

Activities of Daily Living F 311
Minnesota Department of Health
Nursing Home Surveyor Training Resource

Objectives

- To determine if the facility is providing maintenance and restorative programs that will not only maintain, but improve, the resident's abilities in activities of daily living (ADL).

Use

The purpose of this document is to provide a training resource for surveyors regarding residents who require assistance with any part of their ADL's to determine if a resident's ability to perform ADL's has deteriorated.

If the resident has deteriorated in their ability to perform ADL's, then determine if the decline was avoidable. If the deterioration was avoidable, then review F310 Quality of Care/Activities of Daily Living.

- Refer to F312 for dependent residents. These training guidelines under F311 would not be used if the resident is dependent on staff for assistance with ADL's and is not able to participate. F312 would be used for dependent residents.

Procedures

Observations:

Make observations of the resident while cares are being provided to determine if the facility has appropriately assessed the resident and implemented interventions timely to assist the resident in achieving their highest practicable outcome.

- Prior to any observations being made of a resident receiving assistance with personal cares, make certain to get permission from the resident for you to observe (if the resident is able to give permission).
- Observe the resident while staff provide assistance with personal cares during AM and/or PM observations to insure staff are providing services as outlined in the resident's plan of care. Observe and document the amount of assistance staff provided. Did staff encourage the resident to participate as able? Make note if any adaptive clothing or equipment is used in completing their ADL's.
- Document any concerns/problems while staff are providing care such as: privacy not being provided, infection control technique not followed, dignity concerns.

Record Review:

For evaluating a resident's ADL's and determining whether a resident's abilities have declined, improved, or stayed the same, review and compare the most recent MDS to previous MDS's. If there is a decline, then investigate possible causes that may have lead to the deterioration. Review the care plan. Does the care plan address the resident's needs/concerns? Was the care plan consistently implemented? Did staff revise the care plan if necessary?

- Compare the most recent MDS section G 1 g - j, and G 2, to previous MDS's. Make sure to also compare what your observations were to how the facility has assessed the resident. If your observations and the MDS do not match, then interview staff for possible causes for the discrepancy. Also review the ADL RAP to determine if the assessment is comprehensive and accurately reflects the resident's needs.
- Review the resident's care plan. Does it accurately reflect the appropriate treatment and services the resident requires? Any revisions, and if so were they timely? Did staff implement interventions according to the plan of care?
- Review any specialized rehabilitation (PT/OT) assessments and progress notes related to ADL's. Did PT/OT develop any functional maintenance programs (FMP's) for staff to follow to improve the resident's ability? Are they consistently being followed?

Interviews:

- Interview the resident regarding their ability to participate in performing their ADL's. Determine if the resident is provided assistance consistently among all shifts. If the resident indicates there is a concern/problem related to not receiving services, corroborate through observations, interview and record review.
- If the resident is not interviewable, ask the family if they are familiar with the resident's care and personal preferences related to dressing/grooming. Are staff providing care according to the resident's wishes? Is the resident encouraged to participate as able?
- If you observe, or it is documented that the resident refuses assistance with personal cares, interview the staff to determine if the facility discussed this with the resident and/or family regarding the possible ramifications of refusing services? Have they sought out alternatives to help the resident deal with the refusal?

Bathing – Dressing – Grooming

Objective:

- To insure that residents receive the appropriate services in order to maintain or improve their ability to bath, dress, and groom themselves.

Observations:

- Observe the resident during bathing, dressing and grooming. Is the resident clean and free of odors? Are staff providing residents with perineal care following incontinent episodes? Is the resident's clothing clean and in good condition? Is the resident appropriately dressed? Does the resident have clean nails and have they been trimmed? Has the resident been assisted with shaving of facial hair (both males and females)? Did staff provide the resident with any personal preferences regarding their care as directed by the resident and/or family? (eg. make up, perfume, hygiene items, jewelry, hair styles).

Record Review:

- Review the most recent nursing progress notes related to ADL's to determine if your observations match what the staff are documenting. If any discrepancies interview the charge nurse to determine possible reasons.
- Review any documentation completed by the nursing assistants to determine care is being provided according to the plan of care.
- If the facility utilizes some type of a modified care plan for the nursing assistants to use (usually carry with them or on their assignment list) you can ask to review the document if there are questions/concerns regarding services provided.

Interviews:

- Interview the nursing assistant (or staff person providing assistance with personal cares) regarding the resident's ability to participate in ADL's. You can also interview the staff to determine how the staff are informed of the types of services and/or amount of assistance the resident requires and how any changes in the plan of care is communicated to them.
- If you noted any discrepancies between the assessments, observations, and care planning interventions, interview staff as part of your investigation to determine if the facility is providing care to assist the resident to maintain or improve in their abilities to perform ADL's.

