

5. RESIDENT ASSESSMENT PROTOCOL: ACTIVITIES OF DAILY LIVING - FUNCTIONAL REHABILITATION POTENTIAL

I. PROBLEM

Personal mastery of ADL and mobility are as crucial to human existence in the nursing facility as they are in the community. The nursing facility is unique only in that most residents require help with self-care functions. ADL dependence can lead to intense personal distress -- invalidism, isolation, diminished self-worth, and a loss of control over one's destiny. As inactivity increases, complications such as pressure ulcers, falls, contractures, and muscle wasting can be expected.

The ADL RAP assists staff in setting positive and realistic goals, weighing the advantages of independence against risks to safety and self-identity. In promoting independence staff must be willing to accept a reasonable degree of risk and active resident participation in setting treatment objectives.

Rehabilitative goals of several types can be considered:

- To restore function to maximum self-sufficiency in the area indicated;
- To replace hands-on assistance with a program of task segmentation and verbal cueing;
- To restore abilities to a level that allows the resident to function with fewer supports;
- To shorten the time required for providing assistance;
- To expand the amount of space in which self-sufficiency can be practiced;
- To avoid or delay additional loss of independence; and
- To support the resident who is certain to decline in order to lessen the likelihood of complications (e.g., pressure ulcers and contractures).

II. TRIGGERS

The two MDS trigger categories (A and B) suggest the types of residents for who special care interventions may be most important. Such residents may have either the need and potential to improve (Rehabilitation) or the need for services to prevent decline (Maintenance).

ADL TRIGGERS A (Rehabilitation)

Rehabilitation/restorative plans suggested if one or more of following present:

- Bed Mobility - Not Independent
[G1aA = 1-4]^(a)
- Transfer - Not Independent
[G1bA = 1-4]
- Walk in Room - Not Independent
[G1cA = 1-4]

- Walk in Corridor - Not Independent
[G1dA = 1-4]
- Locomotion on Unit - Not Independent
[G1eA = 1-4]
- Locomotion off Unit - Not Independent
[G1fA = 1-4]
- Dressing - Not Independent
[G1gA = 1-4]
- Eating - Not Independent
[G1hA = 1-4]
- Toilet Use - Not Independent
[G1iA = 1-4]
- Personal Hygiene - Not Independent
[G1jA = 1-4]
- Bathing - Not Independent
[G2A = 1-4]
- Resident believes he/she is capable of increased independence in at least some ADLs
[G8a = checked]
- Staff believe resident is capable of increased independence in at least some ADLs
[G8b = checked]

ADL TRIGGERS B (Maintenance)

Maintenance/Complication Avoidance Plan Suggested If: [Note: When both triggers present (A & B), B takes precedence in the RAP Review]

- Severely Impaired Decision Making
[B4 = 3]^(b)

^(a) **Note:** Codes 2,3, and 4 also trigger on the Pressure Ulcer RAP.

^(b) **Note:** This code also triggers on the Cognitive Loss/Dementia RAP.

III. GUIDELINES

Base an approach to a resident's ADL difficulty on clinical knowledge of:

- The causes of dependence;
- The expected course of the problem(s); and
- Which services work or do not work.

The MDS goal is to assist the clinician in identifying residents for whom rehabilitative/restorative goals can be reasonably established. Many ADL-restricted residents can regain partial ability for self-care. Certain types of disease-generated losses will respond

to therapy. In addition, the removal of inappropriate restraints and the close monitoring of potentially toxic medications can often result in increased functioning.

Use the items in the ADL RAP KEY to consider the resident's risk of decline and chance of rehabilitation. Responses to these items permit a focused approach to specific ADL deficits (i.e., selecting and describing the specific ADL areas where decline has been observed or improvement is possible). The first thing that needs to be considered is the possible presence of ***confounding problems*** that may require resolution before rehabilitation goals can be reasonably attempted.

The second task is to clarify the resident's potential for improved functioning. The clinician might find the following sequence of questions useful in initiating an evaluation:

- Does the resident have the ability to learn? To what extent can the resident call on past memory to assist in current problem-solving situations?
- What is the resident's general functional status? How disabled is the resident, and does status vary?
- Is mobility severely impaired?
- Is trunk, leg, arm and/or hand use severely impaired?
- Are there distinct behavioral problems?
- Are there distinct mood problems?
- Is the resident motivated to work at a rehabilitative program?

