROM
	particularly at the left shoulder where the pain appears to be the worst. Nursing was notified of his pain. He now receives medication prior to
	his exercises. Mr. Lowe refused to wear his hand splint twice this week. He was informed that it helped his hand pain and provides support. The
	Charge nurse was notified of his refusals. Plan: Continue with plan. S. Feelgood RNA
4/11/05	Informed OT that Mr. Lowe complains of pain with his exercises and refuses to wear the splint yesterday and today. He complains that the splint
	hurts his hand particularly when ROM exercises are difficult in the morning. OT recommended to begin with warm hand soaks, then ROM before
	applying splint. S. Feelgood RNA
4/14/05	Weekly Summary: Mr. Lowe did not tolerate his exercises as much this week. Warm hand soaks were started per the recommendation of the OT
	to relieve some of his hand pain. Pain in the hand appeared worse than pain in the shoulder. Charge nurse notified of his daily pain. ROM
	exercise program continues to his tolerance. Warm soaks seem to have helped over the past three days. Plan: Continue. S. Feelgood RNA
4/18/05	Mr. Lowe refused ROM and splint yesterday and today saying he was too tired and in pain. Nursing notified. S. Feelgood RNA
4/21/05	Weekly Summary: Mr. Lowe is enjoying the warm hand soaks, but refused twice this week to have ROM exercises done to his left arm or to wear
	the splint. Both nurse and OT notified of his non-compliance this week. Plan: Continue with exercise and splint program. S. Feelgood RNA
4/28/05	Weekly Summary: Mr. Lowe did better this week. No refusals. He is tolerating the ROM to the elbow and hand without any complaints of
	pain. The left shoulder requires gentle movement as he does grimace quite often. All movements are able to be completed. Splint is applied
	with no redness or skin breakdown. Mr. Lowe does enjoy the hand soaks. Plan: Continue with exercise and splint program. S. Feelgood RNA

Resident Name: Lowe, William M. **Room:** # 210-1

RESTORATIVE DINING PROGRAM REFERRAL FORM

CURRENT STATUS	
REASON FOR REFERRAL	EXPLAIN: _Improve self feeding skills with safe swallow techniques._____
DIET	SOLIDS: ☐ Puree ☑ Mechanical Soft ☐ Regular LIQUIDS: ☐ Thick ☑ Semi-Thick ☐ Thin
WEIGHT	IBW: 140-155 PRESENT WEIGHT: 139 ADMISSION WEIGHT: 138 DATE: 3-2-05 DATE: 3-26-05 DATE: 3-2-05
CURRENT FEEDING ABILITY	☐ Takes adequate amounts of food and fluids ☑ Feeds self with minimal assistance ☐ Feeds self with prompting ☐ Chewing problem ☑ Swallowing problem ☐ Currently tube fed ☐ Able to cut food ☐ Other __Learning to feed self with non-dominant hand _____
PHYSICAL LIMITATIONS	☐ Contractures of hands ☐ Trembling ☐ Dentures: Full X Upper ___ Lower___ ☑ Has hand control ☑ Able to hold utensils ☐ Other _____
COGNITION	☑ Alert -- will follow directions ☐ Alert -- will NOT follow directions ☑ Is aware to bring food to mouth ☐ Nonresponsive ☐ Other _____
COMMUNICATION	☑ Able to speak ☐ Able to read ☐ Other __Occasional word finding difficulty_____
VISION	☐ Blind ☐ Right ☐ Left ☐ Partial ☑ Sight good ☐ Other _____
HEARING	☑ Hears without difficulty ☐ Hard of hearing ☐ Right ☐ Left ☐ Hearing aid ☐ Other _____
BEHAVIOR/MOTIVATION	☑ Cooperative ☐ Likes to be independent ☑ Wants to feed self ☐ Does not respond when spoken to ☐ Will not stay seated ☐ Other _____
NEATNESS and TABLE MANNERS	☑ Spills ☑ Misses mouth ☑ Dribbles food and liquids ☐ Neat, eats with appropriate utensils ☐ Food left in mouth ☐ Other ___Monitor right side pocketing_____

SPECIAL NEEDS	
POSITIONING NEEDS	☐ Needs pillow positioning on right X left _____, both sides _____ to maintain upright position for meals ☑ Other __right arm should be flat on table or arm tray_____
ADAPTIVE EQUIPMENT NEEDS	☑ Adaptive spoon ☑ Adaptive fork ☐ Adaptive knife ☑ Plate guard ☐ Adaptive cup ☑ Other ___dycem under plate / bowl_____
PRECAUTIONS:	☐ Other _____

PROBLEMS	GOALS	APPROACHES
Minimal assist with self feeding	Independent self feeding with adaptive equipment	1. Restorative dining 3 meals/day 2. Set up tray and cut food 3. Assist with left hand feeding as needed
Mild – moderate dysphagia	Safe swallow at current diet consistency	4. Cues for double swallow and head position while eating FREQUENCY: 7 day/week DURATION: 2 months

INITIAL ASSESSMENT COMPLETED BY (NURSE/ **THERAPIST**): Sally Speatch, SLP DATE: 3/26/05

RECOMMENDED START DATE: 3/26/05

PROGRAM REVIEWED WITH RNA and TRAINING COMPLETED: I. Pheadem, RNA 4/2/05

DATE OF DISCHARGE: _____

LAST NAME	FIRST NAME	INITIAL	PHYSICIAN	ROOM NO.	RES. NUMBER
Lowe	William	M.	Dr. Bones	210-1	4879

RESTORATIVE DINING PROGRAM RECORD

Month/Year: April/2005

Record number of minutes (required for specific Medicare PPS RUG-III levels only), assist level and percentage of intake for each meal.
If the activity is not provided, note the following in the boxes: S = Res. Sick; R = Res. Refused; U = Res. Unavailable; D = Res. Discharged; X = RNA Unavailable.

A. **SELF-PERFORMANCE** ***(SELF)*** CODE FOR RESIDENT'S PERFORMANCE (NOT INCLUDING SET-UP) (Note: Scoring key from MDS Section G)

O. INDEPENDENT - No help or oversight
1. SUPERVISION - Oversight, encouragement or cueing
2. LIMITED ASSISTANCE - Res. highly involved, provided physical help in maneuvering of limbs or other non-weight bearing assist
3. EXTENSIVE ASSISTANCE - Res. performed part of activity, but help was provided for weight-bearing support or staff provided full assist in some task
4. TOTAL DEPENDENCE - Full staff performance of activity
8. ACTIVITY DID NOT OCCUR DURING THIS PERIOD

B. **SUPPORT (*SUPP*) PROVIDED (CODE REGARDLESS OF RESIDENT'S SELF-PERFORMANCE ACTIVITY**

O. NO SET-UP OR PHYSICAL HELP FROM STAFF
1. SET-UP HELP ONLY
2. ONE PERSON PHYSICAL ASSIST
3. TWO OR MORE PERSONS PHYSICAL ASSIST
8. ACTIVITY ITSELF DID NOT OCCUR

ACTIVITY		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
BREAKFAST	MIN.		45	35	30	40	40	40	45	25	35	40	40	45	45	35	40	40	45	45	40	40	35	35	30	30	30	40	40	35	35	
	SELF		2	2	2	2	2	2	1	2	1	1	2	2	2	1	2	2	1	2	1	1	1	1	1	1	1	2	1	1	1	
Self Feeding with	SUPP		2	2	2	2	2	2	1	2	1	1	2	2	2	1	2	2	1	2	1	1	1	1	1	1	1	2	1	1	1	
Adapt Equip	%		65	65	70	90	95	95	75	50	50	50	65	50	60	65	70	70	90	90	85	75	8	85	70	70	85	75	95	85	85	
LUNCH	MIN.		35	35	30	30	35	35	40	45	40	35	35	35	30	40	40	45	45	40	35	35	45	35	30	30	30	30	35	35	35	
	SELF		2	2	1	1	1	1	1	1	1	1	2	2	2	1	1	2	1	1	1	1	1	1	1	1	1	1	1	1	2	
Self Feeding with	SUPP		2	2	1	1	1	1	1	1	1	1	2	2	2	1	1	2	1	1	1	1	1	1	1	1	1	1	1	1	2	
Adapt Equip	%		95	95	90	90	85	90	90	85	85	95	95	95	90	90	95	95	90	85	95	95	75	95	95	95	85	95	70	95	80	
DINNER	MIN.		30	25	25	30	25	20	20	35	30	30	25	30	25	25	30	30	30	35	25	30	25	25	25	30	30	35	30	35	25	
	SELF		2	2	2	2	2	1	1	2	2	1	2	2	2	1	2	2	2	2	2	1	2	1	1	1	1	2	2	1	2	
Self Feeding with	SUPP		2	2	2	2	2	1	1	2	2	1	2	2	2	1	2	2	2	2	2	1	2	1	1	1	1	2	2	1	2	
Adapt Equip	%		50	50	50	65	75	75	50	50	50	65	65	75	75	70	70	75	85	85	65	85	65	95	95	95	50	50	50	75	50	
RECORD INITIALS DAILY			ip	ip	ip	ip	mt	mt	ip	ip	ip	ip	ip	mt	Mt	ip	ip	ip	ip	ip	mt	mt	ip	ip	ip	ip	ip	mt	mt	ip	ip	

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE
IP	I. Pheadem	MT	Mai Tern				

Resident Name Lowe, William M.

