Restorative Nursing

Documentation

Select Rehabilitation

Objectives

- Provide guidelines for completing restorative documentation
- Assist facilities with supportive documentation
- Review MDS terminology for documentation on daily flow sheet

Select Rehabilitation

Purpose

- Provide a record of treatment
- Establish standards of care
- Act as a daily communication tool
- Basis for evaluating care

Select Rehabilitation

Intake Data

- Program/area(s) treated
- Procedures to be performed
- Duration/repetitions
- Frequency and duration
- Resident-specific strategies
- Goals for each program

Documentation

- Daily Documentation
  - Remember – if it is not documented – It is not done
  - Specific restorative nursing interventions
  - Daily flow sheet
- Weekly Notes
  - Describe ability to perform activities
  - Compare to goals
  - Determine if progress is made

Weekly Summary

- Number of times resident was seen
- Any gains made
- Any unusual occurrences
- Response to treatment
- Strategies addressed in treatment
  - For example, extremities ranged, distance walked, ADL status, percent eaten

Documentation Guidelines

- Daily note required
- Time spent per program must be documented
- Neat and legible
- Compare progress
- Reason for missed or refused session
  - Try to make up minutes
- Document IDT communication

Program Specific Documentation

- Ambulation
  - Length/distance walked
  - Assistance needed
  - Weight bearing precautions
  - Assistive devises used

Program Specific Documentation

- Range of Motion
  - Joint(s) ranged
  - Type of range (PROM, AROM, AAROM)
  - Number of repetitions
  - Amount of movement
  - Application of splint
  - Positioning

Program Specific Documentation

- Restorative Dining
  - Amount eaten
  - Assistance needed
  - Assistive devices used
  - Precautions for safety in swallowing
    - Thickened liquids
    - Positioning
    - Compensatory techniques

Program Specific Documentation

- Activities of Daily Living
  - Progress toward stated goals
  - Assistance needed
  - Assistive devices
  - Compensatory strategies used

Program Specific Documentation

- Continence
  - Goal
  - Assistance needed
  - Adaptive equipment used
  - Voiding/bladder training schedule
  - Number/frequency of incontinent episodes
  - Toileting program
  - Medications impacting continence

Program Specific Documentation

- Toileting Programs
  - Bladder Retraining
  - Prompted Voiding
  - Habit Training/Scheduled Voiding
  - Check and Change

Sample Problem List

- Communication
  - Difficulty expressing wants and needs
  - Difficulty following simple instructions
  - Difficulty understanding Y/N questions
  - Slurred speech
  - Difficulty naming or using common ADL objects
  - Difficulty following conversation

Sample Problem List

- Swallowing
  - Doesn't swallow all food
  - Coughs during meals
  - Recent weight loss
  - Altered diet
  - Compensatory swallow strategies
  - Difficulty accepting oral intake
  - Difficulty or prolonged chewing
  - Pocketing

Sample Problem List

- Ambulation
  - Can ambulate only short distances
  - Difficulty with transfers
  - Poor balance
  - Limited UE/LE function
  - Leans when ambulating
  - Impaired ambulation due to injury
  - Learning to use assistive device for ambulation

Sample Problem List

- Range of Motion
  - Impaired extremity use due to CVA
  - Developing hand contractures
  - Foot drop
  - Edema in arms or legs
  - Needs to be taught self-repositioning

Sample Problem List

- Self-feeding
  - Tires easily at mealtime; eats slowly
  - Needs encouragement or cues
  - Recent removal of feeding tube
  - Recent weight loss
  - Needs socialization at mealtime
  - Reminders to eat
  - Does not finish meals
  - Decreased attention to eating task
  - Difficulty recognizing food and/or utensils
  - Learning to use adaptive equipment

Sample Problem List

- Activities of Daily Living
  - Tires easily during morning routine
  - Task segmentation
  - Needs encouragement and/or cues
  - Poor balance
  - Limited use of upper extremities
  - Easily distracted
  - Learning compensatory strategies for deficits in self-care
  - Need to use adaptive equipment for ADL

Sample Problem List

- Continence versus incontinence
  - Urge to urinate but cannot make it to the restroom
  - Frequent urination
  - Leaks while laughing, coughing, sneezing
  - Frequent episodes of urinary incontinence
  - Slow to make it to the restroom

Discharge

- Performing activity at independent level
- Performing activity under nursing supervision
- Further improvement not anticipated
- Regression has occurred
  - Nursing and/or Therapy should be consulted