Oral Care

Objective:

- To insure that the resident who has been assessed as needing assistance with oral care receives the appropriate treatment/services.

Observations:

- If the resident has difficulty grasping, is adaptive equipment (large handled toothbrush/electric toothbrush) available if it would maintain independence?
- If the resident has dentures or partials, is the resident able to participate in caring for the dentures/partial? Are they provided with assistance in order to maintain as much independence as possible? Note the condition of the dentures/partial and document any concerns.
- If the resident has dentures, is he/she provided with a method to swab or rinse his mouth and given appropriate assistance with this?
- Note any concerns with pain related to oral care and observe the resident's oral cavity if concerns.

Interviews:

- On day 2 or later, interview nursing assistants (NA's) who work routinely with the resident and ask about the how the resident does with oral care and how they usually provide assistance.
- Follow up later in the survey with interview to determine what does their information say about this resident's participation.
- If there is a problem with NA's following through on the care plan, how do they monitor NA care delivery to assure it is consistent with the resident's assessed needs and plans?

Record Review:

- Check for dental exams and recommendations.
- Does the staff examine the resident's mouth, and do they follow up on recommendations by the dentist regarding oral care?
- Are there any OT assessments for adaptive equipment/toothbrushes as necessary?
- Does the facility document oral care, if so, check that documentation?

Ambulation

Objective:

- To insure that the resident who has been assessed as needing assistance with ambulation receives the appropriate treatment/services to maintain or improve their ability to ambulate.

Observations:

- At the time of the initial tour, when the surveyor enters the resident's room, make note of all mobility equipment present.
- When the resident is ambulating, note any difficulty the resident may have in locomotion in specific terms related to shuffling gait, one sided problems, actual use of the assistive devices and it's fit for the resident, where used, if assisted, number of individuals assisting.
- Observe if the resident is ambulated, by whom and level of participation by the resident. Observe the resident's ability to stand and participate in a standing transfer, weight bearing?
- Observe and document how the resident got to his/her meals and activities. Were they assisted to ambulate or did staff transport them in a wheelchair.

Interviews:

- During tour, interview the accompanying staff person if this resident has any problems with ADL's. Ask if they are ambulatory or need assistance.
- During tour, when alone with resident, if present, ask if they use the mobility devices and if staff assist them to use them.
- On day 2 or later, interview Physical Therapy (if involved in resident's care) about the content of their assessment if one was done. If a difference in what you saw is evident, can the Physical Therapist shed any light on the reason for the difference? If they had provided PT services, what was the basis for the discontinuation, recommendation for following up and by whom, policy for re-referral? What do they see as the need for this resident at their current performance level?
- On day 2 or later, interview aides who work routinely with the resident and ask about the how the resident does with ambulation.
- At the time of tour, ask if there is a restorative nursing program. If the resident is assisted with ambulation by the restorative aides, interview them regarding the resident's ambulation program.

Record Review:

- Analyze the information in the last Physical Therapy assessment. Does it describe the resident as you observed them? If not sure interview staff to determine when the change occurred and their thoughts about why it occurred.
- Has there been a decline in range of motion in any body part that may have contributed to the ambulation problem if one occurred?
- Has there been significant medication, psychotropic or cardiovascular, or mentation changes since the ambulation change has occurred?
- Has the resident experienced falls? With Injury?
- Has there been any use of restraint?
- Has there been consistent documentation of the provision of the service since it was order, as it was ordered? If the treatment records indicate omissions in documenting assistance according to the plan of care, interview staff for possible reasons.
- If refusals are documented, is there evidence of documentation to the resident and family as to the consequences of on going refusal?
- Is there any evidence that the care plan has been modified when initial problems arose?

Toileting

See F315. Concerns related to urinary incontinence would most often be cited under F315 and appropriate assessment tags.

Eating

Objective:

- To insure that the resident who has been assessed needing assistance with eating receives the appropriate treatment/services to maintain their ability to feed themselves.

Observations:

- During meals and snacks observe and document the resident's abilities and needs. Are the resident's needs being met with the assistance staff is giving and/or the adaptive equipment provided? If the resident has difficulty grasping, is adaptive equipment (such as adaptive flatware) available if it would maintain independence? If the resident has difficulty with cups are nosey cups or special anti-tip cups provided? Are rimmed plates/anti-skid dishes provided as needed?
- Observe if resident is encouraged to participate if she/he has that ability or do staff just feed the resident because that is faster?
- If the resident can physically feed himself but has cognitive impairments, is appropriate verbal cueing/supervision provided in a timely and consistent manner?