Room #210-1

DATE	**RESTORATIVE DINING PROGRAM PROGRESS NOTES** *Write DAILY narrative of special occurrences and WEEKLY summary of resident's progress, which may include the following information: (1) Describe resident's specific behavior for each activity; (2) Document the average self-performance and support assistance needed during activity; (3) Describe improvements, declines or maintenance in resident's activities; (4) Describe resident's pain (where, when, and how much (0=none;1-3=mild; 4-7=moderate; 8-10=severe); (5) Note recommendations for continuing and or changing the resident's plan.* **SIGNATURE of Restorative Assistant** *and/or Licensed Nurse*
4/5/05	Weekly Summary: Mr. Lowe attends restorative dining for all three meals. He requires limited assist of one person as he tends to fatigue with
	self feeding half way through the meal. He is using his left hand though he tires easily and requires encouragement to do for himself. Use of
	fork in the left hand is just awkward. His spirits are good. He had a good appetite for lunch and fair for breakfast and dinner. Mr. Lowe
	states that he has never been much of a breakfast eater. Plan: Continue to encourage Mr. Lowe to feed self. I. Pheadem RNA
4/12/05	Weekly Summary: Mr. Lowe has had a good week. He is feeding himself with more success using the built up fork and spoon in his left
	hand. He seems to be happy with his success. He requires only a few cues to tuck his chin. He has had no problems with swallowing or
	chewing his food. Appetite continues to be fair for breakfast and dinner but better for lunch. Mr. Lowe appears to enjoy the group dining
	as he is conversing with other residents prior to receiving his tray. He does need to focus on feeding during the meal rather than talking.
	Plan: Continue with feeding program. I. Pheadem RNA
4/19/05	Weekly Summary: Mr. Lowe continues to do well in the Restorative Dining program. He attends for all three meals. He has not had any
	chewing or swallowing problems. Only occasional cues are needed for double swallow and chin tuck. Self feeding is very good at lunch time
	when he appears to be at his best. Appetite has improved at all meals. Mr. Lowe does not show any signs of frustration and has been
	in good spirits. Plan: Continue to encourage resident to feed self. I. Pheadem RNA
4/26/05	Weekly Summary: Mr. Lowe has made good progress this week in his ability to feed self. He is now completing breakfast and lunch with
	supervision and set up only. He is handling the built up spoon and fork without problems. There are no more tremors with his self feeding. He
	has spilled only a couple of times. No swallowing or chewing problems noted. Mr. Lowe's appetite has also improved. He attends Restorative
	Dining for all three meals. Plan: Continue with plan. I. Pheadem RNA

Resident Name: Lowe, William M. **Room:** #210-1

RESTORATIVE NURSING PROGRAM REFERRAL FORM

CURRENT STATUS ▶	SELF-PERFORMANCE ASSIST LEVEL					
ACTIVITY ▼	INDEPEND.	SUPERV.	LIMITED ASSIST	EXTENSV. ASSIST	TOTAL DEPEND.	ACTVTY. DID NOT OCCUR
RANGE OF MOTION -- PASSIVE/ACTIVE						
SPLINT OR BRACE ASSISTANCE						
BED MOBILITY						
TRANSFERS						
WALKING		X				
DRESSING OR GROOMING		X				
EATING OR SWALLOWING		X				
AMPUTATION AND PROSTHETIC CARE						
COMMUNICATION			X			
EXERCISE						
WHEELCHAIR MOBILITY						
POSITIONING						
OTHER						

COMMUNICATION STATUS	ABLE	UNABLE	WITH VERBAL CUES	WITH GESTURES	ADDITIONAL COMMENTS
ABILITY TO UNDERSTAND			X		
ABILITY TO SEE/READ	X				
ABILITY TO SPEAK			X		
ABILITY TO MAKE DECISIONS			X		

STRENGTH: (FAIR, POOR ABSENT) NA

ROM: SPECIFY EXTREMITY/JOINT & ASSIST LEVEL (WFL, LIMITED -- SEVERE, MODERATE, MINIMAL) NA

COMMENTS: (PRECAUTIONS, BEHAVIOR, COGNITION, POSITIONING NEEDS, BOWEL & BLADDER, EQUIPMENT NEEDS)

Is in the middle stage of Alzheimer's requiring mod cueing and structure for recall and completion of activities.

PROBLEMS	GOALS	APPROACHES
1. Increased agitation 2. Not taking meds 3. Decreased memory for daily tasks and events	1. Decrease agitation and med compliance using the memory cueing system 100% of the time 2. Using memory cueing system follow safety precautions with PT protocol 100% 3. Increase daily recall of events, activities, visits and tasks using a memory cueing system 100%	Memory book for: Calendar schedule of daily activities/events for orientation. Visitor and medication log for daily occurrences Hourly diary of activities Personal information guide for ongoing references. FREQUENCY: 7 wk DURATION: 60 days

INITIAL ASSESSMENT COMPLETED BY (NURSE/ THERAPIST): S. Sunshine, SLP DATE: 6/23/06

RECOMMENDED START DATE: 6/23/06

PROGRAM REVIEWED WITH RNA and TRAINING COMPLETED: Joe Smith, RNA 6/22/06

DATE OF DISCHARGE: _____

LAST NAME	FIRST NAME	INITIAL	PHYSICIAN	ROOM NO.	RES. NUMBER
Wave	Ava	Q.	Dr. Surf	246	2468

RESTORATIVE NURSING PROGRAM ACTIVITY RECORD

Month/Year June 2006

Record number of minutes (required for specific Medicare PPS RUG-III levels only) and assist level for each activity in the boxes below.
If the activity is not provided, note the following in the boxes: S = Res. Sick; R = Res. Refused; U = Res. Unavailable; D = Res. Discharged; X = RNA Unavailable.

E. **SELF-PERFORMANCE** ***(SELF)*** CODE FOR RESIDENT'S PERFORMANCE (NOT INCLUDING SET-UP) (Note: Scoring key from MDS Section G)

O. INDEPENDENT - No help or oversight
1. SUPERVISION - Oversight, encouragement or cueing
2. LIMITED ASSISTANCE - Res. highly involved, provided physical help in maneuvering of limbs or other non-weight bearing assist
3. EXTENSIVE ASSISTANCE - Res. performed part of activity, but help was provided for weight-bearing support or staff provided full assist in some task
4. TOTAL DEPENDENCE - Full staff performance of activity
8. ACTIVITY DID NOT OCCUR DURING THIS PERIOD

F. **SUPPORT (*SUPP*) PROVIDED (CODE REGARDLESS OF RESIDENT'S SELF-PERFORMANCE ACTIVITY**

O. NO SET-UP OR PHYSICAL HELP FROM STAFF
1. SET-UP HELP ONLY
2. ONE PERSON PHYSICAL ASSIST
3. TWO OR MORE PERSONS PHYSICAL ASSIST
8. ACTIVITY ITSELF DID NOT OCCUR

ACTIVITY		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Memory book – Morning	MIN.																							10	10	10	10	10	10	10		
	SELF																							1	1	1	1	1	1	1		
	SUPP																							2	2	1	1	1	1	1		
Memory book Afternoon	MIN.																							10	10	10	10	10	10	10		
	SELF																							1	1	1	1	1	1	1		
	SUPP																							1	2	1	1	1	1	1		
Memory book Evening	MIN.																							10	10	10	10	10	10	10		
	SELF																							1	1	1	1	1	1	1		
	SUPP																							1	2	1	1	1	1	1		
RECORD INITIALS DAILY																								js	ss	js	ss	ss	ss	ss		

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE
JS	Joe Smith	SS	Suzie Soother				

Resident Name: Wave, Ava

Room #246

DATE	**RESTORATIVE NURSING PROGRAM PROGRESS NOTES** *Write DAILY narrative of special occurrences and WEEKLY summary of resident's progress, which may include the following information: (1) Describe resident's specific behavior for each activity; (2) Document the average self-performance and support assistance needed during activity; (3) Describe improvements, declines or maintenance in resident's activities; (4) Describe resident's pain (where, when, and how much (0=none;1-3=mild; 4-7=moderate; 8-10=severe); (5) Note recommendations for continuing and or changing the resident's plan.* **SIGNATURE of Restorative Assistant** *and/or Licensed Nurse*
6/25/06	Mrs. AW was anxious about a visit from her son and I had to use her memory book, especially during meals to remind that is was a meal and that she wouldn't be missing his visit tonight. Joe Smith, RNA
6/29/06	Weekly Summary: Mrs. AW's orientation to events, medications, activities and visitors is much better with very little agitation when she is able to refer to her memory book and see her own entries. She is not always convinced when the entries are made by others. The SLP has suggested encouraging her to make all her entries or to sign the ones she isn't making herself. Occasionally she will refuse to record in her memory book so we will write her activities in for her. Suzie Soother, RNA

Resident Name: Wave, Ava **Room** #246

RESTORATIVE DINING PROGRAM REFERRAL FORM

CURRENT STATUS	
REASON FOR REFERRAL	EXPLAIN : 15 lb weight loss due to inattention and forgetting and to chew. Possible oral dysphagia
DIET	SOLIDS: ☐ Puree ☐ Mechanical Soft ☑ Regular LIQUIDS: ☐ Thick ☐ Semi-Thick ☑ Thin
WEIGHT	IBW: _____ PRESENT WEIGHT: _____ ADMISSION WEIGHT: _____ DATE: _____ DATE: _____ DATE: _____
CURRENT FEEDING ABILITY	☐ Takes adequate amounts of food and fluids ☐ Feeds self with minimal assistance ☑ Feeds self with prompting ☑ Chewing problem ☐ Swallowing problem ☐ Currently tube fed ☐ Able to cut food ☑ Other Resident forgets to eat.
PHYSICAL LIMITATIONS	☐ Contractures of hands ☐ Trembling ☐ Dentures: Full ___ Upper ___ Lower___ ☐ Has hand control ☐ Able to hold utensils ☐ Other _____
COGNITION	☑ Alert -- will follow directions ☐ Alert -- will NOT follow directions ☐ Is aware to bring food to mouth ☐ Nonresponsive ☐ Other _____
COMMUNICATION	☑ Able to speak ☐ Able to read ☐ Other _____
VISION	☐ Blind ☐ Right ☐ Left ☐ Partial ☐ Sight good ☐ Other _____
HEARING	☑ Hears without difficulty ☐ Hard of hearing ☐ Right ☐ Left ☐ Hearing aid ☐ Other _____
BEHAVIOR/MOTIVATION	☐ Cooperative ☑ Likes to be independent ☐ Wants to feed self ☐ Does not respond when spoken to ☐ Will not stay seated ☑ Other -- Distracted
NEATNESS and TABLE MANNERS	☐ Spills ☐ Misses mouth ☐ Dribbles food and liquids ☐ Neat, eats with appropriate utensils ☐ Food left in mouth ☐ Other _____

SPECIAL NEEDS	
POSITIONING NEEDS	☐ Needs pillow positioning on right _____, left _____, both sides _____ to maintain upright position for meals ☐ Other _____
ADAPTIVE EQUIPMENT NEEDS	☐ Adaptive spoon ☐ Adaptive fork ☐ Adaptive knife ☐ Plate guard ☐ Adaptive cup ☐ Other _____
PRECAUTIONS:	☐ Other _____

PROBLEMS	GOALS	APPROACHES
1. Resident is distracted and does not finish meals 2. She is experiencing difficulty with chewing	Resident will be able to participate in and complete meals at breakfast, lunch and dinner. Resident will be in the RNP dining program for all 3 meals. Resident will be chew and swallow her meals with min cueing.	1. RNP dining for structure and simple redirection and orientation to meals. 2. Swallow strategies including alternating sips and bites and min cues to swallow food in her mouth. 3. Orientation and redirection to her plate and the task of completing a meal. FREQUENCY: 7x/wk DURATION: 2 months

INITIAL ASSESSMENT COMPLETED BY (NURSE/ THERAPIST): S. Sunshine, SLP DATE: 6/23/06

RECOMMENDED START DATE: 6/23/06

PROGRAM REVIEWED WITH RNA and TRAINING COMPLETED: Joe Smith, RNA 6/22/06

DATE OF DISCHARGE: _____

LAST NAME	FIRST NAME	INITIAL	PHYSICIAN	ROOM NO.	RES. NUMBER
Wave	Ava	Q.	Dr. Surf	246	2468

RESTORATIVE DINING PROGRAM RECORD

Month/Year June 2006

Record number of minutes (required for specific Medicare PPS RUG-III levels only), assist level and percentage of intake for each meal.
If the activity is not provided, note the following in the boxes: S = Res. Sick; R = Res. Refused; U = Res. Unavailable; D = Res. Discharged; X = RNA Unavailable.

