Examples: ADL Self-Performance and Support	Self-Perf.	Support
Personal Hygiene		
New resident, in nursing facility adjustment phase, liked to sleep in his clothes in case of fire. He remained in the same clothes for 2 - 3 days at a time. He cleaned his hands and face independently and would not let others help with any personal hygiene activities.	0	0
Once grooming articles were laid out and arranged by staff, resident regularly performed the tasks of personal hygiene by receiving verbal directions from one person throughout each task.	1	1
Resident carried out personal hygiene but was not motivated. She received daily cueing and positive feedback from nursing staff to keep self clean and neat. Once started, she could be left alone to complete tasks successfully.	1	0
Resident shaves self with an electric razor, washes his face and hands, brushes his teeth, and combs his hair. Because he is losing his sight, staff stand-by to hand grooming articles to the resident and return articles to their proper location.	1	1
Resident performed all tasks of personal hygiene except shaving. The facility barber visited him on the unit three times a week to shave his thick beard.	3	2
Resident required total daily help combing her long hair and arranging it in a bun. Otherwise she was independent in personal hygiene.	3	2

G2. Bathing (7-day look back)

Bathing is the only ADL activity for which the ADL Self-Performance codes in Item G1A do not apply. A unique set of Self-Performance codes, to be used only in the Bathing assessment, are described below. The Self-Performance codes for the other ADL items would not be applicable for bathing given the normal frequency with which the bathing activity is carried out during a one-week period. Assuming that the average frequency of bathing during a seven-day period would be one or two baths, the coding for the other ADL Self- Performance items, which permits one or two exceptions of heavier care, would result in the inaccurate classification of almost all residents as "Independent" for Bathing.

If a facility has a policy that all residents are supervised when bathing (i.e., they are never left alone while in the bathroom for a bath or shower, regardless of resident capability), it is appropriate to code the Staff Support as supervision, even if the supervision is precautionary.

The ADL Support Provided codes given in Item G1B, however, continue to apply to the Bathing activity.

Intent: To record the resident's Self-Performance and Support provided in bathing, including how the resident transfers into and out of the tub or shower. This item is intended to capture how much of the bathing activity the resident can perform for him/herself and how much staff assistance is needed.

Definition: **Bathing** - How the resident takes a full body bath, shower, or sponge bath, including transfers in and out of the tub or shower. The definition does not, however, include the washing of back or hair.

Coding: **(A) Bathing Self-Performance Codes** - Record the resident's self-performance in bathing according to the codes listed below. When coding, apply the code number that reflects the maximum amount of assistance the resident received during bathing episodes.

0. Independent - No help provided
1. Supervision - Oversight help only.
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence
8. Activity itself did not occur during entire 7 days

(B) Support - Next, score the maximum amount of support provided in bathing activities using the ADL Support Scale (Item G1B).

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Bathing		
Resident received verbal cueing and encouragement to take twice-weekly showers. Once staff walked resident to bathroom, he bathed himself with periodic oversight.	1	0
On Monday, one staff member helped transfer resident to tub and washed his legs. On Thursday, resident had physical help of one person to get into tub but washed himself completely.	3	2
Resident afraid of mechanical lift. Given full sponge or bed bath by nurse assistant twice weekly. Actively involved in this activity.	3	2
For one bath, resident received light guidance of one person to position self in bathtub. However, due to her fluctuating moods, she received total help for her other bath. ***Rationale:*** The coding directions for bathing state, "code for most dependent in self performance and support."	4	2

G3. Test for Balance (7-day look back)

Residents with impaired balance in standing and sitting are at greater risk of falling. It is important to assess an individual's balance abilities so that interventions can be implemented to prevent injuries (e.g., strength training exercises; safety awareness; restorative nursing; nursing-based rehabilitation).

Intent: To record the resident's capacity of **a.** Balance while standing (not walking) without an assistive device or assistance of a person, and **b.** Balance while sitting **without using the back or arms of the chair for support.**

Process **a. Balance While Standing**

Preparation:

- Obtain a watch with a second hand to time the test.
- Pick a time to test the resident when he or she is likely to be at his or her best. If the resident refuses, negotiate a better time and try again later. In approaching a resident for a balance test, staff should provide privacy and an explanation. The resident may, of course, decline the test, but the

facility should attempt to determine why the resident is refusing. Since this would affect the MDS response, it seems worthy of a short notation, which may be written directly on the MDS form. Surveyors will accept individual residents declining to participate, but will probably be suspicious if an untoward number of residents decline participation in this test.

- Place a chair directly behind the resident in case the resident needs to sit down.

- Stand close to the resident while testing balance in order to catch or balance the resident, if necessary.

- If the resident is heavy or tall or seems frail, ask another staff person to stand by with you in case the resident needs assistance.

- Test balance without assistive devices (but with prostheses, if used). For residents who use walkers, make sure the walker is placed directly in front of the resident within easy reach in case it is needed for rebalancing.

Conducting the tests:

- **DO** each of the following tests (10 seconds each) on residents who are able to stand without physical help.

- **DO NOT** attempt to test residents who cannot stand by themselves. Code these residents as "3", Not able to attempt test without physical help.

- For persons with visual impairment who may not be able to see your demonstrations of feet placement, provide rich verbal descriptions.

