MDS Alert

QUALITY OF CARE: Shore Up ADL Care Safety With 4 Pivotal Strategies

Don't overlook these triggers for revisiting how much help a resident needs.

Envision this: A resident and the staff person helping him to transfer out of bed topple to the floor. The resident ends up in the hospital -- the caregiver on workers' comp.

Your facility can help prevent that type of scenario by using a fourprong approach for assisting residents with their activities of daily living (ADLs).

1. Develop a systematic admission ADL assessment. "All patients admitted to the nursing home should have some level of screening at admission to determine dependencies," advises **Michael Dionne, PT,** with Choice Physical Therapy Inc. in Gainesville, Ga.

"Some people use part of the MDS ... to identify a resident's ADL help needs, says **Kathleen Rockefeller, PT, ScD, MPH,** with the School of Physical Therapy & Rehabilitation Sciences at the University of South Florida. She hasn't, however, seen one assessment system used exclusively. "The team can come up with a system that works for them and the particular patients in the facility."

Whatever the assessment system used, nurses and rehab therapists should share their observations about the resident's mobility and functionalstatus, Rockefeller suggests. To do that effectively, they may have to get on the same page in using terminology that describes levels of assistance and weight bearing.

"The MDS language differs from the FIM -- for example, a maximum assist in therapy involves providing help with at least 75 percent of moving the patient's body weight," Rockefeller says.

2. Enlist therapy to teach nursing safe transfer techniques. Therapy can educate the staff workin with a patient on how to do transfers safely, notes **Pauline Franko, PT, MCSP,** owner of Encompass Education and Consulting in Tamarac, Fla. "If a patient is on the therapy caseload, the staff training time can be billed to Part A or Part B, if the patient is present when the therapist does the teaching." She also recommends "bringing all the staff together and teaching them how to transfer and reposition patients safely."

3. Identify triggers for revisiting the ADL care plan. This is important to do, emphasizes attorney **Christy Tosh Crider,** in Nashville, Tenn., who defends nursing homes in lawsuits alleging that a resident was injured due to inadequate staff assistance during transfers. (Continued on page 148.)

Crider often finds that the care plan in such cases does show the care team made a determination about how much help the resident required, including use of an assistive device, such as a Hoyer lift. The question then becomes whether the facility should have updated the care plan to reflect a change in condition, says Crider.

Example: If a caregiver has to lower a resident to the floor during a transfer, that should be a trigger for taking a look at how much assistance the resident needs, Crider says.

Tip: When you have to lower a person to the floor during a transfer, look at potential reasons, including a new medication or drug-drug interactions, advises **Sandra Fitzler, RN,**senior director of clinical services for the American Health Care Association. An ADL decline that comes on suddenly could signal a UTI or other acute medical condition, adds Franko.

Pain can also trigger a fall during a transfer. "A person may stand up on his own and then something hurts, so the person falls," says Rockefeller.

Don't miss the following signs that the team should review the resident's ADL help requirements:

• Significant weight gain. A weight increase of 50 pounds, for example, might affect the ability of one CNA to transfer the person, says Crider.

• A decline in ability to follow directions. If you are telling the person to "put your hand here, straighten your knees, etc.," and he is no longer cognitively able to follow the instructions -- "that's a problem," says Rockefeller.

• Use of furniture or walls as "mobility aids." "Keep an eye on the patient to see if he's always or often grabbing hold of something," advises Rockefeller.

Key point: The team should make an effort to keep each other informed about those kinds of observations and changes, stresses Rockefeller. And if a resident does show a decline in one or more ADLs, get restorative nursing or therapy on the case. Franko recommends trying restorative nursing first, "and if that doesn't work, get a referral from the physician for a therapy evaluation."

4. Implement the ADL care plan consistently. Staffing shortfalls can derail the best-laid ADL care plans. While transitional care and rehab units "tend to have more staff due to overall higher patient acuity," some facilities fail to recognize that "staffing needs may change as the level of patient acuity on a unit changes," cautions **Carol White,RN, MS, ANPC, GNPC, DNP,CLNC,** principal of NationalHI Inc.in Huntington, Ind.

Staff should also address a resident's refusal to use a mechanical lift. Say a resident declines to use a prescribed mechanical lift to get out of bed to use the commode. The caregiver should offer the person a bedpan, and let the person know she's going to get whoever is in charge to talk to him about using the lift, suggests Dionne.

Tip: Make sure the updated master care plan jibes with the working care plan, including ADL directives, suggested an attendee at a presentation at the recent American Association of Homes & Services for the Aging annual meeting, held this year in Chicago.