G. **SELF-PERFORMANCE** ***(SELF)*** CODE FOR RESIDENT'S PERFORMANCE (NOT INCLUDING SET-UP) (Note: Scoring key from MDS Section G)

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3. EXTENSIVE ASSISTANCE - Res. performed part of activity, but help was provided for weight-bearing support or staff provided full assist in some task
4. TOTAL DEPENDENCE - Full staff performance of activity
8. ACTIVITY DID NOT OCCUR DURING THIS PERIOD

H. **SUPPORT (*SUPP*) PROVIDED (CODE REGARDLESS OF RESIDENT'S SELF-PERFORMANCE ACTIVITY**

O. NO SET-UP OR PHYSICAL HELP FROM STAFF
1. SET-UP HELP ONLY
2. ONE PERSON PHYSICAL ASSIST
3. TWO OR MORE PERSONS PHYSICAL ASSIST
8. ACTIVITY ITSELF DID NOT OCCUR

ACTIVITY		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
BREAKFAST	MIN.																							25	30	30	10	25	20	30		
Simple re-direction	SELF																							1	1	1	2	1	1	2		
Alt. sips/bites	SUPP																							1	1	1	2	1	1	2		
Cue to swallow	%																							85	90	100	40	90	95	95		
LUNCH	MIN.																							45	45	35	15	45	40	45		
Simple re-direction	SELF																							1	1	1	2	1	1	1		
Alt. sips/bites	SUPP																							1	1	1	2	1	1	1		
Cue to swallow	%																							100	100	80	50	100	95	100		
DINNER	MIN.																							30	30	30	30	30	30	45		
Simple re-direction	SELF																							1	1	1	1	1	1	1		
Alt. sips/bites	SUPP																							1	1	1	1	1	1	1		
Cue to swallow	%																							75	75	100	75	90	95	100		
RECORD INITIALS DAILY																								js	bv	bv	js	js	js	bv		

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE
JS	Joe Smith	BV	Bob Verigood				

Resident Name: Ava Wave

Room #246

DATE	**RESTORATIVE DINING PROGRAM PROGRESS NOTES** *Write DAILY narrative of special occurrences and WEEKLY summary of resident's progress, which may include the following information: (1) Describe resident's specific behavior for each activity; (2) Document the average self-performance and support assistance needed during activity; (3) Describe improvements, declines or maintenance in resident's activities; (4) Describe resident's pain (where, when, and how much (0=none;1-3=mild; 4-7=moderate; 8-10=severe); (5) Note recommendations for continuing and or changing the resident's plan.* **SIGNATURE of Restorative Assistant** *and/or Licensed Nurse*
6/25/06	Resident very distracted at breakfast. I had to set up her tray this morning. Needed help with paying attention and I had to encourage drinking between bites. I had to hand her the cup for her to drink. Got up and left dining room saying she was too tired to eat. Told RNPC. Joe Smith, RNA
6/26/06	Today Mrs. AW needed to have her tray set up to get started. Reminded her to swallow and to drink her liquids. Joe Smith, RNA
6/29/06	Weekly Summary: The memory book is working well to remind Mrs. AW of when and where meals occur. She responds well to the cueing to attend to her meals and finishing them. Verbal cues for her to swallow and switch between sips and bites keep her attention on finishing her meals. Occasionally the RNP will need to hand her utensils or her glass to keep her on task. Roseanne Tulip, RN

Resident Name: Ava Wave **Room** #246

DOCUMENTATION CROSSWALK LANGUAGE

MDS SCALE	MDS ADL SUPPORT SCALE	REHAB SCALE	FIM SCALE	PERCENT RESIDENT INDEPEND.
0 -- Independent No help or oversight	0 -- No Help	Independent	7 -- Independent (no equipment) 6 -- Modified Independence (equipment) No helper	100% Independent
1 -- Supervised Oversight, encouragement or cueing	0 -- No Help 1 -- Set-up help only	Standby Supervision Verbal Cueing	5 -- Standby Supervision No physical assist	90% Independent
2 -- Limited Assistance Guided maneuvering of limbs or other non weight bearing assistance	2 -- One person physical assist	Contact Guard Minimal Assistance	4 -- Minimal Assistance Up to 25% assistance	75% Independent
3 -- Extensive Assistance Help provided for weight bearing support and/or full staff performance during part of activity	2 -- One person physical assist 3 -- Two or more person physical assist	Moderate Assistance Maximal Assistance	3 -- Moderate Assistance 26% - 50% assistance 2 -- Maximal Assistance 51% to 75% assistance	25 - 74% Independent
4 -- Total Dependence Full staff performance during activity	2 -- One person physical assist 3 -- Two or more person physical assist	Dependent	1 -- Total Assistance 76% or more assistance	0 - 24% Independent
8 -- Activity did not occur	8 -- ADL activity did not occur	No applicable/Not tested	Not applicable/Not tested	Not tested

RESTORATIVE NURSING PROGRAM RESIDENT ROSTER

MONTH/YEAR ______________________________

RES. Rm #	ACTIVITY	FREQ. & DURATION	REVIEW DATE	D/C DATE

REGULATIONS

Skilled Nursing Facilities are regulated by many laws and regulations. Facilities must strive to continue to maintain compliance with those regulations. The staff who work in restorative nursing programs need to realize their role in this regulatory process. If all staff do the best job possible, they will be contributing to our residents' quality of life and quality of care.

The following are the OBRA regulations that impact the Restorative Nursing Program:

Code	Regulation	Guidelines
684	**Quality of Care**: The facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	Each facility must ensure that the resident reaches optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process.
676	**Activities of Daily Living**: Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable.	Each facility must ensure that a resident's abilities in ADLs do not deteriorate unless the deterioration was unavoidable. FUNCTIONAL STATUS means the resident's ability to perform activities of daily living including bathing, dressing and grooming, transferring and ambulation, toilet use, eating and using speech language and other communication systems. Included determining the resident's need for staff assistance and assistive devices or equipment to maintain or improve functional abilities.
677	**Activities of Daily Living**: A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	The intent of this regulation to stress that the facility is responsible for providing maintenance and restorative program that will not only maintain but improve as indicated by the resident's comprehensive assessment and that residents who are dependent on staff for ADLs receive the care and services needed.
685	**Vision and Hearing**: The facility must, if necessary, to ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, in making appointments, and arranging for transportation to and from the office of a practitioner.	The facility's responsibility is to assist residents and their families in locating and utilizing any available resources for the provision of the services the resident needs such as assistive devices. Assistive devices to maintain vision include glasses, contact lenses, and magnifying glasses. Assistive devices to maintain hearing include hearing aids.
686	**Pressure Ulcers**: Based on the comprehensive assessment of a resident, the facility must ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote	Restorative nursing staff must do all they can to prevent skin breakdown (e.g., pressure relieving cushions and mattresses, moving resident without causing shearing, keep clean and dry, repositioning, turning etc.) Restorative nursing staff must report any changes in skin integrity to charge nurses.

	healing, prevent infection and prevent new ulcers from developing.	
688	**Mobility**: The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. The facility is to provide appropriate treatment and services to a resident with limited range of motion to increase range of motion and/or to prevent further decrease in range of motion.	Clinical conditions that are the primary risk factors for a decreased range of motion are: immobilization (e.g., bedfast); deformities arising out of neurological deficits (e.g., strokes, multiple sclerosis, cerebral palsy, polio and pain, spasms and immobility associated with arthritis or late-stage Alzheimer's disease. The facility is responsible for developing a plan of care to prevent avoidable decline of range of motion. Restorative Nursing program can play a role in preventing a decline in the residents' ROM or muscle atrophy. Ongoing assessment and modification of the plan of care should prevent decline in avoidable loss of a resident's ROM. Assessment should be conducted quarterly.
689	**Accidents and Incident**: The facility must ensure that the resident environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistance devices to prevent accidents.	Facilities must identify each resident at risk for accident and/or falls, and adequately plan care and implement procedures to prevent accidents. The facility should monitor the use of resident's assistive devices to ensure they properly fit and provide adequate supervision of the resident to prevent accidents and incidents of injury.
690	**Incontinence**: The facility must ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	The facility is responsible to provide care to restore or improve bladder functioning when necessary. If staff determine that continence cannot be improved or maintained, there is to be a plan to prevent incontinent-related complications and to maintain resident dignity. (e.g., skin care after each episode of incontinence, adult sanitary padding, etc.). Restorative Nursing staff can help by offering resident fluids, if not contraindicated, to assure resident is adequately hydrated and to prevent Urinary tract infections.
692	**Nutrition and Hydration**: Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; and is offered sufficient fluid intake to maintain proper hydration and health.	Parameters of nutritional status which are unacceptable include unplanned weight loss as well as other indices such as peripheral edema, malnutrition/wasting and laboratory tests. Weight loss (or gain) is a guide in determining nutrition status. An analysis of weight loss or gain should be examined in light of the resident's former lifestyle as well as the current diagnosis. Often Restorative Nursing staff are involved in weighing residents. It is important, at least for residents at risk for weight variance that consideration be given to consistency e.g., same scale, weighing same time of day, same clothing etc. RNA/C.N.A. must report weight variance to charge nurses. The facility should provide care to reduce the risks of dehydration and assure adequate fluid intake (e.g., keep fluids next to the resident at all times and assist in or cuing the resident to drink). If adequate fluid intake is difficult to maintain, alternative treatment approaches should be developed (e.g., use of popsicles, gelatin, and other similar non-liquid foods).