Position 1 -

"I would like you to stand with your feet together, side-by-side, like this (demonstrate as illustrated). [Note, in this and all tests, both feet should be firmly on the floor for support.]

"Do not move your feet until I say stop. Ready, OK, begin." If the resident is ABLE to maintain this position for 10 seconds, proceed to test resident in Position 2. **If the resident is NOT ABLE to maintain this position for 10 seconds, stop testing here.** Do not proceed with Position 2 for balance testing.

Position 2 -

"Now I would like you to stand with one foot halfway in front of the other like this" (demonstrate as illustrated).

"You may use either foot, whichever is more comfortable for you. Ready, OK, begin." If the resident is ABLE to maintain this position for 10 seconds, proceed to test resident in Position 3. **If the resident is NOT ABLE to do this, stop testing here.**

Position 3 -

"Now I would like you to stand with the heel of one foot in front of you touching the toes of the other foot like this (demonstrate as illustrated). You may use either foot, whichever is more comfortable for you. Ready, OK, begin."

Coding:

0. **Maintained Position as Required in Test** - Resident was able to maintain all 3 standing positions for 10 seconds without moving feet out of position.

1. **Unsteady, but Able to Rebalance Self Without Physical Support** - Resident was unable to maintain one or more standing positions for 10 seconds each without moving feet out of position. Resident was unsteady but was able to rebalance self without physical support from others or from an assistive device in at least the first position.

2. **Partial Physical Support During Test, or Stands but Does Not Follow Directions for Test** - While the resident performed part of the activity, resident was unable to maintain one or more standing positions without physical support from other(s) or from an assistive device. This category also includes residents who can stand but are unable or refuse to follow your directions to perform a test of balance.

3. **Not Able to Attempt Test Without Physical Help** - Resident is not able to stand without physical help from another person or an assistive device.

Examples of Balance Testing

Mrs. R usually walks with a walker. After completing the test preparation steps for safety, which include placing Mrs. R's walker directly in front of her in case she needs it during the test, you briefly explain to Mrs. R what you are going to ask her to do. You also demonstrate the actions. Once Mrs. R is standing, start to test her in Position 1 by giving her the brief directions and your demonstration of the position. You start timing her once you say, "Ready, OK, begin."

Results: During the 10-second test, Mrs. R moves her feet out of position to rebalance herself.

How to proceed: Tell Mrs. R, "That was a good try." STOP the test because the next 2 positions are harder to perform. If Mrs. R cannot maintain Position 1, it is unlikely she will be able to maintain Positions 2 or 3.

Coding: "1", Unsteady, but able to rebalance self without physical support.
Rationale: Mrs. R moved her feet out of position but did not need to hold her walker, or lean against the chair behind her, or receive assistance from you during the 10 seconds.

Mr. C has cognitive and hearing impairment and restlessness. He usually walks independently (wandering) and occasionally stands at the nurses' station to be with the unit secretary. Therefore, you know he can stand, but you do not know if he would be able to maintain his balance if her were asked to "hold" specific standing positions for 10 seconds each. After completing the test preparation, and steps for safety, you give Mr. C the brief directions and demonstration for testing position 1.

Results: During your interaction with Mr. C he becomes agitated, says "No, no" and walks away.

How to proceed: STOP the test.

Coding: "2", Partial physical support during test or stands, but does not follow directions for test.

Rationale: This is the best you can do under the circumstances. Although Mr. C did not need physical help to balance, you really do not know what his true balance capacity is. All you know is that he is able to stand, but you can't test his balance capacity because he refuses and is unable to follow directions.

Ms. M has multiple sclerosis and has been confined to her bed and reclining chair for the last 2 years.

How to proceed: DO NOT perform any standing balance tests. Ms. M cannot stand.

Coding: "3", Not able to attempt test without physical help.

Process: **b. Balance while sitting - position, trunk control**

Preparation:

- Obtain a watch with a second hand to time the test.
- Do not conduct sitting balance in wheelchair. Find a chair with a firm, solid seat to conduct the test.
- The height of the chair seat should be low enough to allow the bottom of the resident's feet to rest on the floor for support. (Of course, this does not apply to persons with bilateral leg amputations.)
- It is safer to use a chair with arms in case the resident needs physical support during the test.
- Stand close to the resident while testing sitting balance in order to catch or balance the resident, if necessary.
- If the resident is heavy or tall or seems frail, ask another staff person to stand by with you in case the resident needs assistance.

Conducting the test:

- DO NOT attempt to test residents who are clearly unable to sit without physical help. Code these residents as "3", Not able to attempt test without physical help.
- Instruct the resident to sit in a chair with arms folded across his or her chest without using the back or arms of the chair for support. Make sure the resident's feet are both flat on the floor for support. Demonstrate the action to the resident. Observe balance for 10 seconds, then ask resident to stop.

Coding:

0. Maintained Position as Required in Test - Resident was ABLE to sit for 10 seconds without touching the back or sides of the chair for support.

1. Unsteady, but Able to Rebalance Self Without Physical Support - Resident was unable to maintain sitting balance for 10 seconds without touching the back or sides of the chair for support. Resident was unsteady but was ABLE to rebalance self.

2. Partial Physical Support by Others During Test or Sits but Does Not Follow Directions for Test - While resident performed part of activity, resident was UNABLE to maintain sitting balance without physical support from other(s) or from touching the backs or sides of the chair for support.

