



# ACTIVITIES OF DAILY LIVING

DOCUMENTATION GUIDE

# QUALITY OF CARE

## §483.25 Quality of Care

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

# QUALITY OF CARE

## §483.25(a) (1) Activities of Daily Living

A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to --

- (i) Bathe, dress, and groom;
- (ii) Transfer and ambulate;
- (iii) Toilet;
- (iv) Eat; and
- (v) Use speech, language, or other functional communication systems.

# ADL SELF-PERFORMANCE

RESIDENT PERFORMANCE

# ADL RESIDENT PERFORMANCE

- \* Consider every component or part of the ADL activity to determine how much assistance the resident required during a particular task.
- \* Record what actually happened, not the type and level of assistance the resident “should” be receiving based on the care plan.
- \* The resident’s ability to perform a task may vary from day to day, shift to shift, or within shifts.

## Independent = 0

### NO TALK, NO TOUCH, NO GESTURES

- \* Staff does not assist, instruct, or cue
- \* Resident does all the activity **ALONE**
- \* The resident was independent **EVERY TIME** the activity occurred during the 7-day look-back.

## Supervision=1

### TALK, GESTURE, NO TOUCH

- \* Staff provides instructions or cueing (verbal and /or gestures), but does not provide hands on assistance.

## Limited assistance = 2

### STAFF TALKS TO, GIVES INSTRUCTIONS, OR CUES AND TOUCHES RESIDENT TO ASSIST

- \* Staff hands are used for more than set up, but do not lift any part of the resident.
- \* The resident is still very much involved. Staff did some hands on assistance but it was **NONWEIGHT BEARING**.

## Extensive assistance = 3

### TALK, TOUCH, and LIFT

- \* Staff uses their muscle power to assist the resident. This includes lifting, moving, and shifting.
- \* The resident performed part of the activity, but **WEIGHTBEARING ASSIST** (lifting a part of the body) was required.

## Total Dependence = 4

### ALL ACTION BY STAFF

- \* Resident does **ABSOLUTELY NOTHING** to participate in any part of the activity being done for him/her **EVERY TIME** the activity occurred during the 7-day look-back.

**7 = Activity occurred only once or twice**

**8 = Activity did not occur**

- \* Or the activity did occur and care was provided 100% by family or non-facility staff.

# ADL STAFF SUPPORT

ADL SUPPORT PROVIDED

# ADL STAFF SUPPORT

- \* Report most support provided even if that level of support only occurred **ONCE**.
- \* Guided Maneuvering versus Weight-bearing
  - \* Determine **WHO** is supporting the weight of the resident's extremity or body.



## ADL Staff Support Provided

- \* Staff did Nothing = 0
- \* Set up help only = 1
- \* One person providing physical assistance = 2
- \* Two or more people providing physical assistance =3
- \* Activity did not occur=8

- \* Code for the **MOST SUPPORT PROVIDED** over all shifts
- \* Code regardless of resident's self performance classification

# CHANGE IN CONDITION

OBSERVATION AND REPORTING

# DETECTING CHANGE IN A RESIDENT'S CONDITION

- \* Know the resident's normal (baseline) condition
- \* Note the resident's ability to move around
- \* Know how the resident manages ADLs
- \* Know the resident's preferences for activities, eating and dressing

***CHANGES FROM THE RESIDENT'S NORMAL CONDITION CAN SIGNAL A MEDICAL CHANGE***

# RECOGNIZING CHANGES

- \* 3 KEY STEPS TO IDENTIFY A CHANGE:
  - \* Complete a shift-to-shift comparison (i.e., speak to other CNAs/staff members/family, review previous documentation)
  - \* Determine if a change occurred in any of the resident's vital signs
  - \* Assess urinary and bowel records (i.e. last BM, constipation, diarrhea and number of times, decreased/increased urination, painful urination, color)

# TOP 12 CHANGES IN RESIDENTS

## \* PHYSICAL CHANGES:

- \* Walking
- \* Urination and bowel patterns
- \* Skin
- \* Level of weakness
- \* Falls
- \* Vital signs

## \* NON-PHYSICAL CHANGES:

- \* Demeanor
- \* Appetite
- \* Sleeping
- \* Speech
- \* Confusion or agitation
- \* Complaints of pain

**A more complete assessment is needed when changes in these areas occur.**

# WHAT IS INTERACT?

- \* **INTERACT** is a quality improvement program designed to improve the early identification, assessment, documentation and communication about changes in the status of residents.
- \* The goal of **INTERACT** is to improve care with early detection and effective communication to reduce potentially avoidable transfers to the hospital.
- \* **INTERACT** Tools and resources may be found at:
  - \* <https://interact2.net>

# EARLY WARNING TOOL

## “STOP AND WATCH”



If you have identified an important change while caring for a resident today, use the following, and on a separate paper/form, document the change and discuss with the charge nurse before the end of your shift. Indicate who you reported to, the date, time, and your signature.

Indicate the name of the resident on the paper/form

**S**eems different than usual

**T**alks or communicates less than usual

**O**verall needs more help than usual

**P**articipated in activities less than usual

**A**te less than usual (Not because of dislike of food)

**N**

**D**runk less than usual

**W**eight change

**A**gitated or nervous more than usual

**T**ired, weak, confused, or drowsy

**C**hange in skin color or condition

**H**elp with waling, transferring, toileting more than usual

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QIES Help Desk

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**For Questions Call:  
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