604	**Respect and Dignity**: The resident has a right to be treated with respect and dignity, including the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	Residents that are restrained may face a loss of autonomy, dignity, and self-respect, and may show symptoms of withdrawal, depression, or reduced social contact. From a restorative standpoint, restraint use can reduce independence, functional capacity, and quality of life. Nursing staff must supervise care and services and do whatever is possible to prevent a decline in physical or mental functioning that could be caused by use of restraints.
561	**Self-determination**: The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice. The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	The facility has the responsibility to provide those services that will help the resident to be as functional as possible. The resident has the right to refuse treatment if the resident has capacity to make a health care decision; If a resident is unable to make a health care decision a decision by the resident's surrogate or representative to forego treatment may, subject to law, be equally binding on the facility. The facility should determine exactly what the resident is refusing and why. To the extent the facility is able to, it should obviate the resident's concern. For example, a resident requires physical therapy to learn to walk again after sustaining a fractured hip. The resident refuses therapy. The facility is expected to assess the reasons for the resident's refusal, clarify and educate the resident as to the consequences of refusal, offer alternative treatments and continue to provide all other service.
600	**Free from Abut and Neglect:** The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptom.	Restorative staff must be trained in appropriate interventions to deal with aggressive and/or catastrophic reactions of residents; how staff should report their knowledge related to allegations without fear of reprisal; how to recognize signs of burnout, frustration and stress that may lead to abuse and what constitutes abuse. Restorative staff must demonstrate excellent technique and avoid harming residents (e.g., bruising, skin tears etc.)
550	**Resident Rights**: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.	The facility has the responsibility to provide those services that will help the resident to be as functional as possible. The resident has the right to refuse treatment if the resident has capacity to make a health care decision; If a resident is unable to make a health care decision a decision by the resident's surrogate or representative to forego treatment may, subject to law, be equally binding on the facility. The facility should determine exactly what the resident is refusing and why. To the extent the facility is able to, it should obviate the resident's concern. For example, a resident requires physical therapy to learn to walk again after sustaining a fractured hip. The resident refuses therapy. The facility is expected to assess the reasons for the resident's refusal, clarify and educate the resident as to the consequences of refusal, offer alternative treatments and continue to provide all other service.
583	**Privacy and Confidentiality of Records**: The resident has a right to personal privacy and confidentiality	Facility must examine and treat residents in a manner that maintains the privacy of their bodies. If an individual requires assistance, staff should respect the individual's

	of his or her personal and medical record	need for privacy. Only authorized staff directly involved in treatment should be present when treatment is given. People not involved in the care of the individual should not be present without the individual's consent while they are being examined or treated. Often the things we do in restorative nursing are done out in the open with a lot of other people around. It's not uncommon to have a lot of residents working out in the gym at the same time. Or to do certain treatments out in other common areas. It is important, however to be sensitive to the resident's sense of privacy. Activities which may seem generic and common place and O.K. to do out in public" to staff, may be embarrassing to resident A common problem that we run into is facilities that conduct restorative feeding out in an open section of the main dining room. Assistance with feeding is an area that many alert residents are particularly sensitive to. In addition to looking for a more secluded area to conduct restorative feeding in order to cut down on distractions, we should be doing it in a secluded area to provide the residents with a sense of privacy during treatment. The residents' clinical record must be maintained in a confidential manner at all times.
880	**Infection Control:** The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections	The facility is to have an established program that includes monitoring direct care staff routine hand washing practices. Hand washing should be consistent with aseptic techniques, when appropriate. Always wash hands after touching a resident and before touching another resident. Always disinfect an item that a resident has been using before it is used by another resident. Pay particular attention to treatment mat and items that residents manipulate with their hands.
726	**Nursing Services:** The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment	The facility's assessment must address/include an evaluation of staff competencies that are necessary to provide the level and types of care needed for the resident population. Additionally, staff are expected to demonstrate competency with the activities listed in the training requirements. Nurse aides are expected to demonstrate competency with the activities and components that are required to be part of an approved nurse aide training and competency evaluation program. Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as Resident Rights, Person centered care, Communication, Basic nursing skills, and Basic restorative services.
MDS	**Section O0500: Restorative Nursing Programs:** 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,	Included are nursing interventions that assist or promote the resident's ability to attain his or her maximum functional potential. This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in item O0400 of the MDS. In addition, to be included in this section, a rehabilitation or restorative practice must meet all of the following additional criteria:

	mental, and psychosocial functioning. 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.	• Measurable objectives and interventions must be documented in the care plan and in the clinical record. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the resident's medical record. • Evidence of periodic evaluation by licensed nurse must be present in the clinical record. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established. • Certified Nurse Assistants must be trained in techniques that promote resident involvement in the activity. • A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. Restorative nursing does not require a physician's order. Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies or O0425, Part A Therapies, because the specific interventions are considered restorative nursing services (see item O0400, Therapies and O0425, Part A Therapies). The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs. • This category does not include groups with more than four residents per supervising helper or caregiver.

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home Comprehensive (NC) Item Set

Section A Identification Information

A0050. Type of Record

Enter Code
1. **Add new record** → Continue to A0100, Facility Provider Numbers
2. **Modify existing record** → Continue to A0100, Facility Provider Numbers
3. **Inactivate existing record** → Skip to X0150, Type of Provider

A0100. Facility Provider Numbers

A. **National Provider Identifier (NPI):**

B. **CMS Certification Number (CCN):**

C. **State Provider Number:**

A0200. Type of Provider

Enter Code
Type of provider
1. **Nursing home (SNF/NF)**
2. **Swing Bed**

A0300. Optional State Assessment
Complete only if A0200 = 1

Enter Code
A. **Is this assessment for state payment purposes only?**
0. **No**
1. **Yes**

A0310. Type of Assessment

Enter Code
A. **Federal OBRA Reason for Assessment**
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

Enter Code
B. **PPS Assessment**
PPS Scheduled Assessment for a Medicare Part A Stay
01. **5-day** scheduled assessment
PPS Unscheduled Assessment for a Medicare Part A Stay
08. **IPA** - Interim Payment Assessment
Not PPS Assessment
99. **None of the above**

Enter Code
E. **Is this assessment the first assessment** (OBRA, Scheduled PPS, or Discharge) **since the most recent admission/entry or reentry?**
0. **No**
1. **Yes**

Enter Code
F. **Entry/discharge reporting**
01. **Entry** tracking record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** tracking record
99. **None of the above**

A0310 continued on next page

Section A Identification Information

A0310. Type of Assessment - Continued

Enter Code
G. **Type of discharge** - Complete only if A0310F = 10 or 11
1. **Planned**
2. **Unplanned**

Enter Code
G1. **Is this a SNF Part A Interrupted Stay?**
0. **No**
1. **Yes**

Enter Code
H. **Is this a SNF Part A PPS Discharge Assessment?**
0. **No**
1. **Yes**

A0410. Unit Certification or Licensure Designation

Enter Code
1. **Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State**
2. **Unit is neither Medicare nor Medicaid certified but MDS data is required by the State**
3. **Unit is Medicare and/or Medicaid certified**

A0500. Legal Name of Resident

A. **First name:** B. **Middle initial:**

C. **Last name:** D. **Suffix:**

A0600. Social Security and Medicare Numbers

A. **Social Security Number:** ___ – ___ – ____

B. **Medicare number:**

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

A0800. Gender

Enter Code
1. **Male**
2. **Female**

A0900. Birth Date

__ – __ – ____
Month Day Year

A1000. Race/Ethnicity

↓ **Check all that apply**

- ☐ A. **American Indian or Alaska Native**
- ☐ B. **Asian**
- ☐ C. **Black or African American**
- ☐ D. **Hispanic or Latino**
- ☐ E. **Native Hawaiian or Other Pacific Islander**
- ☐ F. **White**

Section A Identification Information

A1100. Language

Enter Code
A. **Does the resident need or want an interpreter to communicate with a doctor or health care staff?**
0. **No** → Skip to A1200, Marital Status
1. **Yes** → Specify in A1100B, Preferred language
9. **Unable to determine** → Skip to A1200, Marital Status

B. **Preferred language:**

A1200. Marital Status

Enter Code
1. **Never married**
2. **Married**
3. **Widowed**
4. **Separated**
5. **Divorced**

A1300. Optional Resident Items

A. **Medical record number:**

B. **Room number:**

C. **Name by which resident prefers to be addressed:**

D. **Lifetime occupation(s)** - put "/" between two occupations**:**

A1500. Preadmission Screening and Resident Review (PASRR)
Complete only if A0310A = 01, 03, 04, or 05

Enter Code
Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?
0. **No** → Skip to A1550, Conditions Related to ID/DD Status
1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions
9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status

A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions
Complete only if A0310A = 01, 03, 04, or 05

↓ **Check all that apply**

- ☐ A. **Serious mental illness**
- ☐ B. **Intellectual Disability**
- ☐ C. **Other related conditions**

Section A Identification Information

A1550. Conditions Related to ID/DD Status
If the resident is 22 years of age or older, complete only if A0310A = 01
If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

↓ **Check all conditions that are related to ID/DD status** that were manifested before age 22, and are likely to continue indefinitely

ID/DD With Organic Condition
- ☐ A. **Down syndrome**
- ☐ B. **Autism**
- ☐ C. **Epilepsy**
- ☐ D. **Other organic condition related to ID/DD**

ID/DD Without Organic Condition
- ☐ E. **ID/DD with no organic condition**

No ID/DD
- ☐ Z. **None of the above**

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

__ – __ – ____
Month Day Year

A1700. Type of Entry

Enter Code
1. **Admission**
2. **Reentry**

A1800. Entered From

Enter Code
01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **ID/DD facility**
07. **Hospice**
09. **Long Term Care Hospital** (LTCH)
99. **Other**

A1900. Admission Date (Date this episode of care in this facility began)

__ – __ – ____
Month Day Year

A2000. Discharge Date
Complete only if A0310F = 10, 11, or 12

__ – __ – ____
Month Day Year

Resident _____ Identifier _____ Date _____

Section A Identification Information

A2100. Discharge Status
Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **ID/DD facility**
07. **Hospice**
08. **Deceased**
09. **Long Term Care Hospital** (LTCH)
99. **Other**

A2200. Previous Assessment Reference Date for Significant Correction
Complete only if A0310A = 05 or 06

Month – Day – Year

A2300. Assessment Reference Date

Observation end date:
Month – Day – Year

A2400. Medicare Stay
Complete only if A0310G1= 0

Enter Code

A. Has the resident had a Medicare-covered stay since the most recent entry?
0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:
Month – Day – Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:
Month – Day – Year

Resident _____ Identifier _____ Date _____

Look back period for all items is 7 days unless another time frame is indicated

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code

Persistent vegetative state/no discernible consciousness
0. **No** → Continue to B0200, Hearing
1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