This category also includes residents who can sit but are unable or refuse to follow your directions to perform this test of sitting balance.

3. **Not Able to Attempt Test Without Physical Help** - Resident is not able to sit without physical help from another, or an assistive/adaptive device, or chair back/arms for support.

Examples of Sitting Balance

Ms. Z spends a lot of time sitting in a wheelchair on a gel cushion for pressure relief. She has a left-sided below-the-knee amputation. She does not have a leg prosthesis. She also has a left-sided hemiparesis from a CVA 1 year ago. You complete the test preparation activities for safety, assist Ms. Z to transfer into a chair with a firm seat, and ask her to place her right foot firmly on the floor. You instruct her to cross her arms over her chest. She cannot lift her left arm across her chest but is able to hold it across her abdomen. You instruct her to "sit up in the chair without leaning on the chair back or arms for support." You demonstrate this activity from another chair. Once the resident begins, you time for 10 seconds.

Results: Ms. Z maintained the position for the full 10 seconds without touching the chair back/arms for support.

How to proceed: Tell Ms. Z, "You did an excellent job. That's all we have to do." STOP testing. The test is complete.

Coding: "0", Maintained position as required in test.

G4. Functional Limitation in Range of Motion (7-day look back)

(A) Limitation in Range of Motion.

Intent: **Limitation in the Range of Motion**: To record the presence of (A) functional limitation in range of joint motion or (B) loss of voluntary movement.

Definition: Limitation that interferes with daily functioning (particularly with activities of daily living), or places the resident at risk of injury.

Process: **Assessing for Functional Limitations:** This test is a screening item used to determine the need for a more intensive evaluation. It does not need to be performed by a physical therapist. Rather, it can be administered by a member of any clinical discipline in accordance with these instructions.

- Do each of the following tests on all residents unless contraindicated (e.g., recent fracture or joint replacement).

- Perform each test on both sides of the resident's body.

- If the resident is unable to follow verbal directions demonstrate each movement (e.g., Ask the resident to do what you're doing). If a resident lacks all ability to perform ROM (range of motion) exercises on request due to impaired cognition, these items are coded based on the resident's ability to perform range of motion and voluntary movement. For Item G4a, a resident who is unable to follow your verbal instructions or a demonstration of movements can be actively assisted in range of motion exercises to assess for limitations. Move the resident's joints through slow, active assisted ROM by providing support and direction with each activity. In this section, you can also use observations, by the staff, of what the resident can do.

- If resident is still unable to perform the activity after your demonstration, move the resident's joints through slow, active assisted range of motion to assess for limitations. In active/assistive range of motion exercises, the health professional provides support and direction with the resident performing some of the activity.

- Staff observations of the ROM activity can be used to determine whether or not a resident can actually perform the activity, regardless of whether or not the movement was "on command," provided the movement fits the criteria specified for G1(B), ADL Support Provided, and occurred during the assessment period of observation.

- STOP if a resident experiences pain.

a. **Neck** - With resident seated in a chair, ask him or her to turn the head slowly, looking side to side. Then ask the resident to return head to center and then try to reach the right ear towards the right shoulder, and then left ear towards left shoulder.

b. **Arm** - including shoulder or elbow - With resident seated in a chair instruct him or her to reach with both hands and touch palms to back of the head (mimics the action needed to comb hair). Then ask the resident to touch each shoulder with the opposite hand. Alternatively, observe the resident donning or removing a shirt over the head.

c. **Hand** - including wrist or fingers - For each hand, instruct the resident to make a fist, and then open the hand (useful actions for grasping utensils, letting go).

d. Leg - including hip or knee - While resident is lying supine in a flat bed, instruct the resident to lift his or her leg (one at a time), bending it at the knee. [The knee will be at a right angle (90 degrees)]. Then ask the resident to slowly lower his or her leg, and extend it flat on the mattress.

e. Foot - including ankle or toes - While supine in bed, instruct the resident to flex (pull toes up towards head) and extend (push toes down away from head) each foot.

f. Other Limitation or Loss - Decreased mobility in spine, jaw, or other joints that are not listed.

Coding: For each body part, code the appropriate response for the resident's active (or assistive/passive) range of motion function during the past seven days. Enter the code in the column labeled (A). **If the resident has an amputation on one side of the body, use Code "1", Limitation on one side of the body. If there are bilateral amputations, use code "2", Limitation on both sides of the body.**

If no assessment has been conducted and documented by a therapist within the last seven days, then a clinical professional (e.g., nurse) may assess this area following the guidance in this manual. In this Item, we are moving from performance issues to structural issues. We are not asking how an activity is carried out; we are determining the structural ability of the limbs to move. A therapist or nurse should conduct the evaluation.

0. No limitation - Resident has full function range of motion on the right and left side.

1. Limitation on One Side of the Body (Either Right or Left Side) - that interferes with daily functioning or places the resident at risk of injury.

2. Limitation on Both Sides of the Body - that interferes with daily functioning or places the resident at risk of injury.

Example of Coding for
(A) Limitation in Range of Motion

Mr. O was admitted to the nursing facility for rehabilitation following right knee surgery. His right leg is in an immobilizer. With the exception of his right leg, Mr. O has full active range of motion in all other areas.

	Coding (A)
Neck	0
Arm	0
Hand	0
Leg	1
Foot	0
Other	0

(B) Loss of voluntary movement.

