ADL Script

Slide 1

My name is Maureen Valvo. I am a Sr. Quality Improvement Specialist on the IPRO Nursing Home Team in the Health Care Quality Improvement Department. I will review the Activities of Daily Living, specifically Bed Mobility Self-Performance and Transfer Self-Performance since these affect the Pressure Ulcer Quality Measure. A resident's inability to move in bed or to transfer by themselves makes them high risk for Pressure Ulcers.

Slide 2

A resident's ADL self-performance may vary from day to day, shift to shift, or within shifts.

Do NOT record the type of assistance that the resident "should" be receiving according to the written plan of care.
The level of assistance actually provided might be very different from what is indicated in the plan.

RECORD WHAT ACTUALLY HAPPENED.

Slide 3

This is a visual Guide for the Activities of Daily Living, to help capture the Residents' Self performance, and the level of assistance staff provide, we will look at these individually.

Level 0 Independent, the resident needed no help or oversight, the resident stick figure is waving at the staff or other residents, the care giver is not with the resident.

Level 1 Supervision, the residents need cues, verbal encouragement. Staff provides verbal directions, verbal cues, the staff stick figure with the conversation bubble is giving directions to resident

Level 2 Limited Assistance, the resident was highly involved in the activity, but required non-weight bearing assistance- the stick figure staff member is just guiding resident.

Level 3 Extensive Assistance, the resident performed part of the activity but required weight bearing assistance, lifting a part of the resident's body. To get up the stick figure staff is lifting part of the resident's body.

Slide 4
MDS rule of 3 for ADL coding.
The MDS Coordinator will code the MDS at the most dependent level that occurred 3 times in the last 7 days.

That is why we are reviewing this coding, to remind you to capture the extra assistance you occasionally provide.

Take credit for the work you do.

For example, Monday a resident who usually is up and running but needs your assistance to get up and moving this Monday morning. Then he is usually able to getting back into bed but on Wednesday evening the resident asked for assistance lifting his legs on to the bed. Then on Thursday night the resident, who usually sleeps all night woke up to go to the bathroom. Sometimes it is easier to slip out of bed then to get back in to bed, especially when tired and the resident as to wait for some to asks for assistance to lift legs on to the bed.

The MDS assessor would see that the resident needed extensive assistance Monday morning, Wednesday evening, and Thursday night and the residents would be coded as extensive assistance.

Slide 5

Coding for ADLs, first currently focusing on the coding of Bed Mobility Self- Performance. This was shared by a MDS coordinator on the American Association of Nurse Assessment Coordinators. A verbal description guide used with their staff.

For BED MOBILITY, how the resident moves to and from a lying position, turns side to side, and positions body while in bed, in a recliner, or other type of furniture that the resident sleeps in.

Remember to consider ALL aspects of bed mobility when coding ADLs

Repositioning, after Resident has slid to the foot of the bed, or returned to bed but climbed in near the bottom, the scooting up in bed if staff provide partial weight-bearing assistance of pulling up on lift sheet while resident pushes up feet, or staff must physically lift and reposition him toward the head of the bed. Resident helped by bending his knees and pushing when cued by staff. This is extensive assistance.

Lying to sitting & sitting to lying position Extensive assistance is the weight-bearing assistance of lifting trunk to sitting position and/or lifting legs to put over the edge of bed, or legs lifted in bed when resident is laid down.

Turning side to side, positioning in a side-lying position (Sim's) is extensive assistance, partial weight-bearing assistance of holding resident over so he does not fall backwards while on side, using lift sheet to pull & position hips, lifting legs to position with pillow or padding between knees.

Please take credit for the work you do.

Slide 6

This was shared by a MDS coordinator on the American Association of Nurse Assessment Coordinators. A verbal description guide used with their staff focusing on Transfer Self Performance.

Transfer is how the resident moves between surfaces that is to or from bed, chair, wheelchair, or standing position.

This does not include moving to or from the bath or the toilet which is covered under the questions of Toilet use and Bathing.

Remember to include All parts of transfer when coding ADLS.

Rising to a standing position from bed or chair is extensive, partial weight-bearing assistance of full or partial lifting resident from sitting to standing position. The resident did not lift his own bottom off the bed or chair without your help.

Pivoting or taking a couple steps to bed or chair is extensive partial weight-bearing assistance if the resident fully or partially leaned on staff for balance during pivot, or staff holding resident up while assisting to lift legs or to slide feet to move feet in pivot motion.

Lowering to a sitting position on the bed or in the chair is extensive partial weight-bearing assistance of holding resident up so he does not fall down while lowering slowly to the bed or chair, or bearing the resident's weight for balance to get to sitting position.

Please take credit for the work you do.

Slide 7

Some photos to help discuss this further.

