5. ACTIVITIES OF DAILY LIVING (ADLs) – FUNCTIONAL STATUS/REHABILITATION POTENTIAL

Review of Indicators of ADLs - Functional Status/Rehabilitation Potential

✓	**Possible underlying problems** that may affect function. Some may be reversible.	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☑	• Delirium (C1310) (clinical record and Delirium CAA)	**Nurses notes dated 10/1/22 indicate Mrs. Smith has had an acute mental status change, i.e., appears less sharp than usual. Activities notes dates 9/24/22 indicate that she has not been attending activities. CNA interview on 9/25 indicates that Mrs. Smith does not seem to make decisions about her daily needs as quickly as usual.**
☐	• Acute episode or flare-up of chronic condition (I8000, clinical record)	
☐	• Changing cognitive status (C0100) (see Cognitive Loss CAA)	
☐	• Mood decline (D0100) (clinical record and Mood State CAA)	
☐	• Daily behavioral symptoms/decline in behavior (E0200) (see Behavioral Symptoms CAA)	
☐	• Use of physical restraints (P0100) (See Physical Restraints CAA)	
☐	• Pneumonia (I2000)	
☐	• Fall(J1700) (from record and Falls CAA)	
☐	• Hip fracture (I3900)	
☐	• Recent hospitalization (clinical record) (A1700, A1800= 3, 4)	
☑	• Fluctuating ADLs (G0110A-J, G0120, G0300A-E, G0900) (observation, clinical record)	**Section G evaluation indicated that Mrs. Smith has had a decline in bed mobility, transfers and ambulation since the last assessment. Recently picked up by therapy on 10/4/22 related to decline in bed mobility, transfers and ambulation. See therapy notes dated 10/4 and following**
☐	• Nutritional problems (K0510A1, K0510A2) (clinical record and Nutrition CAA)	
☐	• Pain(J0700) (See Pain CAA)	
☐	• Dizziness	
☐	• Communication problems (B0200, B0700, B0800) (clinical record and Communication CAA)	
☐	• Vision problems(B1000) (observation, interview, clinical record, and Vision CAA)	
✓	**Abnormal laboratory values** (from clinical record)	**Supporting Documentation**
☐	• Electrolytes	
☐	• Complete blood count	
☐	• Blood sugar	
☑	• Thyroid function	**Abnormal TSH, T3 and T4 levels. See lab report dated 9/25/22.**
☐	• Arterial blood gases	
☐	• Other	

✓	**Medications** that can contribute to functional decline	**Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)**
☐	• Psychoactive medications (N0410A-D)	
☐	• Opioids (N0410H)	
☑	• Other medications – ask consultant pharmacist to review medication regimen to identify these medications	**Recent physician order change for dosage change for synthroid dated 10/1/22**
	Limiting factors resulting in need for assistance with any of the ADLs (observation, interview, clinical record)	**Supporting Documentation**
☑	• Mental errors such as sequencing problems, incomplete performance, or anxiety limitations	**Nurses notes dated 9/20 indicate that Mrs. Smith apepars less energetic and less mentally sharp than usual and that complains of feeling cold most of the time.**
☐	• Physical limitations such as weakness (G0110A–J.1 = 2,3, 4) (G0110 A-J.2 = 2, 3), limited range of motion (G0400A = 1, 2, G0400B = 1, 2), poor coordination, poor balance (G0300A-E =2), visual impairment (B1000 = 1-4), or pain (J0300 = 1, J0700 =1)	
☐	• Facility conditions such as policies, rules, or physical layout	
✓	**Problems resident is at risk for** because of functional decline (from observation, assessment, clinical record)	**Supporting Documentation**
☐	• Falls (J1700)	
☐	• Weight loss (K0300)	
☐	• Unidentified pain (J0700)	
☐	• Social isolation	
☐	• Restraint use (P0100)	
☐	• Depression(D0100)	
☐	• Complications of immobility, such as — Pressure ulcer/injury (M0210) — Muscular atrophy — Contractures (G0400 A, B = 1, 2) — Incontinence (H0300, H0400) — Urinary (I2300) and respiratory infections	

Input from resident and/or family/representative regarding the care area. (Questions/Comments/Concerns/Preferences/Suggestions)
Family Indicates that Mrs. Smith has had a diagnosis of Hypothyroidism for the last 45 years. She has had similar episodes of decline in the past that have precipitated medication adjustments.

Analysis of Findings		Care Plan Considerations
Review indicators and supporting documentation, and draw conclusions. Document: • Description of the problem; • Causes and contributing factors; and • Risk factors related to the care area.	Care Plan Y/N	Document reason(s) care plan will/ will not be developed.
Mrs. Smith has a current diagnosis of hypothyroidism that her family reports has been part of her history for 45 years. She is usually energetic and bright, usually able to make clear decisions about her daily needs. Recently Mrs. Smith has had a decline in her ADL function and has been become less energetic and less mentally sharp. She has not been to activities as much in the last week and she complains of being cold most of the time. Recent lab values indicate that she has had abnormal thyroid function and she has had a recent adjustment to her thyroid medication. She has begun a therapy regemen to address her recent decline in ADL function.	**Y**	**The IDT will proceed to care plan related to Mrs. Smith history of Hypothyroid disease and history of episodes of decline as reported by her family.**

Referral(s) to another discipline(s) is warranted (to whom and why): **_Referral to psych services due to recent mental status change. _____**

_____

☑ Yes ☐ No

Information regarding the CAA transferred to the CAA Summary (Section V of the MDS):

Signature/Title: ___*Billy Bob Johnson*_____ Date: ___10/7/22_____

Where rehabilitation goals are envisioned, use of the ***ADL Supplement*** will help care planners to focus on those areas that might be improved, allowing them to choose from among a number of basic tasks in designated areas. Part 1 of the supplement can assist in the evaluation of all residents that trigger this care area. Part 2 of the supplement can be helpful for residents with rehabilitation potential (ADL Triggers A), to help plan a treatment program.