Definition: **Loss of Voluntary Movement:** Impairment in purposeful (intentional) functional movement. This category refers to a range of impairments exhibited when a resident tries to perform a task and includes deficits such as uncoordinated movements, tremors, spasms, muscular rigidity, "freezing," choreiform movements (jerking) as well as lack of initiation of movement. Impairments in voluntary movement are often due to injury or disease of muscles, bones, nerves, spinal cord or the brain and can place a resident at risk for functional disability and injury.

Process: While performing the assessment of range of motion in Item G4(A) above, observe the resident for impairment(s) in purposeful movement on each side of the resident's body. A therapist or nurse should conduct the evaluation.

Coding: For each body part, code the appropriate response for the resident's function during the past seven days. Enter the code in the column labeled (B). **If the body part is missing on one side (e.g., left above knee amputation), code "1", Partial loss of voluntary movement. If missing bilaterally, code "2", Full loss of voluntary movement**.

0. **No Loss of Voluntary Movement** - Resident moves body part to complete the required task. Movements are smooth and coordinated.

1. **Partial Loss of Voluntary Movement** - Resident is able to initiate and complete the required task but movements are slow, spastic, uncoordinated, rigid, choreiform, frozen, etc. on one or both sides. Residents with full loss of voluntary movement on one side of the body and full range on the other would be coded (1) partial loss of voluntary movement. Residents with partial loss on one side and full loss on the other would be coded (1) partial loss of voluntary movement.

2. **Full Loss of Voluntary Movement** - Resident is not able to initiate the required task. There is no voluntary movement on either side.

Example of Functional Limitation

Mrs. X is a diabetic who sustained a CVA 2 months ago. She can only turn her head slightly from side to side and tip her head towards each shoulder (limited neck range of motion). She can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. She is unable to move her left side (limited arm, hand, and leg motion) as she has a flaccid left hemiparesis. She is able to extend her legs flat on the bed. She has no feet. She has no other limitations.

Coding

	(A) Limitation in Range of Motion	(B) Loss of Voluntary Movement
a. Neck	2	0
b. Arm	1	1
c. Hand	1	1
d. Leg	1	1
e. Foot	2	2
f. Other	0	0

5. Modes of Locomotion (7-day look back)

Intent: To record the type(s) of appliances, devices, or personal assistance the resident used for locomotion (on and off unit).

Definition:

a. Cane/Walker/Crutch - Also check this item in those instances where the resident walks by pushing a wheelchair for support, or uses an enclosed four-wheeled walker with/without a posterior seat and lap cushion.

b. Wheeled Self - Includes using a hand-propelled or motorized wheelchair, as long as the resident takes responsibility for self-mobility, even for part of the time.

c. Other Person Wheeled - Another person pushed the resident in a wheelchair.

d. Wheelchair Primary Mode of Locomotion - Even if resident walks some of the time, he or she is primarily dependent on a wheelchair to get around. The wheelchair may be motorized, self-propelled, or pushed by another person.

e. ***NONE OF ABOVE (is not used on the MPAF)***

Coding: Check all that apply during the last 7 days. If no appliances or assistive devices were used, check *NONE OF ABOVE*.

G6. Modes of Transfer (7-day look back)

Intent: To record the type(s) of appliances or assistive devices the resident used for transferring in and out of bed or chair, and for bed mobility.

Definition:

a. Bedfast All or Most of the Time - Resident is in bed or in a recliner in own room for 22 hours or more per day. This definition also includes residents who are primarily bedfast but have bathroom privileges. For care planning purposes this information is useful for identifying residents who are at risk of developing physical and functional problems associated with restricted mobility, as well as cognitive, mood, and behavior impairment related to social isolation. **Code this item when it occurs on at least 4 of the last 7 days.**

The concept of bedfast is meant to capture residents who spend 22 hours or more in a bed or recliner in their own room regardless of their level of function. Immobility, whether innate or self-inflicted, places residents at risk for a myriad of clinical problems. For example, being bedfast may also be an indicator that a resident is withdrawn from others and suffers from depression.

b. Bed Rail(s) Used for Bed Mobility or Transfer - Refers to any type of side rail(s) attached to the bed USED by the resident as a means of support to facilitate turning and repositioning in bed, as well as for getting in and out of bed. **Do not check this item if resident did not use rails for this purpose.** In classifying any device as a restraint, the assessor must consider the effect the device has on the individual, not the intent of its use. It is possible for a device to improve the resident's mobility and also have the effect of restraining the individual. When a bed rail is both a restraint and a transfer or mobility aid, it should be coded at Item P4 (a or b, as appropriate) and at Item G6b (bed rails used for mobility or transfer).

c. Lifted Manually - The resident was completely lifted by one or more persons.

d. Lifted Mechanically - The resident was lifted by a mechanical device (e.g., mechanical lift). Does not include a bath lift.

e. Transfer Aid - Includes devices such as slide boards, trapezes, canes, walkers, braces, and other assistive devices, such as gait belts when used during the transfer of a resident.

f. ***NONE OF ABOVE (is not used on the MPAF)***

Coding: Check all that apply. If none of these items apply, check *NONE of ABOVE*.