Residents use these items, canes and walkers to be independent. How do they get to standing and walking with the cane or walker? Some days they may be totally independent and some days or some

times of the day like afternoon or in evenings, or even getting up in the morning, they may need your partial weight bearing assistance to lift themselves if they are feeling weak, tired or fear they might fall. Maybe this is not every day but maybe some days.

Photo 1 resident has a cane and a brace. The staff may be just monitoring but they are there in case the resident does need some weight bearing support. This is the same for photos 2 and 3, where the resident is using a walker with staff at their side. Photo 3 is Grandma Chase a patient care mannequin. The mannequin can't stand without being supported. For the Transfer ADL, think how did the resident get to this position to walk with the cane or to walk with the walker? Once you provided partial weight bearing assistance, are they then able to walk with the cane or the walker.

Please take Credit for the work you do.

Slide 8

Photo 5 As I just mentioned how does the resident get out of the chair or off the bed. They may be Independent usually but sometimes they may need to hold your hand or you support their elbow providing partial weight bearing support to elevate themself.

In this picture, using the assistant's right hand and support from assistant's left hand at the residents back and under the elbow, the resident elevates off the bed with partial weight bearing assistance which is extensive assistance.

Some days or different times of the day the resident may need a little bit of an extra hand, more help than the Plan of Care indicates.

Please take Credit for the work you do.

Slide 9

These are pictures of needing partial weight bearing assistance. Photo 6 lifting the resident's legs, to transfer back in to bed at night or in afternoon for nap, maybe not every day but some days and staff must take credit for the care you provide.

Photo 7 Bed Mobility Lifting Leg while in bed

And photo 8 Position legs in bed, Bed mobility

Please take Credit for the work you do.

Slide 10

In photo 9, you may not always assist residents to lower themselves in to the chair. Maybe they usually independently do it, but one day you notice they drop themselves and flop into the chair in a bad position- you reposition them and monitor to assist with transfers later in the day.

Photo 10 is help with pivoting. Pivoting is the action of turning from bed to chair or chair to bed. This is when residents may lose their balance and possibly fall. The resident may fully or partially be leaning on staff for balance during pivot or staff assists with moving resident's feet in the pivoting motion.

Please take Credit for the work you do.

Slide 11

This is how the resident independently turns to sit up and transfer himself out of bed even with one sided weakness as in photo on left number 11. None of your residents actually do a sit up, they usually turn to their side and push up as in photo 12. Some days they may

unstable in this action and at any step in the action, you "catch" them, hold them, support them, so that they do not fall back, that is partial weight bearing assistance, therefore extensive assistance for your usually limited assistance resident. You must remember to code that transfer as extensive. Maybe Monday and Tuesday they do not need help, but by Wednesday they need your help or they can't get up.

Please take Credit for the work you do.

Slide 12

Some residents may get into bed, but need or ask you to help them move, once they are in the bed. That is extensive assistance for bed mobility, even though that is all you did photo 13.

In photo 14, staff is helping to move the resident's upper body to sitting position.

In photo 15 and 16 staff are assisting to move the resident up in bed while the resident pushes with their feet

You could not lift this resident up in bed without them pushing with their feet and they could not move up in the bed without you supporting their shoulders or their side. You are providing extensive assistance for bed mobility.

Please take Credit for the work you do.

Slide 13

Some residents can get themselves into bed but they may need you to turn them. That may be all you do but if you must turn them, or help them to turn, even though they may partially move themself, that is

partial weight bearing assistance which is extensive assistance for bed mobility.

While giving this presentation, I have had a Certified Nursing Assistant mention that this was all that she did for one resident every evening. The resident could not turn in bed without assistance. Since this is one brief moment of partial weight bearing assistance, the Certified Nursing Assistant was not coding extensive assistance.

Please take Credit for the work you do.

Slide 14

How to get pillows into position.

I photo 19, every resident should at least have pillows under their heels to relieve pressure and prevent or to heal ulcers on the heels. How does that pillow get there? Your resident maybe able to lift his legs, but can they lift them high enough to get the pillow underneath. You may ask them to lift their legs to place the pillow and automatically you lift the legs higher to actually place pillow, thus you are giving partial weight bearing assistance without even thinking about it, extensive assistance for bed mobility. Many of your residents do not have the abdominal muscle strength to do a leg lift.

Photo 20 and 21, if the plan of care indicates a place a pillow between the residents legs will lying on their backs, do you have to help move the resident's legs to position the pillow?

Looking at Photo 22, 23, and 24, the resident is on their side. How do you get the pillow between the resident's legs to prevent knee on knee pressure? Can your resident do a leg lift while on their side for you to place a pillow between their legs? They may be able to move their leg but not wide enough for you to place pillow. Take credit for the extensive assistance you provided. That is partial weight bearing assistance.

In photo 23, there is also a positioning pillow at the resident's back. How is that placed there?

Please take credit for the work you do.

Slide 15

For review, first the stick figure for Independent. The resident needed no help or oversight. The resident stick figure is waving at the staff or other residents. The care giver is not with the resident.

