

Activities of Daily Living (ADL) Critical Element Pathway

Use this pathway for a resident who requires assistance with or is unable to perform ADLs (Hygiene – bathing, dressing, grooming, and oral care; Elimination – toileting; Dining – eating, including meals and snacks; and Communication including – speech, language, and other functional communication systems) to determine if facility practices are in place to identify, evaluate, and intervene, to maintain, improve, or prevent an avoidable decline in ADLs. Refer to the Positioning/Mobility/ROM pathway, for concerns related to mobility (transfer, ambulation, walking), positioning, contractures, or ROM.

Review the Following in Advance to Guide Observations and Interviews:

- Review the most current comprehensive assessment and most recent quarterly (if the comprehensive isn't the most recent assessment) MDS/CAAs for Sections C - Cognitive Patterns, E – Behavior - E0500 (Impact on Resident) and E0800 (Rejection of Care), F – Preferences for Customary Routine and Activities, G – Functional Status, J – Health Conditions - Pain, O – Special Treatment/Proc/Prog – SLP (O0400A), OT (O0400B), PT (O0400C) and Restorative Nursing Program (O0500).
- Physician's orders (e.g., therapy, restorative, and ADL needs).
- Pertinent diagnoses.
- Care plan (e.g., ADL assistance, specific care interventions staff will provide, premedication prior to ADLs, environmental approaches and devices used to maximize independence, therapy interventions, or restorative approach).

Observations Across Shifts:

- Ensure ADLs are provided in accordance with accepted standards of practice, the care plan, and the resident's choices and preferences.
- For a resident **receiving assistance with ADLs** observe the following: If concerns are identified, describe.
 - Observe for the provision of ADL's (e.g., teeth clean, hair clean and brushed, nails clean and trimmed, bathing, based upon preferences whether shaving is provided or female facial hair removed, appropriate hygiene including toileting and continence care, and dressed per resident's preference)?
 - Did staff explain all procedures to the resident prior to providing the care? Does the resident require special communication devices? If so, are they being used?
 - Does staff encourage the resident to perform ADLs as much as the resident is able?
- For a resident **who is unable to carry out ADLs** observe for the following: If concerns are identified, describe.
 - Observe for the provision of ADL's (e.g., teeth clean, hair clean and brushed, nails clean and trimmed, bathing, based upon preferences whether shaving is provided or female facial hair removed, appropriate hygiene including toileting and continence care, and dressed per resident's preference)?
 - Did staff explain all procedures to the resident prior to providing the care?
 - If the resident refuses the care, how does staff respond?
 - Is assistance with ADL's provided within a timely manner and per resident preference?
- Does staff provide assistive devices to maximize independence, including but not limited to the following?

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- Did staff provide the necessary level of assistance that meets the resident's current needs?
 - Does staff allow sufficient time for the resident to complete tasks independently (e.g., putting on their own shirt)?
 - If equipment or devices are used during ADL care, was the equipment clean and in good repair, and was it used correctly?
 - How are care-planned interventions implemented?
 - If the resident wears prostheses, are they in place or removed in accordance with the time of day, activities, and resident preference?
- Hygiene – assistive grooming devices such as built up grooming aids.
 - Elimination – elevated toilet seat, grab bar, commode.
 - Dining – assistive devices such as built-up utensils, plate guard, nose cup, three-compartment dish, scoop plate/bowl, weighted or swivel utensils, cup with lid and handles, non-slip materials.
 - Communication – communication board, electronic augmentative communication device.

Resident, Resident Representative, or Family Interview:

- How did the facility involve you in developing the care plan? Did you talk about your preferences and choices regarding care (e.g., when care should be provided such as bathing)?
- If you are aware that the resident has specific ADL concerns, ask: What did staff discuss with you regarding how they would maintain or improve your ability to [ask about specific ADL]?
- Are you able to actively participate in ADLs? If so, what is your involvement? How and who instructed you in the interventions? Does staff provide encouragement and revision to the interventions as necessary?
- What type of interventions are done? Have assistive devices been provided (e.g., reachers, mobility devices, or communication devices)? If so, were you instructed on how to use them? If not, why not?
- How much help do you need from staff with [ask about specific ADL]? If help is needed or the resident is unable to perform ADLs, ask the following:
 - Does staff tell you what they are going to do before they do it?
 - How does staff encourage you to do as much as you can?
 - Does staff allow ample time for you to do as much as you can on your own?