B0200. Hearing

Enter Code

Ability to hear (with hearing aid or hearing appliances if normally used)
0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. **Moderate difficulty** - speaker has to increase volume and speak distinctly
3. **Highly impaired** - absence of useful hearing

B0300. Hearing Aid

Enter Code

Hearing aid or other hearing appliance used in completing B0200, Hearing
0. **No**
1. **Yes**

B0600. Speech Clarity

Enter Code

Select best description of speech pattern
0. **Clear speech** - distinct intelligible words
1. **Unclear speech** - slurred or mumbled words
2. **No speech** - absence of spoken words

B0700. Makes Self Understood

Enter Code

Ability to express ideas and wants, consider both verbal and non-verbal expression
0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

B0800. Ability To Understand Others

Enter Code

Understanding verbal content, however able (with hearing aid or device if used)
0. **Understands** - clear comprehension
1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** - responds adequately to simple, direct communication only
3. **Rarely/never understands**

B1000. Vision

Enter Code

Ability to see in adequate light (with glasses or other visual appliances)
0. **Adequate** - sees fine detail, such as regular print in newspapers/books
1. **Impaired** - sees large print, but not regular print in newspapers/books
2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** - object identification in question, but eyes appear to follow objects
4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

B1200. Corrective Lenses

Enter Code

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Attempt to conduct interview with all residents

Enter Code

0. **No** (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*
Number of words repeated after first attempt
0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code

Ask resident: "*Please tell me what year it is right now.*"
A. Able to report correct year
0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Enter Code

Ask resident: "*What month are we in right now?*"
B. Able to report correct month
0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter Code

Ask resident: "*What day of the week is today?*"
C. Able to report correct day of the week
0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Ask resident: "*Let's go back to an earlier question. What were those three words that I asked you to repeat?*"
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

Enter Code

A. Able to recall "sock"
0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code

B. Able to recall "blue"
0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code

C. Able to recall "bed"
0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. BIMS Summary Score

Enter Score

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

Enter Code

0. **No** (resident was able to complete Brief Interview for Mental Status) → Skip to C1310, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status
Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed

C0700. Short-term Memory OK

Enter Code

Seems or appears to recall after 5 minutes
0. **Memory OK**
1. **Memory problem**

C0800. Long-term Memory OK

Enter Code

Seems or appears to recall long past
0. **Memory OK**
1. **Memory problem**

C0900. Memory/Recall Ability

↓ **Check all that the resident was normally able to recall**

- ☐ **A. Current season**
- ☐ **B. Location of own room**
- ☐ **C. Staff names and faces**
- ☐ **D. That he or she is in a nursing home/hospital swing bed**
- ☐ **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code

Made decisions regarding tasks of daily life
0. **Independent** - decisions consistent/reasonable
1. **Modified independence** - some difficulty in new situations only
2. **Moderately impaired** - decisions poor; cues/supervision required
3. **Severely impaired** - never/rarely made decisions

Delirium

C1310. Signs and Symptoms of Delirium (from CAM©)
Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

A. Acute Onset Mental Status Change

Enter Code

Is there evidence of an acute change in mental status from the resident's baseline?
0. **No**
1. **Yes**

Coding:
0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Codes in Boxes**

- ☐ **B. Inattention** - Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
- ☐ **C. Disorganized Thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
- ☐ **D. Altered Level of Consciousness** - Did the resident have altered level of consciousness, as indicated by any of the following criteria?
  - **vigilant** - startled easily to any sound or touch
  - **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch
  - **stuporous** - very difficult to arouse and keep aroused for the interview
  - **comatose** - could not be aroused

Confusion Assessment Method. ©1988, 2003, Hospital Elder Life Program. All rights reserved. Adapted from: Inouye SK et al. Ann Intern Med. 1990; 113:941-8. Used with permission.

Resident _____ Identifier _____ Date _____

Section D Mood

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

Enter Code ☐
0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0200, Resident Mood Interview (PHQ-9©)

D0200. Resident Mood Interview (PHQ-9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. ***Little interest or pleasure in doing things***	☐	☐
B. ***Feeling down, depressed, or hopeless***	☐	☐
C. ***Trouble falling or staying asleep, or sleeping too much***	☐	☐
D. ***Feeling tired or having little energy***	☐	☐
E. ***Poor appetite or overeating***	☐	☐
F. ***Feeling bad about yourself - or that you are a failure or have let yourself or your family down***	☐	☐
G. ***Trouble concentrating on things, such as reading the newspaper or watching television***	☐	☐
H. ***Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual***	☐	☐
I. ***Thoughts that you would be better off dead, or of hurting yourself in some way***	☐	☐

D0300. Total Severity Score

Enter Score ☐☐ **Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 00 and 27.
Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

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Resident _____ Identifier _____ Date _____

Section D Mood

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)
Do not conduct if Resident Mood Interview (D0200-D0300) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)

2. Symptom Frequency
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things	☐	☐
B. Feeling or appearing down, depressed, or hopeless	☐	☐
C. Trouble falling or staying asleep, or sleeping too much	☐	☐
D. Feeling tired or having little energy	☐	☐
E. Poor appetite or overeating	☐	☐
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down	☐	☐
G. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual	☐	☐
I. States that life isn't worth living, wishes for death, or attempts to harm self	☐	☐
J. Being short-tempered, easily annoyed	☐	☐

D0600. Total Severity Score

Enter Score ☐☐ **Add scores for all frequency responses in Column 2**, Symptom Frequency. Total score must be between 00 and 30.

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Resident _____ Identifier _____ Date _____

Section E Behavior

E0100. Potential Indicators of Psychosis

↓ **Check all that apply**

☐ A. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
☐ B. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
☐ Z. **None of the above**

Behavioral Symptoms

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

Coding:
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

↓ **Enter Codes in Boxes**

☐ A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
☐ B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
☐ C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

E0300. Overall Presence of Behavioral Symptoms

Enter Code ☐ **Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?**
0. **No** → Skip to E0800, Rejection of Care
1. **Yes** → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below

E0500. Impact on Resident

Did any of the identified symptom(s):

Enter Code ☐ **A. Put the resident at significant risk for physical illness or injury?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Significantly interfere with the resident's care?**
0. **No**
1. **Yes**

Enter Code ☐ **C. Significantly interfere with the resident's participation in activities or social interactions?**
0. **No**
1. **Yes**

E0600. Impact on Others

Did any of the identified symptom(s):

Enter Code ☐ **A. Put others at significant risk for physical injury?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Significantly intrude on the privacy or activity of others?**
0. **No**
1. **Yes**

Enter Code ☐ **C. Significantly disrupt care or living environment?**
0. **No**
1. **Yes**

E0800. Rejection of Care - Presence & Frequency

Enter Code ☐ **Did the resident reject evaluation or care** (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

Resident _____ Identifier _____ Date _____

Section E Behavior

E0900. Wandering - Presence & Frequency

Enter Code ☐ **Has the resident wandered?**
0. **Behavior not exhibited** → Skip to E1100, Change in Behavior or Other Symptoms
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

E1000. Wandering - Impact

Enter Code ☐ **A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place** (e.g., stairs, outside of the facility)?
0. **No**
1. **Yes**

Enter Code ☐ **B. Does the wandering significantly intrude on the privacy or activities of others?**
0. **No**
1. **Yes**

E1100. Change in Behavior or Other Symptoms

Consider all of the symptoms assessed in items E0100 through E1000

Enter Code ☐ How does resident's current behavior status, care rejection, or wandering **compare to prior assessment (OBRA or Scheduled PPS)?**
0. **Same**
1. **Improved**
2. **Worse**
3. **N/A** because no prior MDS assessment

Resident _____ Identifier _____ Date _____

Section F Preferences for Customary Routine and Activities

F0300. Should Interview for Daily and Activity Preferences be Conducted? - Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other

Enter Code ☐

0. **No** (resident is rarely/never understood and family/significant other not available) → Skip to and complete F0800, Staff Assessment of Daily and Activity Preferences
1. **Yes** → Continue to F0400, Interview for Daily Preferences

F0400. Interview for Daily Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:
1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

Enter Codes in Boxes	
☐	**A.** *how important is it to you to* ***choose what clothes to wear?***
☐	**B.** *how important is it to you to* ***take care of your personal belongings or things?***
☐	**C.** *how important is it to you to* ***choose between a tub bath, shower, bed bath, or sponge bath?***
☐	**D.** *how important is it to you to* ***have snacks available between meals?***
☐	**E.** *how important is it to you to* ***choose your own bedtime?***
☐	**F.** *how important is it to you to* ***have your family or a close friend involved in discussions about your care?***
☐	**G.** *how important is it to you to* ***be able to use the phone in private?***
☐	**H.** *how important is it to you to* ***have a place to lock your things to keep them safe?***

F0500. Interview for Activity Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:
1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

Enter Codes in Boxes	
☐	**A.** *how important is it to you to* ***have books, newspapers, and magazines to read?***
☐	**B.** *how important is it to you to* ***listen to music you like?***
☐	**C.** *how important is it to you to* ***be around animals such as pets?***
☐	**D.** *how important is it to you to* ***keep up with the news?***
☐	**E.** *how important is it to you to* ***do things with groups of people?***
☐	**F.** *how important is it to you to* ***do your favorite activities?***
☐	**G.** *how important is it to you to* ***go outside to get fresh air when the weather is good?***
☐	**H.** *how important is it to you to* ***participate in religious services or practices?***

F0600. Daily and Activity Preferences Primary Respondent

Enter Code ☐

Indicate primary respondent for Daily and Activity Preferences (F0400 and F0500)
1. **Resident**
2. **Family or significant other** (close friend or other representative)
9. **Interview could not be completed** by resident or family/significant other ("No response" to 3 or more items")

Resident _____ Identifier _____ Date _____

Section F Preferences for Customary Routine and Activities

F0700. Should the Staff Assessment of Daily and Activity Preferences be Conducted?