Slide 16

Other MDS assessors developed these visualization for ADL assistance provide. Think about what image works for you.

For Independent the closed door indicates the care giver doesn't see the residents

The verbal for independent highlights No Talk No Touch is No assistance, no instruction, no cueing, the resident does the activity ALONE, no monitoring, no hands on assistance. With eyes staff may watch the resident from the door.

For Independent the picture of a closed door indicates the care giver doesn't see the residents.

The bottom stick figure resident is relaxed and independent and staff is not involved.

Slide 17

Review Level 1 Supervision, the residents need cues, verbal encouragement. The staff stick figure with the conversation bubble is giving directions to resident

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Slide 18

Here are additional Guides for Supervision. The verbal description Staff Talk, the Staff do not touch the resident, give verbal instructions or cueing but does not provide physical, hands on assistance. Oversight and cueing, staff uses mouth and voice No hands.

Also provided here symbol s of lips indicating talking, and the eye indicating watching the resident, and a stick figure using a bullhorn to talk, provide verbal cues, encouragement with voice, observe with eyes, watch resident from the door.

Slide 19

Level 2 Limited Assistance, the resident was highly involved in the activity, but required non-weight bearing assistance- the stick figure staff member is just guiding resident.

Slide 20

Level 2 Limited assistance: The verbal description indicates that Staff Talk and Touch. Staff talks to give instructions or cues and touches resident to assist. This can be as simple as putting hands on resident's back or holding his or her elbow while walking. Staff Hands are used for more than set up but does not lift any part of the resident. The resident is highly involved and the staff provide non weight bearing assistance.

The symbol of an open hand indicates only guiding the residents . If you cup your hand you may be giving weight bearing assistance. This is used in some electronic medical records. An open hand guides the resident , provides non weight bearing ASSISTANCE – open hand on

their back guiding them in the direction as to go to the dining room or guiding had to use walker.

The Staff "cup" their hand, BEND AND PARTIALLY CLOSE THEIR HAND to lift, to provide weight bearing assistance.

Last 2 stick figures touching hands. The resident is highly involved and the staff did some hands on assistance but it non weight bearing guidance.

Slide 21

Level 3 Extensive Assistance, the resident performed part of the activity but required weight bearing assistance, lifting a part of the resident's body. To get up, the stick figure staff is lifting part of the resident's body.

Slide 22

For Level 3 Extensive Assistance the verbal description Talk, Touch and Lift. Staff uses muscle power lift move or shift. This includes lifting legs into bed, "scooting" buttocks into position in bed, lifting the arm to assist in self feed. The resident performed part of the activity, but weight bearing assist, lifting part of the body, was required.

Think of the symbol of bar bells for lifting weight or the stick figure carrying boxes. The resident did part of the activity but staff lifting of some part of the body is required.

Slide 23

What I am hoping that each member of the staff will be thinking while providing care: that I am Cueing the resident which equals Supervision or Guiding the resident which equals Limited Assistance or providing Partial Weight Bearing Assistance to the resident which equals Extensive Assistance.
***AND PLEASE remember to* Take Credit for the Care you provide when you chart.**

Why is this such a challenge?
Because each staff member needs to remember a quick brief moment when they provided additional partial weight bearing assistance to someone who usually doesn't need that help and chart it.

The charting challenge is that on the day shift staff usually get the resident up, assist with two meals and with toileting two times, and chart while running out the door. Staff must remember the additional help provided throughout the day and do not copy the usual assistance per care plan or previous charting.
Evenings may have the best time to capture accurately the care they provided, if they have quiet time at the end of the shift. But staff must remember that for that evening they lifted the residents legs, which happened so quickly and easily and can be forgotten, if it is not usual. Actually, while giving this presentation to evening staff, I learned that some staff are not aware that if they lift legs on to bed every night for a resident and that is all they do for many of their residents, they must capture that action as extensive assistance. Some staff on the evening shift have said they lift every resident's legs on to the bed at night. It happens every night because the resident is tired at the end of the day, but they do not need help during the day.

Night shift charting also occurs at the end of the shift at their busiest time. Their busiest time, morning care starts by 6 and the staff are running out the door at 7am, depending on the time of the nursing

homes shifts. We ask the night shift to please be sure to capture the care they provide that shift on the few residents that are different, need partial weight bearing assistance. Nights also has the best chance of capturing bed mobility issues. Residents may sleep through most nights, but on the night they do wake up, they may need assistance in bed mobility. They may get in bed but need assistance to move up to the head of the bed.

The MDS Coordinator sends up list of which residents MDS are due. Please check it, then you can think about those residents and remember to capture accurately the care provided.

Discuss with your co-workers, especially regarding residents who are usually limited assistance, the brief moments that are worth capturing.

The Last slide is our IPRO Nursing home team information and IPRO Nursing Home Website. Please contact us with any questions. Thank You