Discharge Summary

- Start of care
- Type of services received
- Goal(s)
- Performance at the start of care and at discharge
- Length of treatment
- Reason for discharge
- Follow up to be provided

Documentation Tips

- Remember if it is not documented, it is not done
- Don't save it until the end of the day
- Document during/soon after session when the information is fresh in your mind
- Do not complete all weekly summaries on one day
- If daily notes are complete, weekend staff can assist with weekly notes

Daily Flow Sheet

- Accurately record and document function
- ID techniques and strategies used by nursing
- Augments other documentation and communication tools
- Completed every shift

Daily Flow Sheet

- Bladder and bowel function
  - Pattern of continence during shift
- Skin care
  - Specific/generic skin treatments received during shift
- Shower/shampoo given
- Mood/behavior patterns
  - Any indicators of depression, anxiety or sad mood expressed during shift

Daily Flow Sheet

- Percentage of meals eaten
- Bedrail/side rail position
  - Indicate reason for use
- Range of motion
  - Indicate active or passive
- Splint or brace application
  - Include specific schedule or instructions

Daily Flow Sheet

Training and skill practice

- Bed mobility
- Transfer
- Walking
- Dressing or grooming
- Eating or swallowing
- Amputation/ prosthesis care
- Communication
- Diabetic management
- Medication management
- Ostomy care
- Cardiac rehabilitation

Daily Flow Sheet

Indicate self-performance and support

- Bed mobility
- Transfer
- Walk in room
- Walk in corridor
- Locomotion on unit
- Locomotion off unit
- Dressing
- Eating
- Toilet use
- Personal hygiene
- Bathing

Coding Instructions

- Consider each episode of the activity during the look-back period
- Identify what the resident actually does for himself or herself
- Note when and what type of assistance is received
- Code based on level of assistance when using adaptive equipment

Coding Instructions

- Self-performance may vary from day to day, shift to shift, or within shifts
- Capture the total picture of the resident's self-performance
- Self-performance coding options are intended to reflect real world situations where slight variations in self-performance are common
- It is necessary to know whether an activity occurred three or more times within the look-back period
- It is recommended that self-performance is scored before support

Coding Instructions
Rule of Three

- If an activity occurs 3 times at one given level, code that level
- If an activity occurs 3 times at multiple levels, code the most dependent
- If an activity occurs at various levels, but not 3 times at any one 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
  - If none of the above are met, code supervision.

ADL Self-Performance

- Code for performance over all shifts – not including set up
- Coding total dependence requires full staff performance every time

ADL Self-Performance

Code	MDS Code	Definition
Activity did not occur	8	Activity was not performed by resident or staff over 7 day period
Activity occurred only once or twice	7	Activity occurred only once or twice
Total dependence	4	Full staff performance every time during entire 7-day period
Extensive Assistance	3	Resident involved in activity; staff provide weight-bearing support
Limited Assistance	2	Resident highly involved in activity; staff provided guided maneuvering of limbs or other non-weight-bearing assistance
Supervision	1	Oversight, encouragement or cueing
Independent	0	No help or staff oversight

Bathing Self-Performance

Code	Definition
8	Activity did not occur: the resident was not bathed during the look-back period
4	Total dependence: the resident is unable to participate in the bathing activity
3	Physical help in part of bathing activity: the resident required assistance with some aspect of bathing
2	Physical help limited to transfer only: the resident performs the bathing activity, with help only for transfer
1	Supervision: the resident required oversight
0	Independent: the resident required no help

ADL Support

- Code for the most support provided over all shifts
- Code regardless of resident's self-performance classification

ADL Support

Code	MDS Code
ADL activity itself did not occur during entire period	8
Two + persons physical assist	3
One person physical assist	2
Setup help only	1
No setup or physical help from staff	0

Tips for Accurate Coding

- Ensure all staff use the same terminology
- Review documentation and paint a complete picture of resident ability
- Some residents sleep on furniture other than a bed – consider this when scoring bed mobility
- Do NOT record potential to perform ADL
- Do NOT record level of assistance the resident "should" receive according to the care plan
- Do NOT include assistance provided by family/visitors

Documentation to Support Rehab

- Must support services provided to the resident
- Reflect coordination between nursing and rehab
- Can impact a claim if reviewed
- Avoid subjective terms and conflicts rehab documentation

Documentation to Support Rehab

- Assistance required
- Safety awareness
- Adaptive equipment
- Cognitive issues
- Functional activity tolerance
- Compensatory strategies
- Communication
- Dysphagia
- Positioning
- Pain