Interviews:

- On day 2 or later, interview aides who work routinely with the resident and ask about the how the resident does with eating and how they usually provide assistance.
- Validate with staff (nursing assistants and/or nurses) to determine if your observations are the resident's normal behaviors.
- If there is a problem with NA's following through on the care plan, how do they monitor meals to assure NA assistance with meals is consistent with the resident's assessed needs and plans?

Record Review:

- Look for speech therapy evaluations and recommendations if appropriate.
- Are there any OT assessments for adaptive equipment as necessary.
- Does the facility document intake, if so, check that documentation.
- How are the resident's feeding assistance plans communicated to the NA's and dietary staff?

Use of Speech, Language, or other Functional Communication Systems

Objective:

- To insure that the resident who has been assessed as having a need for assistance in communication abilities, receives the appropriate services and assistance.

Observations:

- During morning and evening cares observe how the resident is able to express concerns and communicate effectively.
- Observe how staff communicates with the resident.
- Does the resident have difficulties in transmitting messages, comprehending messages and/or using a variety of communication skills such as questions and commands?
- How does the resident effectively communicate requests? Needs? Opinions? How do they participate in activities or social conversation?
- For the resident who cannot speak, were alternative approaches used? Observe and document what system was used or provided and how effective it was working.
- Observe if resident is encouraged to participate in conversation or if staff do not take the time to use a communication board or allow the resident to write down his/her concerns.

Interviews:

- During tour, interview the accompanying staff person if this resident has problems with communication. Find out what method the resident is using to communicate.
- If family interview, ask the family how they communicate with the resident and if they know what the facility does to maintain this skill and whether the facility has asked them for assistance with ideas to encourage use. If not, do they have any ideas they share with you?
- If it is documented that the resident refuses this service (for example, a communication board) interview case manager, family, speech therapy and investigate if the facility has sought out alternatives to help the resident deal with the refusal?
- On day 2 or later, interview aides who work routinely with the resident and ask about how the resident does with the communication device and how they usually provide assistance.
- Ask Speech Therapy or charge nurse: What did the facility do to improve speech production? What care does the resident receive to improve communication abilities?

- If there is a problem with NA's following through on the care plan, how do they monitor NA care delivery to assure it is consistent with the resident's assessed needs and plans?

Record Review:

- What risk factors did the facility address or identify for decline in communication abilities (for example, Alzheimer's, CVA, hearing loss)
- Look for speech assessments for therapy, suggested approach, equipment and recommendations to maintain or improve communication abilities.

Potential Tags for Additional investigation:

During investigation, the surveyor may have identified concerns related to other outcome, process and/or structured requirements. The surveyor should investigate these requirements before determining whether noncompliance may be present. The following are examples of related outcome, process and/or structure requirements that should be considered.

- **F155** Refusal of care. The facility did not attempt to determine the reason for the ongoing refusal of not participating in areas related to ADL's in order to assist the resident in maintaining their skill by providing adjunctive therapy such as pain medication, psychological therapy, adaptive equipment, or seeking the family's advise, or assistance in managing the problem.
- **F164** Privacy. Staff failed to provide the resident with privacy during cares.
- **F241** Dignity. Residents were not provided an opportunity to dress or groom themselves in a manner that is consistent with their preferences or beliefs.
- **F272** Comprehensive Assessments. Staff failed to comprehensively assessed the identified needs/concerns of the resident.
- **F278** Accuracy of Assessments. Staff failed to ensure assessments are accurate.
- **F279** Resident Care Plan. Staff failed to develop an individualized plan of care including interventions to ensure the resident receives the care as identified on the comprehensive assessment.
- **F280** Failure to revise the care plans. Staff failed to revise the care plan when necessary.
- **F282** Failure to follow the care plan. Staff were observed not to follow the requirements for care identified in the care plan.
- **F 310** Avoidable decline in ADL's. The facility failed to provide the necessary treatment/services to ensure the residents ability to perform their ADL's does not diminish unless determined unavoidable.
- **F 318.** Range of Motion. Determine if the reason for diminished ambulation is related to changes in range of motion.
- **F325** Maintain nutritional status. Staff failed to provide the necessary assistance with eating to maintain acceptable parameters of nutrition.
- **F353** Insufficient staffing. Determine if the facility had qualified staff in sufficient numbers to provide the necessary treatment/services to ensure residents maintain or improve their abilities to perform ADL's.
- **F411/F412** Dental Services. Determine if the facility is assuring the resident receives appropriate dental services and then follows-up on the recommendations from these visits.