G7. Task Segmentation (7-day look back)

Intent: To identify residents who are more involved and independent in personal care tasks (such as eating, bathing, grooming, dressing), because they have received help in breaking tasks down into smaller steps. Some residents become overwhelmed and anxious when there are expectations for greater independence and they are no longer able to perform the steps necessary to complete an ADL activity. Such residents are at great risk for becoming dependent on others unless activities are made easier for them to manage by task segmentation. These residents usually have some deficits in memory, thinking, or paying attention to the task consequent to problems such as dementia, head injury, CVA, or depression. Other residents receive task segmentation care because of body-control problems, poor stamina, or other physical difficulties that limit self-performance.

Definition: **Task Segmentation** - Provides the resident with directions, such as verbal cues, physical cues, or verbal and physical cues - for performing each constituent step in an ADL activity.

Verbal cueing involves giving a verbal direction to complete the first step in a task, and once the step is accomplished, giving another verbal direction to complete the next step. Verbal encouragement, praise, and feedback for the resident's successful completion of the steps are usually given by the direct care staff person prior to providing the next verbal cue. For example, "That looks good. Now put on this skirt."

Physical cueing involves giving the resident an object as a reminder of what needs to be done - e.g., handing the resident some toilet paper as a cue to wipe self, or placing an item from a food tray in front of the resident and handing him or her a fork as a cue to eat the item.

Physical and verbal cueing involves use of objects and words to stimulate action - e.g., giving the resident one item of clothing at a time and saying "Put this shirt on," which is less confusing to a cognitively impaired resident than putting all clothing items before him or her and saying "Get dressed."

Examples	
Task Segmentation	**No Task Segmentation**
• When handed a face cloth and asked, "Would you please wash your face?", the resident washes her face. • When a nurse assistant sets a mirror in front of the resident, and hands him a brush, the resident brushes his hair. • When the nurse assistant hands the resident a sock and says "Put this sock on this foot" and upon completion of the step hands the resident another sock and says "Put this sock on this foot," the resident dons his socks. • When single food items and only one utensil are presented to the resident in succession, the resident eats independently. • When a nurse assistant gives verbal directions for each step in transferring from a wheelchair (e.g., "Lock the brakes... Hold onto the arms of the chair and push yourself up... Hold onto your walker with both hands like this [demonstrates]"), the resident succeeds in transferring himself from a seated to a standing position.	• When a washbasin, a face cloth, a towel, and various grooming supplies are placed before the resident, the resident becomes overwhelmed. • When a nurse assistant places the resident's clothes for the day on the bed and says, "Get dressed," the resident becomes confused and is unable to dress self. • When a tray containing an entire meal and several different utensils are placed before the resident on a table, the resident becomes confused and is unable to eat by herself. • When a nurse assistant lifts a resident from a sitting to a standing position and does not involve the resident in the process of self-care in the activity, the resident becomes more physically dependent on the nurse assistant.
For all above examples, **Code "1" for Yes.**	For all above examples, **Code "0" for No.**

Process: Ask the nurse assistant to think about how the resident completes activities of daily living, or ways the nurse assistant helped the resident complete an activity of daily living over the last seven days. Specifically: Did the nurse assistant break the ADL activity into subtasks (smaller steps) so that the resident could perform them? Did this occur in the last seven days?

Coding: Code "**0**" if task segmentation was not done. Code "**1**" if ADLs were broken into a series of subtasks so that resident could perform them.

Clarification:

- Evidence of Task Segmentation (Item G7) information may be documented anywhere in the clinical record (e.g., nurse's notes or therapy notes). Some facilities may choose not to document task segmentation separately, but to use the MDS to indicate the activity. It makes sense however, that staff should be knowledgeable about how to break down task(s) for individual residents (i.e., based upon that individual's needs) so that they may integrate task segmentation into the resident's care.

G8. ADL Functional Rehabilitation Potential (7-day look back)

Intent: To describe beliefs and characteristics related to the resident's functional status that may indicate he or she has the capacity for greater independence and involvement in self-care in at least some ADL areas. Even if highly independent in an activity, the resident may believe he or she can do better (e.g., walk longer distances, shower independently).

Process: Ask if the resident thinks he or she could be more self-sufficient given more time. Listen to and record what the resident believes, even if it appears unrealistic. Also, as a clue to whether the resident might do better all the time, ask if his or her ability to perform ADLs varies from time to time, or if ADL function or joint range of motion has declined or improved in the last three months.

Ask direct care staff (e.g., nurse assistants on all shifts) who routinely care for the resident if they think he or she is capable of greater independence, or if the resident's performance in ADLs varies from time to time. Ask if ADL function or range of motion of joints declined or improved in the last three months. You may need to prompt staff to consider such factors as:

- Has self-performance in any ADL varied over the last week (e.g., the resident usually requires two-person assistance but on one day transferred out of bed with assistance of one person)?

- Has resident's performance varied during the day (e.g., more involved and independent in the afternoon than in the morning)?

- Was the resident so slow in performing some activities that staff members intervened and performed the task or activity? Is the resident capable of increased self-performance when given more time? - OR - Is the resident capable of increased self-performance when tasks are broken into manageable steps?

- Does the resident tire noticeably during most days?

- Does the resident avoid an ADL activity even though physically or cognitively capable (e.g., refuses to walk alone for fear of falling, demands that others attend to personal care because they do it better)?

- Has the resident's performance in any ADL improved?