Enter Code ☐

0. **No** (because Interview for Daily and Activity Preferences (F0400 and F0500) was completed by resident or family/significant other) → Skip to and complete G0110, Activities of Daily Living (ADL) Assistance
1. **Yes** (because 3 or more items in Interview for Daily and Activity Preferences (F0400 and F0500) were not completed by resident or family/significant other) → Continue to F0800, Staff Assessment of Daily and Activity Preferences

F0800. Staff Assessment of Daily and Activity Preferences

Do not conduct if Interview for Daily and Activity Preferences (F0400-F0500) was completed

Resident Prefers:

Check all that apply	
☐	**A. Choosing clothes to wear**
☐	**B. Caring for personal belongings**
☐	**C. Receiving tub bath**
☐	**D. Receiving shower**
☐	**E. Receiving bed bath**
☐	**F. Receiving sponge bath**
☐	**G. Snacks between meals**
☐	**H. Staying up past 8:00 p.m.**
☐	**I. Family or significant other involvement in care discussions**
☐	**J. Use of phone in private**
☐	**K. Place to lock personal belongings**
☐	**L. Reading books, newspapers, or magazines**
☐	**M. Listening to music**
☐	**N. Being around animals such as pets**
☐	**O. Keeping up with the news**
☐	**P. Doing things with groups of people**
☐	**Q. Participating in favorite activities**
☐	**R. Spending time away from the nursing home**
☐	**S. Spending time outdoors**
☐	**T. Participating in religious activities or practices**
☐	**Z. None of the above**

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0110. Activities of Daily Living (ADL) Assistance

Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3
- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

1. ADL Self-Performance
Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times
0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times
7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. ADL Support Provided
Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:
0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

	1. Self-Performance	2. Support
	Enter Codes in Boxes	
A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture	☐	☐
B. Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)	☐	☐
C. Walk in room - how resident walks between locations in his/her room	☐	☐
D. Walk in corridor - how resident walks in corridor on unit	☐	☐
E. Locomotion on unit - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	☐	☐
F. Locomotion off unit - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	☐	☐
G. Dressing - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses	☐	☐
H. Eating - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)	☐	☐
I. Toilet use - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag	☐	☐
J. Personal hygiene - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers)	☐	☐

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0120. Bathing

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support

Enter Code ☐

A. Self-performance
0. **Independent** - no help provided
1. **Supervision** - oversight help only
2. **Physical help limited to transfer only**
3. **Physical help in part of bathing activity**
4. **Total dependence**
8. **Activity itself did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

Enter Code ☐

B. Support provided
(Bathing support codes are as defined in item **G0110 column 2, ADL Support Provided**, above)

G0300. Balance During Transitions and Walking

After observing the resident, **code the following walking and transition items for most dependent**

Coding:
0. **Steady at all times**
1. **Not steady, but able to stabilize without staff assistance**
2. **Not steady, only able to stabilize with staff assistance**
8. **Activity did not occur**

Enter Codes in Boxes	
☐	**A. Moving from seated to standing position**
☐	**B. Walking** (with assistive device if used)
☐	**C. Turning around** and facing the opposite direction while walking
☐	**D. Moving on and off toilet**
☐	**E. Surface-to-surface transfer** (transfer between bed and chair or wheelchair)

G0400. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury

Coding:
0. **No impairment**
1. **Impairment on one side**
2. **Impairment on both sides**

Enter Codes in Boxes	
☐	**A. Upper extremity** (shoulder, elbow, wrist, hand)
☐	**B. Lower extremity** (hip, knee, ankle, foot)

G0600. Mobility Devices

Check all that were normally used	
☐	**A. Cane/crutch**
☐	**B. Walker**
☐	**C. Wheelchair** (manual or electric)
☐	**D. Limb prosthesis**
☐	**Z. None of the above** were used

G0900. Functional Rehabilitation Potential

Complete only if A0310A = 01

Enter Code ☐

A. Resident believes he or she is capable of increased independence in at least some ADLs
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐

B. Direct care staff believe resident is capable of increased independence in at least some ADLs
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

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
Complete only if A0310B = 01

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.

GG0110. Prior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

↓ Check all that apply	
☐	**A. Manual wheelchair**
☐	**B. Motorized wheelchair and/or scooter**
☐	**C. Mechanical lift**
☐	**D. Walker**
☐	**E. Orthotics/Prosthetics**
☐	**Z. None of the above**

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

GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	↓ Enter Codes in Boxes
☐☐	☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

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

GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	↓ Enter Codes in Boxes
☐☐	☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	☐☐	**G. Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

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

GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B) - Continued
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	↓ Enter Codes in Boxes
☐☐	☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
		☐ **Q1. Does the resident use a wheelchair and/or scooter?** 0. **No** → Skip to GG0130, Self Care (Discharge) 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		☐ **RR1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		☐ **SS1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

Resident _____ Identifier _____ Date _____

Section GG Functional Abilities and Goals - Discharge (End of SNF PPS Stay)

GG0130. Self-Care (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Resident _____ Identifier _____ Date _____

Section GG Functional Abilities and Goals - Discharge (End of SNF PPS Stay)

GG0170. Mobility (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	**G. Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Resident _____ Identifier _____ Date _____

Section GG Functional Abilities and Goals - Discharge (End of SNF PPS Stay)

GG0170. Mobility (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C) - Continued
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.

Coding:
Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.
Activities may be completed with or without assistive devices.
06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:
07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
☐	**Q3. Does the resident use a wheelchair and/or scooter?** 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
☐	**RR3. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
☐	**SS3. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

Resident _____ Identifier _____ Date _____

Section H Bladder and Bowel

H0100. Appliances

Check all that apply ↓

☐ **A. Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
☐ **B. External catheter**
☐ **C. Ostomy** (including urostomy, ileostomy, and colostomy)
☐ **D. Intermittent catheterization**
☐ **Z. None of the above**

H0200. Urinary Toileting Program

Enter Code ☐ **A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training)** been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility?
0. **No** → Skip to H0300, Urinary Continence
1. **Yes** → Continue to H0200B, Response
9. **Unable to determine** → Skip to H0200C, Current toileting program or trial

Enter Code ☐ **B. Response** - What was the resident's response to the trial program?
0. **No improvement**
1. **Decreased wetness**
2. **Completely dry** (continent)
9. **Unable to determine** or trial in progress

Enter Code ☐ **C. Current toileting program or trial** - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?
0. **No**
1. **Yes**

H0300. Urinary Continence

Enter Code ☐ **Urinary continence** - Select the one category that best describes the resident
0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)
3. **Always incontinent** (no episodes of continent voiding)
9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

H0400. Bowel Continence

Enter Code ☐ **Bowel continence** - Select the one category that best describes the resident
0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** resident had an ostomy or did not have a bowel movement for the entire 7 days

H0500. Bowel Toileting Program

Enter Code ☐ **Is a toileting program currently being used to manage the resident's bowel continence?**
0. **No**
1. **Yes**

H0600. Bowel Patterns

Enter Code ☐ **Constipation present?**
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

I0020. Indicate the resident's primary medical condition category
Complete only if A0310B = 01 or 08

Enter Code

Indicate the resident's primary medical condition category that best describes the primary reason for admission

01. **Stroke**
02. **Non-Traumatic Brain Dysfunction**
03. **Traumatic Brain Dysfunction**
04. **Non-Traumatic Spinal Cord Dysfunction**
05. **Traumatic Spinal Cord Dysfunction**
06. **Progressive Neurological Conditions**
07. **Other Neurological Conditions**
08. **Amputation**
09. **Hip and Knee Replacement**
10. **Fractures and Other Multiple Trauma**
11. **Other Orthopedic Conditions**
12. **Debility, Cardiorespiratory Conditions**
13. **Medically Complex Conditions**

I0020B. ICD Code

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Cancer
- **I0100. Cancer** (with or without metastasis)

Heart/Circulation
- **I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
- **I0300. Atrial Fibrillation or Other Dysrhythmias** (e.g., bradycardias and tachycardias)
- **I0400. Coronary Artery Disease (CAD)** (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
- **I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)**
- **I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
- **I0700. Hypertension**
- **I0800. Orthostatic Hypotension**
- **I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**

Gastrointestinal
- **I1100. Cirrhosis**
- **I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer** (e.g., esophageal, gastric, and peptic ulcers)
- **I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**

Genitourinary
- **I1400. Benign Prostatic Hyperplasia (BPH)**
- **I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)**
- **I1550. Neurogenic Bladder**
- **I1650. Obstructive Uropathy**

Infections
- **I1700. Multidrug-Resistant Organism (MDRO)**
- **I2000. Pneumonia**
- **I2100. Septicemia**
- **I2200. Tuberculosis**
- **I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)**
- **I2400. Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
- **I2500. Wound Infection** (other than foot)

Metabolic
- **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
- **I3100. Hyponatremia**
- **I3200. Hyperkalemia**
- **I3300. Hyperlipidemia** (e.g., hypercholesterolemia)
- **I3400. Thyroid Disorder** (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)

Musculoskeletal
- **I3700. Arthritis** (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
- **I3800. Osteoporosis**
- **I3900. Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
- **I4000. Other Fracture**

Neurological
- **I4200. Alzheimer's Disease**
- **I4300. Aphasia**
- **I4400. Cerebral Palsy**
- **I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
- **I4800. Non-Alzheimer's Dementia** (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)

Neurological Diagnoses continued on next page

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Neurological - Continued
- **I4900. Hemiplegia or Hemiparesis**
- **I5000. Paraplegia**
- **I5100. Quadriplegia**
- **I5200. Multiple Sclerosis (MS)**
- **I5250. Huntington's Disease**
- **I5300. Parkinson's Disease**
- **I5350. Tourette's Syndrome**
- **I5400. Seizure Disorder or Epilepsy**
- **I5500. Traumatic Brain Injury (TBI)**

Nutritional
- **I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder
- **I5700. Anxiety Disorder**
- **I5800. Depression** (other than bipolar)
- **I5900. Bipolar Disorder**
- **I5950. Psychotic Disorder** (other than schizophrenia)
- **I6000. Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- **I6100. Post Traumatic Stress Disorder (PTSD)**

Pulmonary
- **I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
- **I6300. Respiratory Failure**

Vision
- **I6500. Cataracts, Glaucoma, or Macular Degeneration**

None of Above
- **I7900. None of the above active diagnoses** within the last 7 days

Other

I8000. Additional active diagnoses
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____
H. _____
I. _____
J. _____

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J0100. Pain Management - Complete for all residents, regardless of current pain level

At any time in the last **5** days, has the resident:

Enter Code **A. Received scheduled pain medication regimen?**
0. **No**
1. **Yes**

Enter Code **B. Received PRN pain medications OR was offered and declined?**
0. **No**
1. **Yes**

Enter Code **C. Received non-medication intervention for pain?**
0. **No**
1. **Yes**

J0200. Should Pain Assessment Interview be Conducted?
Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter Code
0. **No** (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain
1. **Yes** → Continue to J0300, Pain Presence

Pain Assessment Interview

J0300. Pain Presence

Enter Code Ask resident: "***Have you had pain or hurting at any time*** *in the last 5 days?*"
0. **No** → Skip to J1100, Shortness of Breath
1. **Yes** → Continue to J0400, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0400. Pain Frequency

Enter Code Ask resident: "***How much of the time have you experienced pain or hurting*** *over the last 5 days?*"
1. **Almost constantly**
2. **Frequently**
3. **Occasionally**
4. **Rarely**
9. **Unable to answer**

J0500. Pain Effect on Function

Enter Code **A.** Ask resident: "*Over the past 5 days,* ***has pain made it hard for you to sleep at night****?*"
0. **No**
1. **Yes**
9. **Unable to answer**

Enter Code **B.** Ask resident: "*Over the past 5 days,* ***have you limited your day-to-day activities because of pain****?*"
0. **No**
1. **Yes**
9. **Unable to answer**

J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating **A. Numeric Rating Scale (00-10)**
Ask resident: "*Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.*" (Show resident 00 -10 pain scale)
Enter two-digit response. Enter 99 if unable to answer.