ADL SUPPLEMENT
(Attaining maximum possible Independence)

PART 1: ADL Problem Evaluation INSTRUCTIONS: For those triggered - In areas physical help provided, indicate reason(s) for this help.	DRESSING	BATHING	TOILETING	LOCOMOTION	TRANSFER	EATING
Mental Errors: Sequencing problems, incomplete performance, anxiety limitations, etc. **Physical Limitations:** Weakness, limited range of motion, poor coordination, visual impairment, pain, etc. **Facility Conditions:** Policies, rules, physical layout, etc.						
PART 2: Possible ADL Goals INSTRUCTIONS: For those considered for rehabilitation or decline prevention treatment -				If wheelchair, check: ☐		
Indicate specific type of ADL activity that might require: 1. Maintenance to prevent decline. 2. Treatment to achieve highest practical self-sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in).	Locates/ selects/ obtains clothes	Goes to tub/ shower	Goes to toilet (include commode/ urinal at night)	Walks in room/ nearby ☐	Positions self in preparation	Opens/ pours/ unwraps/ cuts etc.
	Grasps/puts on upper lower body	Turns on water/ adjusts temperature	Removes/ opens clothes in preparation	Walks on unit ☐	Approaches chair/bed	Grasps utensils and cups
	Manages snaps, zippers, etc.	Lathers body (except back)	Transfers/ positions self	Walks throughout building (uses elevator) ☐	Prepares chair/bed (locks pad, moves covers)	Scoops/ spears food (uses fingers when necessary)
	Puts on in correct order	Rinses body	Eliminates into toilet	Walks outdoors ☐	Transfers (stands/sits/ lifts/turns)	Chews, drinks, swallows
	Grasps, removes each item	Dries with towel	Tears/uses paper to clean self	Walks on uneven surfaces ☐	Repositions/ arranges self	Repeats until food consumed
	Replaces clothes properly	Other	Flushes	Other ☐	Other	Uses napkins, cleans self
	Other		Adjusts clothes, washes hands			Other

Table 2. Clinical Problem Solving and Decision Making Process Steps and Objectives

Process Step / Objectives *	Key Tasks **
Recognition / Assessment *Gather essential information about the individual*	– Identify and collect information that is needed to identify an individual's conditions that enables proper definition of their conditions, strengths, needs, risks, problems, and prognosis – Obtain a personal and medical history – Perform a physical assessment
Problem definition *Define the individual's problems, risks, and issues*	– Identify any current consequences and complications of the individual's situation, underlying condition and illnesses, etc. – Clearly state the individual's issues and physical, functional, and psychosocial strengths, problems, needs, deficits, and concerns – Define significant risk factors
Diagnosis / Cause-and-effect analysis *Identify physical, functional, and psychosocial causes of risks, problems, and other issues, and relate to one another and to their consequences*	– Identify causes of, and factors contributing to, the individual's current dysfunctions, disabilities, impairments, and risks – Identify pertinent evaluations and diagnostic tests – Identify how existing symptoms, signs, diagnoses, test results, dysfunctions, impairments, disabilities, and other findings relate to one another – Identify how addressing those causes is likely to affect consequences
Identifying goals and objectives of care *Clarify purpose of providing care and of specific interventions, and the criteria that will be used to determine whether the objectives are being met*	– Clarify prognosis – Define overall goals for the individual – Identify criteria for meeting goals
Selecting interventions / planning care *Identify and implement interventions and treatments to address the individual's physical, functional, and psychosocial needs, concerns, problems, and risks*	– Identify specific symptomatic and cause-specific interventions (physical, functional, and psychosocial) – Identify how current and proposed treatments and services are expected to address causes, consequences, and risk factors, and help attain overall goals for the individual – Define anticipated benefits and risks of various interventions – Clarify how specific treatments and services will be evaluated for their effectiveness and possible adverse consequences
Monitoring of progress *Review individual's progress towards goals and modify approaches as needed*	– Identify the individual's response to interventions and treatments – Identify factors that are affecting progress towards achieving goals – Define or refine the prognosis – Define or refine when to stop or modify interventions – Review effectiveness and adverse consequences related to treatments – Adjust interventions as needed – Identify when care objectives have been achieved sufficiently to allow for discharge, transfer, or change in level of care

* Refers to key steps in the care delivery process, related to clinical problem solving and decision making
** Refers to key tasks at each step in the care delivery process

The care plan is driven not only by identified resident issues and/or conditions but also by a resident's unique characteristics, strengths, and needs. A care plan that is based on a thorough