Coding: Check all that apply. If none of these items apply check *NONE OF ABOVE*.

a. Resident believes he/she is capable of increased independence in at least some ADLs

b. Direct care staff believe resident is capable of increased independence in at least some ADLs

c. Resident able to perform tasks/activity but is very slow

d. Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings

e. *NONE OF ABOVE*

Examples

Mr. N, who is cognitively impaired, receives limited physical assistance in locomotion for safety purposes. However, he believes he is capable of walking alone and often gets up and walks by himself when staff isn't looking. **Check "a" (Resident believes he/she capable of increased independence).**

The nurse assistant who totally feeds Mrs. W has noticed in the past week that Mrs. W has made several attempts to pick up finger foods. She believes Mrs. W could become more independent in eating if she received close supervision (cueing) in a small group for restorative care in eating. **Check "b" (Direct care staff believes resident is capable of increased independence).**

Mrs. Y has demonstrated the ability to get dressed, but has missed breakfast on several occasions because she was slow getting organized. Therefore, every morning her nurse assistant physically helped her to dress so that she would be ready for breakfast. **Check "c" (Resident able to perform task but is very slow).**

Mrs. F remained continent during day shifts while receiving supervision in toileting. During the evening and night shifts she was incontinent because she was not helped out of bed to the toilet room. After incontinence episodes, direct-care staff provided total help in hygiene. **Check "d" (Difference in ADL self-performance or ADL support, comparing mornings to evenings).**

Mr. K has hemiplegia secondary to a CVA. He receives extensive assistance in bed mobility transfer, dressing, toilet use, personal hygiene and eating. He is totally dependent in locomotion (wheelchair). Whenever he has tried to do more for himself he has experienced chest pain and shortness of breath. Both Mr. K and direct care staff believe that he is involved in self-care as much as he is physically able. **Check "e" (*NONE OF ABOVE*).**

G9. Change in ADL Function (90 days ago)

Intent: To document any changes occurring in the resident's overall ADL self-performance, as compared to status of 90 days ago (or since last assessment if less than 90 days ago). This item asks for a snapshot of "today" as compared to 90 days ago (i.e., a comparison of 2 points in time). These include, but are not limited to, changes in the resident's level of involvement in ADL activities as well as the amount and the type of support received by staff. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Process: Review the record for indications of a change. Consult with the resident and direct care staff. Review Section G from the last assessment and compare these

findings with current findings. For new residents, consult with the primary family caregiver.

Coding: Code "**0**" if there has been no change. Code "**1**" if the resident's ADL function has improved. Code "**2**" if the resident's function has deteriorated. You may find that some ADLs have improved, some deteriorated, and others remain unchanged. You must weigh all of the information and make an overall clinical judgment (e.g., in general, the resident's ADL function has...).

Examples

Dr. B had been highly involved in self-care in most ADL activities. Seven weeks ago he slipped, fell, and bruised his right wrist. For several weeks he received more extensive assistance with dressing, grooming, and eating. However, in the last three weeks he is functioning at the same level of involvement in ADLs as before the fall. **Code "0" for No change.**

Ms. A participated in a structured feeding group during the past six weeks. With lots of encouragement and supervision from the group leader, she has progressed from requiring extensive assistance to feeding herself under staff supervision. Her performance in other ADLs remains unchanged. **Code "1" for Improved.**

Since fracturing her left hip three weeks ago, Mrs. Z receives more weight bearing help with transfers, locomotion, dressing, toileting, personal hygiene, and bathing. However, she has made strides in OT and PT. Her improvement in self-care has been steady although she still has a long way to go to reach her Self-Performance level of 90 days ago. **Code "2" for Deteriorated.**

Mr. L's favorite nurse (Miss McC) transferred to another unit 30 days ago. Although he says he's happy for her, he has become more passive and withdrawn. He no longer dresses himself in a suit and tie. His personal hygiene habits have deteriorated and he now must be frequently coaxed to shave and wash himself and comb his hair. Because he now wears stained clothing, staff has started to select and set out his clothes each day. Despite these losses, Mr. L is now somewhat more self-sufficient in locomotion, making twice-a-week trips to see Miss McC on her new unit. **Code "2" for Deteriorated.** The ***rationale*** for the coding decision is that although some improvement is noted in one ADL activity (locomotion) it only occurs twice weekly. In general, Mr. L has deteriorated in his self-care performance in two ADL activities (dressing and personal hygiene) that require multiple daily tasks.

During a Significant Change assessment for severe mood distress, Mrs. M was found to be more dependent on others for physical assistance in personal hygiene, dressing and toileting. She also received more coaxing and encouragement to eat. These changes represented less involvement in self-care since the last assessment two months ago. **Code "2" for Deteriorated.**

SECTION H.
CONTINENCE IN LAST 14 DAYS

H1. Continence Self-Control Categories (14-day look back)

Note: This section differs from the other ADL assessment items in that the time period for review has been extended to 14 days. Research has shown that 14 days are the minimum required to obtain an accurate picture of bowel continence patterns. For the sake of consistency, both bowel continence and bladder continence are evaluated over 14 days. The 14-day period allows many opportunities for assessment, but it is acceptable to establish voiding patterns in shorter periods of time.

Intent: To determine and record the resident's pattern of bladder and bowel continence (control) over the last 14 days.