Phrases to Avoid

- Custodial care
- Maintaining
- Intermittent care/service
- Out of facility on pass
- Poor or fair rehab potential
- Inability to follow directions
- Refused to participate

Phrases to Avoid

- Chronic condition
- Not motivated
- Extreme depression
- Little change
- Status quo
- Plateau
- Ambulating “ad lib”

Documentation to Support Skill

- Vital signs as per facility policy
- Documentation in Nurses Notes regarding Restorative services
- Daily Flow Sheet corresponding services delivered
- Documentation in care plan with services provided, goals and approaches

Documentation to Support Skill

- Documentation to specific functional status on a daily basis
- Resident response to interventions
- Progress being made toward goals
- Periodic evaluation of goals
  - Still room for improvement?
- Education and training completed to resident and IDT

Grooming

- Express desire but cannot participate?
- More effort to complete grooming?
- Assistive devices used?
- Gestures, verbal/visual cues needed?
- Obtain or use supplies to shave?
- Apply and/or remove cosmetics?
- Wash, comb, style or brush hair?
- Complete nail care? Skin care?
- Apply deodorant?

Dressing

- Express desire but cannot participate?
- More effort to complete dressing?
- Assistive devices used?
- Gestures, verbal/visual cues needed?
- Select appropriate clothing?
- Dress and undress sequentially?
- Fasten and adjust clothing and shoes?
- Don/doff adaptive equipment?

Oral Hygiene

- Performing in bed vs. sink?
- Noticeable odors present even though resident performs hygiene?
- Cues or gestures needed?
- Obtain or use supplies?
- Clean mouth and teeth?
- Remove, clean and reinsert dentures?

Bathing

- More staff to perform bath?
- Take longer yet still not cleaning self?
- Exhibit frustration?
- Assistive devices used?
- Gestures or cues needed?
- Are there safety concerns?
- Obtain and use supplies?
- Soap, rinse and dry all body parts?
- Maintain bathing position?
- Transfer to and from bathing position?

Toilet Hygiene

- Assistance due to balance or sequencing issues?
- As clean as usual?
- Good judgment used?
- Obtain and use supplies?
- Clean self?
- Maintain toileting position?
- Transfer to and from bedpan, toilet and/or commode?

Feeding and Eating

- Cues or gestures needed?
- Food getting into mouth?
- Coughing? Wey/gurgly voice?
- Can the resident sit up straight to eat?
- Is an altered diet consumed?
- Any pocketing?
- Set up food? Use utensils?
- Bring food or drink to mouth?
- Suck, masticate (chew) and swallow?

Functional Communication

- Can a listener understand the resident's words? Gestures?
- Any change from normal?
- Devices or equipment used?
- Make wants and needs known?
- Follow directions?
- Is the resident oriented?

Bed Mobility/Transfers

- Assistance needed to sit up in bed? Roll? Scoot? How many people?
- Assistance more or less than usual?
- Any loss of balance?
- Safety concerns?
- Assistive devices used?

Functional Mobility

- How many people? Assistance?
- Fall risk?
- Assistive devices needed?
- How far can the resident walk? Is this more or less than usual?
- Is assistance needed more or less than usual?
- Safety concerns?

Positioning and ROM

- Less comfortable than before?
- Leaning? Sliding? Falling?
- Safety concerns?

- Joints tighter than usual?
- ROM less than normal?
- Do splints fit?

Documentation Examples

- Resident ate in dining room at lunch
- Resident consumed 50% of food at lunch in dining room. Noted ↑ difficulty with feeding self, (+) tremors

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Documentation Examples

- Dressed and bathed resident at bedside, no c/o
- Resident requires limited assist w/ upper body dressing & bathing at bedside; requires extensive assist with lower body

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Documentation Examples

- Resident walked to BINGO this afternoon; holds onto railings
- Resident ambulated holding onto railing to BINGO; more unsteadiness noted

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Documentation Examples

- Resident falling forward out of w/c; c/o back pain
- Noted ↑ leaning forward in w/c, unable to maintain upright posture w/o assist. Rated back pain 6/10 in sitting.

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Documentation Examples

- Resident wearing ® hand splint today
- Wearing ® hand splint per schedule; skin integrity maintained with no areas of redness; no c/o discomfort

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Documentation Examples

- Resident answers “no” to every question
- Inconsistent responses with yes/no questions – answers “no” to every question. Difficulty making needs known.

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Documentation Examples

- Ambulates ad lib
- Walks in corridors with RW, able to go to/from activities and dining room with cues only

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Thank You!