Enter Code **B. Verbal Descriptor Scale**
Ask resident: "*Please rate the intensity of your worst pain over the last 5 days.*" (Show resident verbal scale)
1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
9. **Unable to answer**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home Comprehensive (NC) Item Set

Section A Identification Information

A0050. Type of Record

Enter Code
1. **Add new record** → Continue to A0100, Facility Provider Numbers
2. **Modify existing record** → Continue to A0100, Facility Provider Numbers
3. **Inactivate existing record** → Skip to X0150, Type of Provider

A0100. Facility Provider Numbers

A. **National Provider Identifier (NPI):**

B. **CMS Certification Number (CCN):**

C. **State Provider Number:**

A0200. Type of Provider

Enter Code
Type of provider
1. **Nursing home (SNF/NF)**
2. **Swing Bed**

A0300. Optional State Assessment
Complete only if A0200 = 1

Enter Code
A. **Is this assessment for state payment purposes only?**
0. **No**
1. **Yes**

A0310. Type of Assessment

Enter Code
A. **Federal OBRA Reason for Assessment**
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

Enter Code
B. **PPS Assessment**
PPS Scheduled Assessment for a Medicare Part A Stay
01. **5-day** scheduled assessment
PPS Unscheduled Assessment for a Medicare Part A Stay
08. **IPA** - Interim Payment Assessment
Not PPS Assessment
99. **None of the above**

Enter Code
E. **Is this assessment the first assessment** (OBRA, Scheduled PPS, or Discharge) **since the most recent admission/entry or reentry?**
0. **No**
1. **Yes**

Enter Code
F. **Entry/discharge reporting**
01. **Entry** tracking record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** tracking record
99. **None of the above**

A0310 continued on next page

Section A Identification Information

A0310. Type of Assessment - Continued

Enter Code
G. **Type of discharge** - Complete only if A0310F = 10 or 11
1. **Planned**
2. **Unplanned**

Enter Code
G1. **Is this a SNF Part A Interrupted Stay?**
0. **No**
1. **Yes**

Enter Code
H. **Is this a SNF Part A PPS Discharge Assessment?**
0. **No**
1. **Yes**

A0410. Unit Certification or Licensure Designation

Enter Code
1. **Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State**
2. **Unit is neither Medicare nor Medicaid certified but MDS data is required by the State**
3. **Unit is Medicare and/or Medicaid certified**

A0500. Legal Name of Resident

A. **First name:** B. **Middle initial:**

C. **Last name:** D. **Suffix:**

A0600. Social Security and Medicare Numbers

A. **Social Security Number:** ___ – ___ – ____

B. **Medicare number:**

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

A0800. Gender

Enter Code
1. **Male**
2. **Female**

A0900. Birth Date

Month – Day – Year

A1000. Race/Ethnicity

↓ **Check all that apply**

- ☐ A. **American Indian or Alaska Native**
- ☐ B. **Asian**
- ☐ C. **Black or African American**
- ☐ D. **Hispanic or Latino**
- ☐ E. **Native Hawaiian or Other Pacific Islander**
- ☐ F. **White**

Section A Identification Information

A1100. Language

Enter Code
A. **Does the resident need or want an interpreter to communicate with a doctor or health care staff?**
0. **No** → Skip to A1200, Marital Status
1. **Yes** → Specify in A1100B, Preferred language
9. **Unable to determine** → Skip to A1200, Marital Status

B. **Preferred language:**

A1200. Marital Status

Enter Code
1. **Never married**
2. **Married**
3. **Widowed**
4. **Separated**
5. **Divorced**

A1300. Optional Resident Items

A. **Medical record number:**

B. **Room number:**

C. **Name by which resident prefers to be addressed:**

D. **Lifetime occupation(s)** - put "/" between two occupations:

A1500. Preadmission Screening and Resident Review (PASRR)
Complete only if A0310A = 01, 03, 04, or 05

Enter Code
Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?
0. **No** → Skip to A1550, Conditions Related to ID/DD Status
1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions
9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status

A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions
Complete only if A0310A = 01, 03, 04, or 05

↓ **Check all that apply**

- ☐ A. **Serious mental illness**
- ☐ B. **Intellectual Disability**
- ☐ C. **Other related conditions**

Section A Identification Information

A1550. Conditions Related to ID/DD Status
If the resident is 22 years of age or older, complete only if A0310A = 01
If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

↓ **Check all conditions that are related to ID/DD status** that were manifested before age 22, and are likely to continue indefinitely

ID/DD With Organic Condition
- ☐ A. **Down syndrome**
- ☐ B. **Autism**
- ☐ C. **Epilepsy**
- ☐ D. **Other organic condition related to ID/DD**

ID/DD Without Organic Condition
- ☐ E. **ID/DD with no organic condition**

No ID/DD
- ☐ Z. **None of the above**

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

Month – Day – Year

A1700. Type of Entry

Enter Code
1. **Admission**
2. **Reentry**

A1800. Entered From

Enter Code
01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **ID/DD facility**
07. **Hospice**
09. **Long Term Care Hospital** (LTCH)
99. **Other**

A1900. Admission Date (Date this episode of care in this facility began)

Month – Day – Year

A2000. Discharge Date
Complete only if A0310F = 10, 11, or 12

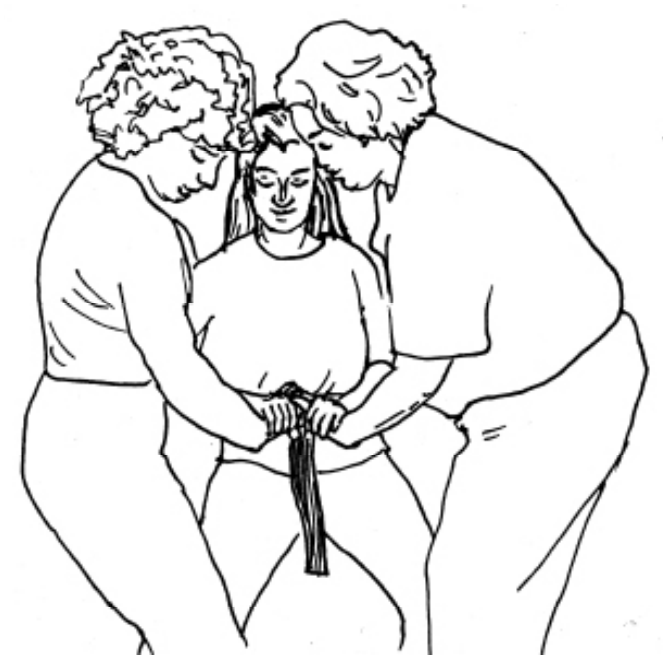
Month – Day – Year

OSHA

The **Occupational Safety and Health Administration (OSHA)** Guidelines for Nursing Homes, *Ergonomics for the Prevention of Musculoskeletal Disorders*, includes advisory recommendations to help reduce the number and severity of work-related musculoskeletal disorders (MSDs) in facilities and serve as a basis to protect workers.

MSDs include conditions such as low back pain, sciatica, rotator cuff injuries, epicondylitis, and carpal tunnel syndrome. The entire document is available on the Internet at www.osha.gov.

This Restorative Nursing Program Certification Course provides training that complements these guidelines by teaching, demonstrating and checking appropriate physical management techniques for protection of the resident and caregiver.



Remember:
A transfer is
a ***shift***,
not a ***lift***!

OSHA recommends that manual lifting of residents be minimized in all cases and eliminated when feasible.

QUALITY IMPROVEMENT MONITOR TOOL

LOCATION: _____ REVIEWER & DATE: _____ KEY: (+) met; (-) not met

INDICATOR: Restorative Nursing Program (RNP) documentation is complete

INDICATOR CRITERIA:

1. Initial Restorative Nursing/Dining Program Referral Form and/or is completed.
2. Restorative Nursing/Dining Program Referral Form matches Resident Care Plan.
3. Daily/per care Restorative Nursing Program RNP documentation is complete.
4. Daily/per care Restorative Nursing Program treatment time is documented. (Required for specific Medicare PPS RUG-III levels only.)
5. Weekly Restorative Nursing Program note reflects progress/lack of progress.
6. Weekly licensed assessments reflect resident's progress/lack of progress toward goal.
7.
8.
9.
10.

RESIDENTS → / CRITERIA ↓	1	2	3	4	5	6	7	8	9	10	COMMENTS
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											

RECOMMENDED ACTIONS, RESPONSIBLE PERSON (S), DUE DATE: _____

_____

QUALITY OF CARE
RESTORATIVE NURSING CARE MONITOR TOOL

Reviewer: _____ **Review Date:** _____

Sample selection: Review random selection of residents each quarter. Review residents who have orders for RNA services, i.e., ambulation, range of motion (active/passive), feeding program, mobility strengthening exercise, adaptive or assistive devices, show a decline in late loss ADLs or decline in ROM.

Resident name: _____

Code	Indicator	Yes	No	Yes	No	Yes	No	Yes	No
	CHART REVIEW								
F 676	Was the resident assessed as needing assistance for ADLs? (Dependent on staff for ADLs.)								
F 676	Was the resident referred to RNA program from MD, Therapy or Nursing?								
F 676	Orders for RNA program are clear and specific? (Who, what, frequency and duration.)								
F 675	Is restorative activity provided and documented per orders on the RNA flow record, i.e., activity, frequency, distance; repetitions, restorative dining, etc.?								
F 656	Is the care plan specific to restorative program with goals and interventions?								
F 659	Is there evidence that the care plan was implemented?								
F 675	Is there a narrative weekly summary documented by the RNA or the Restorative Nurse Coordinator that addresses tolerance, progress/outcomes/pain, restorative dining program, etc.?								
F 675	Do weekly Licensed Nurses Notes include resident's response/ outcomes to RNA program?								
F 656	Is there evidence of updating care plans as conditions change?								
F 658	Are joint mobility assessments completed at least quarterly?								
F 676	If resident is discharged from the RNA program, is there a discharge order and discharge summary explaining reason why?								
	OBSERVATION OF AMBULATION, ROM, ETC.								
F 688	If adaptive equipment or assistive devices are ordered, are they in use?								
F 688	Can RNA describe what services are provided and how resident is responding? (Does description match orders and care plans?)								
F 675	Does resident demonstrate tolerance and ability to complete activity as ordered or care planned? (I.e., ambulate 100 ft. x 5 days per week.)								