Definition: **(a.) Bowel Continence** and **(b.) Bladder Continence**

Refers to control of urinary bladder function and/or bowel movement. This item describes the resident's bowel and bladder continence pattern even with scheduled toileting plans, continence training programs, or appliances. It does not refer to the resident's ability to toilet self - e.g., a resident can receive extensive assistance in toileting and yet be continent, perhaps as a result of staff help. The resident's self-performance in toilet use is recorded in Item G1Ai.

Process: Review the resident's clinical record and any urinary or bowel elimination flow sheets (if available). Validate the accuracy of written records with the resident. Make sure that your discussions are held in private. Control of bladder function and bowel function are sensitive subjects, particularly for residents who are struggling to maintain control. Many people with poor control will try to hide their problems out of embarrassment or fear of retribution. Others will not report problems to staff because they mistakenly believe that incontinence is a natural part of aging and that nothing can be done to reverse the problem. Despite these common reactions to incontinence, many elders are relieved when a health care professional shows enough concern to ask about the nature of the problem in a sensitive, straightforward manner.

- Determination of whether or not to code incontinence is not a matter of volume. It is a matter of skin wetness and irritation, and the associated risk for skin breakdown. According to Dr. Courtney Lyder, Ph.D. a nationally recognized incontinence and pressure ulcer expert from Yale University School of Nursing, "Urinary incontinence is a major risk factor for pressure ulcer development. Hence excessive moisture (from stool and/or urofecal incontinence) can cause the skin to become macerated with less pressure

needed to develop a Stage II pressure ulcer. In the presence of moisture, less pressure may be required to develop an ulcer." Coding incontinence is a matter of acknowledging and recording a resident's incontinence problem on the assessment, and ensuring that the care plan derived from the assessment addresses the problem. If the resident's skin gets wet with urine, or if whatever is next to the skin (i.e., pad, brief, underwear) gets wet, it should be counted as an episode of incontinence - even if it's just a small volume of urine, for example, due to stress incontinence. Any episode of incontinence requires intervention not just in terms of immediate incontinence care, but also in terms of dealing with the underlying problem whenever possible, and instituting a re-training, toileting or incontinence care plan. In addition, since incontinence is a problem that many residents are sensitive about, intervention involves maintaining dignity and life-style.

- Validate continence patterns with people who know the resident well (e.g., primary family caregiver of newly admitted resident; direct care staff).

- Remember to consider continence patterns over the last 14-day period, 24 hours a day, including weekends. If staff assignments change frequently, consider initiating and maintaining a bladder and bowel elimination flow sheet in order to gather more accurate information as a basis for coding decisions and, ultimately, care planning.

- The keys to obtaining, tracking and recording accurate information in this section are 1) interviews with and observations of residents, and 2) communication between licensed and non-licensed staff and other caregivers.

  - Daily communication between nurses, certified nurse assistants (CNAs) and other direct care providers across all shifts is crucial for resident monitoring and care giving in this area. Staff who work most closely with residents will know how often they are dry or wet.

  - Focus your assessment over the last 14 days. When getting information about continence from CNAs, start to narrow your questions to focus on either end of the continence scale, then work your way to the middle. For example using the urinary continence scale, if the resident is always dry, code "0" (Continent). If the resident is always wet, and has no control, code "4" (Incontinent). If incontinence occurs only once a week or less, code "1" (Usually continent). The difference between code "2" (Occasionally incontinent), and code "3" (Frequently incontinent) is that for code "3", the resident is incontinent at least daily or multiple times a day.

Coding: A five-point coding scale is used to describe continence patterns. Notice that in each category, different frequencies of incontinent episodes are specified for bladder and bowel. The reason for these differences is that there are more

episodes of urination per day and week, whereas bowel movements typically occur less often.

0. **Continent** - Complete control (including control achieved by care that involves prompted voiding, habit training, reminders, etc.).

1. **Usually Continent** - Bladder, incontinent episodes occur once a week or less; Bowel incontinent episodes occur less than once a week.

2. **Occasionally Incontinent** - Bladder incontinent episodes occur two or more times a week but not daily; Bowel incontinent episodes occur once a week.

3. **Frequently Incontinent** - Bladder incontinent episodes tend to occur daily, but some control is present (e.g., on day shift); Bowel incontinent episodes occur two to three times per week.

4. **Incontinent** - Has inadequate control. Bladder incontinent episodes occur multiple times daily; Bowel incontinent is all (or almost all) of the time.

Choose one response to code level of bladder continence and one response to code level of bowel continence for the resident over the last 14 days.

Code for the resident's actual bladder and bowel continence pattern - i.e., the frequency with which the resident is wet and dry during the 14-Day assessment period. Do not record the level of control that the resident might have achieved under optimal circumstances.

For bladder incontinence, the difference between a code of "3" (Frequently Incontinent) and "4" (Incontinent) is determined by the presence ("3") or absence ("4") of any bladder control.

To ensure accurate coding in H1a and H1b, assessors must use multiple sources of information to code accurately: resident interview and observation, review of the clinical record (i.e., urinary and bowel elimination flow sheets), and discussions with direct care staff across all shifts.