Where rehabilitation goals are envisioned, use of the ***ADL Supplement*** will help care planners to focus on those areas that might be improved, allowing them to choose from among a number of basic tasks in designated areas. Part 1 of the Supplement can assist in the evaluation of all residents triggered into the RAP. Part 2 of the Supplement can be helpful for residents with rehabilitation potential (ADL Triggers A), to help plan a treatment program.

ADL SUPPLEMENT
(Attaining maximum possible independence)

PART 1: ADL Problem Evaluation INSTRUCTIONS: For those triggered - In areas physical help provided, indicate reason(s) for this help.	<i>DRESSING</i>	<i>BATHING</i>	<i>TOILETING</i>	<i>LOCOMOTION</i>	<i>TRANSFER</i>	<i>EATING</i>
Mental Errors: Sequencing problems, incomplete performance, anxiety limitations, etc. Physical Limitations: Weakness, limited range of motion, poor coordination, visual impairment, pain, etc. Facility Conditions: Policies, rules, physical layout, etc.						
PART 2: Possible ADL Goals						
If wheelchair, check: <input type="checkbox"/>						
INSTRUCTIONS: For those considered for rehabilitation or decline prevention treatment - Indicate specific type of ADL activity that might require: 1. Maintenance to prevent decline. 2. Treatment to achieve highest practical self sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in).	Locates/ selects/ obtains clothes	Goes to tub/ shower	Goes to toilet (include commode/ urinal at night)	Walks in room/ nearby <input type="checkbox"/>	Positions self in preparation	Opens/ pours/ unwraps/ cuts etc.
	Grasps/puts on upper/ lower body	Turns on water/ adjusts temperature	Removes/ opens clothes in preparation	Walks on unit <input type="checkbox"/>	Approaches chair/bed	Grasps utensils and cups
	Manages snaps, zippers, etc.	Lathers body (except back)	Transfers/ positions self	Walks throughout building (uses elevator) <input type="checkbox"/>	Prepares chair/bed (locks pad, moves covers)	Scoops/ spears food (uses fingers when necessary)
	Puts on in correct order	Rinses body	Eliminates into toilet	Walks outdoors <input type="checkbox"/>	Transfers (stands/sits/ lifts/turns)	Chews, drinks, swallows
	Grasps, removes each item	Dries with towel	Tears/uses paper to clean self	Walks on uneven surfaces <input type="checkbox"/>	Repositions/ arranges self	Repeats until food consumed
	Replaces clothes properly	Other	Flushes	Other <input type="checkbox"/>	Other	Uses napkins, cleans self
	Other		Adjusts clothes, washes hands			Other

5. ADL FUNCTIONAL/REHABILITATION POTENTIAL RAP KEY

(For MDS Version 2.0)

TRIGGER – REVISION

ADL TRIGGERS A (Rehabilitation)

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- Bathing – Not Independent
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- Resident Believes He/She is Capable of Increased Independence in at Least Some ADLs
[G8a = checked]
- Staff Believes Resident is Capable of Increased Independence in at Least Some ADLs
[G8b = checked]

ADL TRIGGERS B (Maintenance)

Maintenance/complication avoidance plan suggested if: [Note: When both triggers present (A & B), B takes precedence in the RAP Review]

- Severely impaired decision-making
[B4 = 3]^(b)

^(a) **Note:** Codes 2, 3 and 4 also trigger on the Pressure Ulcer RAP.

^(b) **Note:** This code also triggers on the Cognitive Loss/Dementia RAP.

GUIDELINES

Confounding problems that may require resolution:

- Delirium [B5]
- Persistent Mood Problem [E2]
- Decline in Mood [E3]
- Daily Behavioral Symptoms [E4]
- Decline in Behavior [E5]
- Unstable/Acute Health Problem [J5a,b]
- Use of Psychoactive Medications [O4a,b,c,d]
- Resident Status Deteriorated Since Last Assessment [Q2]

Clarifying issues to be considered:

- Ability to Make Decisions [B4]
- Prior Improvement in Cognition, Mood, Behavior, or ADLs [B6, E3, E5, G9]
- Communication [C]
- Vision [D]
- Test for Balance, Functional Limitation in Range of Motion [G3, G4]

Complete ADL Supplement Part 1 for all triggered residents (see RAI training manual).

For a resident with rehabilitation potential, complete ADL Supplement Part 2 (see RAI training manual).

- Staff/Resident Believe Resident Could Be More Independent [G8a,b]