MDS Alert

In The Spotlight: If You Take Your Restorative Program To New Levels, Your QIs And Bottom Line Will Follow

Find out how an integrated approach, real-time assessment and MDS know-how pays in spades for this facility.

Ever wonder what a state-of-the-art restorative nursing program might do for your facility's quality and fiscal profile?

You might take some lessons from **Mercy Franciscan** at **Schroder,** a nursing facility in Hamilton, OH, which is counting the ways since it implemented a leading-edge integrated restorative approach last year.

Check out these impressive gains:

1. The ability to do more restorative with fewer full-time CNAs. "By integrating restorative into residents' regular care routine, CNAs can provide restorative to more residents in a day and even add restorative treatments," says **Sharon Sacre, RN, BS,** coordinator of the restorative program. And the restorative services still count in coding Section P3. For example, "the CNAs can walk the residents to meals and count that as part of the ambulation time," she adds. "And [CNAs] do range of motion (ROM) during the bath and as part of grooming." CNAs may also attend group activities focused on ROM exercises with residents (in a one-to-four ratio, as required for coding Section P3).

2. Low quality indicators on falls and contractures. While the facility has always touted a low fall rate, the number of falls dropped further once staff integrated restorative techniques into the daily care routine.

   Note of caution: When residents regain their ability to walk, they may fall more in their eagerness to walk everywhere, Sacre has found.

   Schroder residents have very few contractures, thanks to its integrated restorative ROM program. "We put people who are starting to decline in their ROM on a maintenance program to ensure they don't get tightening of the joints," Sacre reports. Thus, most of the residents who do have contractures developed them after a stroke or they came to the facility with them, she adds.

3. Improved Medicaid case-mix. Restorative nursing improves the facility's Medicaid case-mix, reports DON **Mary Pierson, RN.** Schroder's Medicaid case-mix score recently increased from 1.6 to 1.9, which prompted the state to conduct an extensive review to "make sure we are doing everything we claim we are," reports Pierson. "We passed with flying colors, but you have to document all of your restorative services carefully," Pierson cautions.

4. Lower staffing turnover and increased CNA job satisfaction. "The CNAs really value the restorative program ... and are very protective of and caring toward the residents," says Sacre. "They realize how quickly a resident can decline and how the little signs of a resident 'not being him/herself' can signal an acute illness that can lead to a decline in activities of daily living (ADL)."

   Doing Restorative in Real-Time and With the MDS

   To identify and target residents' restorative needs, the interdisciplinary staff operates in "real-time" with its resident assessments and then performs the MDSs as they are due or when residents have a significant change in status.

   Sometimes CNAs give Sacre a "heads up" that a certain resident needs restorative care. "The CNAs might say: Mr. Smith

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isn't walking as well now or as much," she explains.

When doing the quarterly MDS assessments, Sacre and the MDS team look closely at the following sections to identify restorative needs:

5. Mobility and late-loss ADLs in Section G. Sacre looks at whether the person can walk, has suffered a decline in that regard - and whether he is wheelchair-dependent. Pierson flags any resident showing an ADL decline on the quarterly assessment.

6. Falls in Section J. Sacre considers whether the resident could benefit from enablers to improve mobility or prevent falls. Even though the facility is restraint-free, the staff uses geri-chairs in some cases to allow a resident with poor upper-body control to be upright for eating and activities.

7. Bowel and bladder assessment in Section H. The restorative team pays special attention to any resident who is continent throughout the day but not during the evening or at night. "That's a major focus for us right now," says Pierson.

8. Swallowing ability (K1b) and communication/hearing (Section C). "We have a lot of residents with dysphagia," reports Pierson, "so we do staff education and develop the plan of care to make sure the resident is getting the restorative and safety interventions required."

   Schroder is also offering more restorative communication programs to help residents with speech and swallowing problems. Programs include oral motor exercises and use of pictures to help people with impaired hearing. "One resident who had a stroke participates in a communication exercise where she practices writing in a notebook," Sacre reports.

9. Section T2 (walking when most self-sufficient). When a resident is on restorative, the MDS staff always completes Section T2, according to Pierson (for an in-depth focus on this often ignored yet critical MDS section, see the November 2004 MDS Alert).

Taking the Next Steps

The restorative program remains a work in progress, and the facility is working toward two new goals:

1. Shifting some of the restorative interventions to the night and evening shifts. That tack will help "spread the wealth" of restorative to CNAs eager to work in the program, explains Sacre. It also helps eliminate the one downside of integrating restorative on the day shift alone: staffing shortfalls when someone calls in sick, which "leaves a lot of restorative to do" over the eight-hour shift, Sacre comments. "The night shift comes in at 10 p.m. and can do some of the restorative care when residents are awake at night for toileting, etc., and in the morning if residents awaken early," she explains.

2. Targeting acute illness as a cause of falls. "We have identified some residents who fall due to acute illness," says Sacre. "The resident gets sick and the next thing you know, he is on the floor." Thus, the facility is providing inservice education to teach staff to be attuned to early signs that a resident may be developing the flu, pneumonia, UTI, etc.

And Schroder assigns the same caregivers to residents so they can detect subtle changes signaling an acute illness. "Residents with early onset of illness require immediate intervention and implementation of safety measures by frontline staff and the restorative coordinator," emphasizes Pierson.

MDS tip: Crosscheck Section J5 (stability of conditions) with ADL decline in Section G, falls (Section J), pressure ulcers (Section M) and other negative outcomes.

For more information on Schroder's integrated restorative nursing approach, read the article by Sharon Sacre, "The Total Restorative Concept," in the Aug. 8, 2004, Nursing Home magazine at www.nursinghomesmagazine.com/Past_Issues.htm?ID=3153.

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Editor's Note: Do you have a success story about your facility or a specific case study involving resident care that you'd like to share with your colleagues? Please email Editor Karen Lusky at EditorMON@aol.com or call 1-615-370-5042.

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