Examples of Bladder Continence Coding

Mr. Q was taken to the toilet after every meal, before bed, and once during the night. He was never found wet and is considered continent. **Code "0" for "Continent" - Bladder.**

Mr. R had an indwelling catheter in place during the entire 14-Day assessment period. He was never found wet and is considered continent. **Code a "0" for "Continent" - Bladder.**

Although she is generally continent of urine, every once in a while (about once in 2 weeks) Mrs. T doesn't make it to the bathroom to urinate in time after receiving her daily diuretic pill. **Code "1" for "Usually Continent" - Bladder.**

Mrs. A has less than daily episodes of urinary incontinence, particularly late in the day when she is tired. **Code "2" for "Occasionally Incontinent" - Bladder.**

Mr. S is comatose. He wears an external (condom) catheter to protect his skin from contact with urine. This catheter has been difficult for staff to manage as it keeps slipping off. They have tried several different brands without success. During the last 14 days Mr. S has been found wet at least twice daily on the day shift. **Code "3" for "Frequently Incontinent" - Bladder.**

Mrs. U is terminally ill with end-stage Alzheimer's disease. She is very frail and has stiff, painful contractures of all extremities. She is primarily bedfast on a special water mattress, and is turned and re-positioned hourly for comfort. She is not toileted and is incontinent of urine for all episodes. **Code "4" for "Incontinent" - Bladder.**

H2. Bowel Elimination Pattern (14-day look back)

Intent: To record the effectiveness of resident's bowel function.

Definition:

a. **Bowel Elimination Pattern Regular** - Resident has at least one movement every three days.

b. **Constipation** - Resident passes two or fewer bowel movements per week, or strains more than one out of four times when having a bowel movement.

c. **Diarrhea** - Frequent elimination of watery stools from any etiology (e.g., diet, viral or bacterial infection).

d. **Fecal Impaction** - The presence of hard stool upon digital rectal exam. Fecal impaction may also be present if stool is seen on an abdominal x-ray in the sigmoid colon or higher, even with a negative digital exam or documentation in the clinical record of daily bowel movement.

e. *NONE OF ABOVE*

Process: Ask the resident and examine the resident, if necessary; review the clinical record, particularly any documentation on flow sheets of bowel elimination patterns; and consult with direct care staff (e.g., nurse assistants from all shifts).

Coding: Check all that apply in the last 14 days. If no items apply, check *NONE OF ABOVE*.

Clarification:

- The distinction between constipation and fecal impaction has usually been the effort it takes for the resident to have a bowel movement. Most constipation will pass without manual extraction through the use of laxatives, enemas, high fiber diets, and other remedies. In constipated residents, many times just doing a digital exam will stimulate the bowel enough to move the stool.

  On the other hand, fecal impaction may require a digital rectal exam to physically break the hard stool mass into smaller parts and remove them manually. Follow-up enemas may be given to move stool higher in the bowel. Residents with fecal impactions may present with other symptoms such as fever, acute abdomen (pain, cramping, swollen abdomen), nausea, vomiting, and thin watery discharge from the rectum (a sign liquid stool is passing around the hard mass of stool).

  According to Dr. Peter Toth, MD, Ph.D. in an article entitled "Gastroenterology: Constipation and Fecal Impaction" in the University of Iowa Family Practice Handbook, 4th Edition, Chapter 5, a fecal impaction is "a firm, immobile mass of stool most often in the rectum but may also occur in the sigmoid or descending colon." It is also possible for stools to pass around an impaction. Item H2d must be checked whenever a fecal impaction was present during the 14-Day assessment period, regardless of how the determination was made (e.g., digital rectal examination, x-ray, CAT scan or other method). In the presence of symptoms of fecal impaction, the facility is obligated to determine whether or not the resident is, in fact, impacted, and to provide appropriate treatment. Information regarding the article can be found at: **http://www.vh.org/providers/clinref/FPhandbook/outline.html**.

H3. Appliances and Programs (14-day look back)

Definition:

a. Any Scheduled Toileting Plan - A plan whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet. Includes habit training and/or prompted voiding.

b. Bladder Retraining Program - A retraining program where the resident is taught to consciously delay urinating (voiding) or resist the urgency to void. Residents are encouraged to void on a schedule rather than according to their urge to void. This form of training is used to manage urinary incontinence due to bladder instability.

c. External (Condom) Catheter - A urinary collection appliance worn over the penis.

d. Indwelling Catheter - A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by supra-pubic incision.

e. Intermittent Catheter - A catheter that is used periodically for draining urine from the bladder. This type of catheter is usually removed immediately after the bladder has been emptied. Includes intermittent catheterization whether performed by a licensed professional or by the resident. Catheterization may occur as a one-time event (e.g., to obtain a sterile specimen) or as part of a bladder-emptying program (e.g., every shift in a resident with an under active or a contractile bladder muscle).

f. Did Not Use Toilet Room/Commode/Urinal - Resident never used any of these items during the last 14 days, nor used a bedpan.

g. Pads/Brief Used - Any type of absorbent, disposable or reusable undergarment or item, whether worn by the resident (e.g., incontinence garments, adult brief) or placed on the bed or chair for protection from incontinence. Does not include the routine use of pads on beds when a resident is never or rarely incontinent.

h. Enemas/Irrigation - Any type of enema or bowel irrigation, including ostomy irrigations.

i. Ostomy Present - Any type of excretory ostomy of the gastrointestinal or genitourinary tract. Do NOT code gastrostomies or other feeding "ostomies" here.

j. ***NONE OF ABOVE (Not Used on the MPAF)***