QUALITY OF CARE
RESTORATIVE NURSING CARE MONITOR TOOL

Resident name: _____

Code	Indicator	Yes	No	Yes	No	Yes	No	Yes	No
	OBSERVATION OF RESTORATIVE DINING PROGRAM								
F 676	Is the RNA encouraging, cuing and allowing resident to do as much as possible independently?								
F 920	Is the dining program environment calm and quiet?								
F 558	Are adaptive or assistive devices used if recommended?								
F 920	Are the tables adjusted to accommodate individual resident needs?								
F 920	Is there proper positioning to accommodate individual resident needs?								
F 920	Is the staff accurately monitoring and documenting the foods/fluids consumed?								

Negative Outcomes	Corrective Action or Follow Up

QUALITY OF CARE
RESTORATIVE NURSING CARE MONITOR TOOL

Name: _____ **Admission date:** _____

Reviewer: _____ **Review Date:** _____

Sample selection: Determine random selection of all residents each quarter. Review all residents who show a decline in late loss ADLs and decline in ROM. Determine random selection of all diabetics for review of care and treatment of feet.

Code	Indicator	Yes	No	Comments
	CHART REVIEW			
F 641	ADL Section G on the MDS accurately identifies resident's ability in activities of daily living?			
F 676	Has the resident's ability to perform activities of daily living been maintained or improved (as opposed to declined) in bathing, dressing, grooming, transferring, ambulating, toileting, eating and functional communications?			
F 656	Are problems related to ADL ability identified in the care plan with specific goal and interventions individualized to resident's needs?			
F 656	Does the resident's care plan identify the resident as being high risk for development of problems due to specific diagnosis or conditions, e.g., contractures, pressure sores, impaired mobility?			
F 659	Were care plan interventions consistently documented?			
F 656	Was the care plan updated if the resident failed to progress or condition declined or improved?			
F 675	Do progress notes reflect consistent plan of treatment and progress or lack or progress, i.e., ADL records, weekly nursing noted, IDT notes?			
F 842	Is there evidence that the ADL record was completed each day/ each shift? (Without omissions and only on days resident resides in the facility.)			
F 676	Is there evidence that the resident has been referred to Therapy Department and/or a restorative program if indicated?			
F 676	Is there evidence that assistive devices or equipment have been provided to maintain or improve functional abilities if indicated?			
F 685	Are assistive devices to maintain vision and hearing available and in good repair, e.g., glasses, contact lenses, magnifying glasses, hearing aids/batteries, etc.?			
F 697	Does resident receive proper care and treatment for prostheses if indicated?			
F 687	If the resident has problems with toe nails, corns, calluses and/or other foot problems, has care been provided by an appropriate professional?			
F 687	If resident is a diabetic, has preventive foot care been care planned and documented?			

QUALITY OF CARE
RESTORATIVE NURSING CARE MONITOR TOOL

Code	Indicator	Yes	No	Comments
	OBSERVATIONS/INTERVIEWS			
F 656	Do care plan interventions match resident's current status?			
F 675	Can staff describe ADL care plan goals and interventions? (Does their description match care plan?)			
F 676 F 677	Is the resident's hygiene and grooming appropriate?			
F 676 F 677	If assistive devices are ordered, are they available and used as ordered, e.g., splints, positioning pillows, adaptive equipment for eating, etc.?			
F 687	Are feet clean, dry, with no signs and symptoms of infections?			
F 697	If ordered, is resident wearing prosthesis (e.g., artificial limbs, eyes, teeth), and do they fit correctly?			
F 697	Is skin/mucous membrane in contact with the prosthesis free of abrasions, wound or irritation?			

RNA CQI TREND REPORT

CLINICAL INDICATORS	TFA	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
AVERAGE DAILY CENSUS													
# of residents receiving RNA services this month													
# of residents on RNP ambulation													
# of residents receiving ROM													
# of resident on RNP splint application													
# of residents on RNP dining program													
# of residents on a B&B retraining program													
# of new admissions to RNP this month													
# of discharges from RNP this month													
OTHER:													
QUALITY INDICATORS													
QI: Prevalence of bedfast residents													
QI: Incidence of decline in late loss ADL's													
QI: Incidence of decline in ROM													

PROBLEMS/CONCERNS	ACTION	PROGRESS/OUTCOME

RNA CQI TREND REPORT

PROBLEMS/CONCERNS	ACTION	PROGRESS/OUTCOME

Restorative Nursing Progam Certification Course

Competency Checklists

- Dysphagia and Eating 222
- Joint Mobility 223
- Functional Mobility – Ortho 224
- Functional Mobility – Neuro 225

RNP Competency Checklist — DYSPHAGIA AND EATING

RNA/RNPC Name _____ Dates _____

	Return demo. Yes	Return demo. No	Comments	Inst. initials
1. Demonstrate one of the two feeding positions: ☐ Bed ☐ Wheelchair				
2. Identify the following consistencies: ☐ Honey ☐ Nectar				
3. Identify and demonstrate three of the five adaptive feeding devices: ☐ Plate guard ☐ Weighted utensil ☐ Nosey cup ☐ Universal cuff ☐ Built-up handle				
4. Write three suggestions or aids to swallowing: ☐ _____ ☐ _____ ☐ _____				

Instructor _____ Title _____ Initials _____ Date _____
Instructor _____ Title _____ Initials _____ Date _____
Instructor _____ Title _____ Initials _____ Date _____

Note: The individual RNA/RNPC is responsible for obtaining instructors' signatures to show completion of the RNP Competency Checklist.

RNP Competency Checklist

JOINT MOBILITY

RNA/RNPC Name _____ Dates _____

	Return demo. Yes	Return demo. No	Comments	Inst. initials
Verbalize and identify the major muscle groups while demonstrating the following motions (*avoid repeating the same muscle groups*):				
1. Passive Range of Motion: • Upper extremities (one out of four) ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand • Lower extremities (one out of three) ☐ Hip ☐ Knee ☐ Ankle				
2. Active Assisted Range of Motion • Upper extremities (one out of four) ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand • Lower extremities (one out of three) ☐ Hip ☐ Knee ☐ Ankle				
3. Demonstrate one resistive exercise for each area: • Upper extremities (one out of four) ☐ Shoulder ☐ Elbow ☐ Wrist • Lower extremities (one out of three) ☐ Hip ☐ Knee ☐ Ankle				
4. Demonstrate correct application of one of three splints: ☐ Hand – resting splint ☐ AFO ☐ Knee (immobilizer)				
5. Demonstrate one method to reduce upper extremity edema ☐ Elevation				

Instructor _____ Title _____ Initials _____ Date _____
Instructor _____ Title _____ Initials _____ Date _____
Instructor _____ Title _____ Initials _____ Date _____

Note: The individual RNA/RNPC is responsible for obtaining instructors' signatures to show completion of the RNP Competency Checklist.

RNP Competency Checklist — FUNCTIONAL MOBILITY – ORTHO

RNA/RNPC Name _____ Dates _____

	Return demo. Yes	Return demo. No	Comments	Inst. initials
1. Demonstrate the correct components in the use of the gait/transfer belt: ☐ Verbal instructions ☐ Application and fit ☐ Body mechanics with application ☐ Precautions and contraindications				
2. Demonstrate and verbalize the precautions for the following: ☐ Total hip precautions ☐ ORIF – weight bearing				
3. Demonstrate one of the following THR transfers: ☐ Supine to sitting and transfer to chair using an FWW ☐ Chair to bed and return to supine while using an FWW				
4. Demonstrate ambulation assist techniques for hip fracture using an FWW or SPC with one of the following weight-bearing limitations: ☐ TDWB ☐ PWB ☐ WBAT				
5. Demonstrate one of the orthopedic dressing techniques using correct adaptive devices for lower body dressing: ☐ Pants ☐ Socks ☐ Shoes				

Instructor _____ Title _____ Initials _____ Date _____
Instructor _____ Title _____ Initials _____ Date _____
Instructor _____ Title _____ Initials _____ Date _____

Note: The individual RNA/RNPC is responsible for obtaining instructors' signatures to show completion of the RNP Competency Checklist.

RNP Competency Checklist — FUNCTIONAL MOBILITY – NEURO

RNA/RNPC Name _____ Dates _____

	Return demo. Yes	Return demo. No	Comments	Inst. initials
1. Demonstrate proper bed positioning for one of the following situations and identify three major pressure risk areas (include correct UE and LE positions): ☐ Supine with hemiplegia ☐ Side-lying on affected hemiplegic side ☐ Side-lying on unaffected hemiplegic side				
2. Demonstrate one of these four bed mobility techniques: Rolling – to side of bed ☐ Supine to sitting ☐ Sitting to supine ☐ Moving up to the head of the bed				
3. Demonstrate one of the transfers for one-person partial assist, including correct wheelchair positioning and identification of three major pressure risk areas: ☐ Bed to chair ☐ Chair to bed				
4. Demonstrate use of a slide board for one of the following transfers ☐ Bed to chair ☐ Chair to bed				
5. Demonstrate one ambulation technique using assistive devices for the following diagnoses: ☐ CVA – hemi-cane or quad-cane ☐ Weakness – single point cane or FWW ☐ Parkinson – FWW or hand-held assist				
6. Demonstrate this correct dressing technique for hemiplegia (use adaptive equipment as required): ☐ Upper body – one-handed				

Instructor _____ Title _____ Initials _____ Date _____
Instructor _____ Title _____ Initials _____ Date _____
Instructor _____ Title _____ Initials _____ Date _____

Note: The individual RNA/RNPC is responsible for obtaining instructors' signatures to show completion of the RNP Competency Checklist.

Leadership Keys to Success

Activity

1. One thing I know for sure about the RNP is:

2. One question I have about the RNP is:

3. One thing that scares me about the RNP is:

4. I think facilities with the RNP are:

Restorative Nursing Progam Certification Course

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EDD Employment Development Department State of California

California HealthCare Foundation

Quality Care Health Foundation QCHF