PT, OT, SLP, or Restorative Manager Interview:

- When did therapy/restorative start working with the resident?
 - How did you identify that the interventions were suitable for this resident?
 - What are the current goals?
 - How do you involve the resident or resident representative in decisions regarding treatments?
 - How often do you meet with the resident?
 - How often does therapy screen residents? Where are screening results documented?
 - How much assistance does the resident need with [ADLs]?
 - How do you promote the resident's participation in [ADLs]?
- If the resident is not on a therapy or restorative program: How did you decide that the resident would not benefit from a program?
- Does the resident have pain? If so, who do you report it to and how is it being treated?
 - Does the resident refuse? What do you do if the resident refuses?
 - Is the resident's [ADL] ability getting worse? If so, did you report it (to whom and when) and did the treatment plan change?
 - Has the resident had a decline in his/her ability to [ask about specific ADL]? When did the resident's decline in ADLs occur?

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- Does staff provide timely assistance (e.g., toileting needs)?
- How does staff consider your preferences when providing care (e.g., shower vs bath, time of the day for care, clothing choices)?
- Do you have sufficient time to perform ADLs without being rushed? Does staff complete the ADLs for you rather than letting you perform them yourself?
- Do you have discomfort or pain when performing or receiving assistance with any of your ADLs? If so, when does it occur, have you reported it to staff, and how is it being addressed?
- If you know the resident independently does exercises: Do you use certain devices to help you with [ADLs]? Do you have them when you need them?
- Are you getting PT, OT, or Speech Therapy for any of your ADLs? If so, how often do you receive assistance? If the resident isn't getting therapy, ask: Are aides doing exercises or ADL training (e.g., bed mobility, eating or communication) with you? If so, what exercises are they doing and how often?
- If you know the resident has refused specific interventions, ask: Why do you refuse? Did staff attempt alternative approaches? Did staff provide you with education on the risks and benefits of refusing?
- Do you feel you've had a decline in [ADLs]? Has your decline caused you to be less involved in activities you enjoy or caused a change in your mood or ability to function?
- Has your [ADL] ability improved, been the same, or gotten worse? If the resident has declined, ask: Do you know why you are getting worse? Has your decline caused a change in your mood or ability to function?
- Are you included in establishing the type, amount, frequency, and duration of ADL care?
- What therapy or restorative interventions were in place before the [ADL] decline?
- What is therapy/restorative doing to address the resident's [ADL] decline?
- How did you train staff to perform the restorative [ADL] program? Is there documentation that nursing staff were trained (ask to see the documentation)?
- How do you monitor staff to ensure they are implementing care-planned interventions?
- How does staff communicate changes/declines to the rehab department?
- When a resident is discharged from therapy, how do you decide whether to start a restorative or maintenance program?

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Nursing Aide or Restorative Nurse Aide Interviews:

- Does the resident receive assistance with ADLs? How much assistance does the resident need?
- Can you describe the resident's ADL goals? How do you promote the resident's independence with ADLs to the extent possible? What are the resident's choices and preferences for ADLs (shower vs bath, time of day for care)?
- What interventions are done? What equipment or assistive devices have been provided? How was the resident instructed on how to use them? If not provided, why not?
- Does the resident have pain with [ADLs]? If so, who do you report it to and how is it treated?
- Does the resident refuse? What do you do if the resident refuses?
- Is the resident's [ADL] ability getting worse? If so, who and when did you report it to and did the treatment plan change?
- If the resident is receiving restorative services:
 - o When did restorative start working with the resident?
 - o What is the goal of restorative care – to maintain or improve current abilities?
 - o If there is a decline: What is being done to address the resident's [ADL] decline?
 - o How often do you meet with the resident?
 - o How were you trained on the resident's [ADL] restorative program?
- If a resident is unable to perform any ADLs, ask: What do you provide for ADLs, when and how do you determine what must be provided?

Nurse or DON interviews:

- How much assistance does the resident need with [ADLs], how was this determined, and does the resident participate in ADLs?
- Is assistance with ADLs provided in a timely manner, according to the resident's preferences and the care plan?
- Is the goal to maintain or improve the resident's current level of functioning?
- Are all procedures explained and the resident given time to respond to changes in care?
- Has the resident had a decline in ability to independently perform any of his/her ADLs?
- If the resident experiences a decline or improvement in ADL function, what actions are taken by staff and how is the rest of the staff notified? Did the treatment plan change?
- Were any therapy or restorative interventions in place before the [ADL] decline?
- What is therapy/restorative doing to address the resident's [ADL] decline?
- How did you identify that the interventions were suitable for this resident?
- If the resident refuses care, do you know why? How does staff provide alternative treatment options and education on any associated risks? If the resident resists care on a repeated basis, how does staff respond?
- If the resident experiences any pain during ADLs, how does staff respond?
- Are staff, the resident and resident's representative aware of the programs that the resident is involved in to restore or maintain functional abilities?
- How do you involve the resident or resident representative in decisions regarding treatments?
- If the resident is not on a therapy or restorative program: How did you decide that he/she would not benefit from a program?

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Record Review:

- Does the assessment identify the resident's: 1) status in all areas of ADLs, 2) inability to perform ADLs, 3) risk for decline in any ADL ability they have, or 4) ability to improve in identified ADLs? If not, describe.
 - Did the record identify potential areas where a resident may benefit from therapy or restorative services given the resident's current status?
 - Has the facility clearly documented the decision-making process used for determining that a resident would not benefit from receiving therapy or restorative services?
 - Was the need for equipment or assistive devices assessed and identified to maximize independence in all areas of ADLs?
 - Is pain related to ADLs assessed and treatment measures documented?
 - Were changes in ADL status or other risks correctly identified and communicated with staff and MD?
 - Are there underlying risk factors identified (e.g., unstable condition, cognition, or visual problems)?
 - Are preventive measures documented prior to a decline?
 - Does your ADL observation match the description of the resident's abilities in the clinical record?
 - Review the therapy assessment, notes, and discharge plan, if applicable.
 - Has the resident's ADL status changed in the last 12 months?
 - Has therapy assessed the ADL decline, provided treatment as often as ordered, and implemented a plan after therapy?
 - Is there documentation that indicates ADLs have improved, been maintained, or declined?
- How do you monitor staff to ensure they are implementing care-planned interventions?
 - Does the care plan address the resident's ADL needs and goals, including the provision of ADLs if the resident is unable to perform ADLs? Has the care plan been revised to reflect any changes in ADL functioning?
 - How did the resident or resident representative participate in the development of the care plan and do the goals and interventions reflect the resident's choices and preferences?
 - Do interventions encourage maintenance or improvement of ADL abilities? Is there evidence that the care plan has been reevaluated and interventions modified according to the resident's lack of improvement or change in ADL functioning?
 - Does the care plan reflect the presence of pain or discomfort related to ADLs, if present, and interventions identified?
 - Was the resident provided with services such as rehabilitative (physical, occupational, speech) or restorative nursing programs designed to restore or maintain functional abilities?
 - Was there a "significant change" in the resident's condition (i.e., will not resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; impacts more than one area of health; requires IDT review or revision of the care plan)? If so, was a significant change comprehensive assessment conducted within 14 days?
 - If concerns are identified, review facility policies and procedures with regard to the provision of ADLs.

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Critical Element Decisions:

1. Based on observation, interviews, and record review, did the facility ensure a resident's ADL abilities were maintained or improved and did not diminish unless circumstances of the resident's clinical condition demonstrate that a change was unavoidable?
If No, cite F676
NA, the resident is unable to carry out ADLs.
2. Based on observation, interviews, and record review, did the facility provide the resident who is unable to carry out ADLs the necessary services to maintain good nutrition, grooming, and personal and oral hygiene?
If No, cite F677
NA, the resident is able to carry out ADLs.
3. For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.
4. If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.
5. If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.
6. Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?

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If No, cite F641

7. Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?

If No, cite F656

NA, the comprehensive assessment was not completed.

8. Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?

If No, cite F657

NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA) or Tasks (Task) to Consider: Dignity (CA), Admission Orders F635, Abuse (CA), Neglect (CA), Professional Standards F658, Communication and Sensory (CA), Bladder and Bowel (CA), Sufficient and Competent Staffing (Task), Eating Assistive Devices F810, Feeding Assistance F811, Rehabilitative and Restorative (CA), Proficiency of Nurse Aides F726, Resident Records F842.