



Nursing Home Quality Initiative

FAST FACTS: BEDFAST Overview

ISSUE 1

JUNE 2004

PREVALENCE

The prevalence of nursing home residents who are bedfast is estimated to be between 3.5% and 8%.

DEFINITION

Chapter 3 of the Revised Long-Term Care Resident Assessment Instrument User's Manual defines bedfast as all residents who are in a bed or recliner chair for 22 hours or more per day. On the MDS, this item is to be checked off when a resident is in a bed or recliner chair for 22 hours or more at least 4 times within a 7 day period.

RISK FACTORS

Care of the bedfast resident focuses on prevention, treatment and identification of risk factors. Risk factors associated with the bedfast condition include:

- Decreased socialization
- Depression
- Decrease in activities of daily living (transfers, dressing, toileting and eating)
- Pressure ulcers/skin breakdown
- Bladder and/or bowel incontinence
- Constipation
- Decreased muscle tone with an increased risk of contractures
- Hip, vertebral or pelvic fracture
- Increased depression/anxiety
- Cancer (abdominal, breast and pelvic)
- Cardiovascular and respiratory problems (CVA, CHF, COPD)
- Metabolic issues
- Delirium
- Infections (cellulitis, sepsis)
- Medication side effects (Digoxin toxicity, Phenobarbital, Prednisone)
- Gastrointestinal problems
- Multiple concurrent medical problems

BARRIERS TO PREVENTION/TREATMENT

Barriers related to prevention and treatment of individuals who are bedfast include:

- Lack of physical rehabilitation programs
- Lack of social interaction, especially when resident is ill/isolated due to illness
- Improper diagnosis/treatment of depression



**BARRIERS TO
PREVENTION/
TREATMENT
(CONT.)**

- Improper treatment of pain
- Lack of staff time to engage in preventive measures (i.e. Residents who have the potential to walk are wheeled by staff in an effort to save time)
- Lack of skills and/or protocols to assess for risk factors

**FURTHER
READING AND
WEB
RESOURCES**

A more detailed overview of the bedfast condition can be obtained by contacting your state Quality Improvement Organization (QIO). Visit http://www.ahqa.org/pub/connections/162_694_2450.cfm for contact information for your state QIO.

Clark LP, Dion DM, Barker WH. Taking to bed rapid functional decline in an independently mobile older population living in an intermediate-care facility. *J Am Geriatr Soc.* 1990;38(9):967-72.

Fries JF. Aging, natural death, and the compression of morbidity. *N Engl J Med.* 1980;303:130.

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Selikson S, Damus K, Hamerman D. Risk factors associated with immobility. *J Am Geriatr Soc.* 1988;36:707.

Wright WB. How to investigate an old person. *Lancet.* 1978;2:419.

Quality Measures Resource Manual, January 2004, Version 4.0, 6E:1.

Available at:

<http://www.medqic.org/content/nationalpriorities/nursinghome/nhMeasures.jsp?topicID=413> Last accessed 6/7/2004.

Revised Long-Term Care Resident Assessment Instrument User's Manual, December 2002, Version 2.0, 3:112. Available at:

<http://www.cms.hhs.gov/medicaid/mds20/raich3.pdf> Last accessed 6/7/2004



WHAT IS SCREENING?

A question or test to determine if a person may or may not need further evaluation for a problem or condition. If the result of the screening is positive, it should trigger a comprehensive evaluation of a resident’s problem or condition. If the result is negative, the facility should conduct periodic re-screening.

KEY STEPS IN SCREENING

- Assign a person who will assume responsibility for screening and any follow-up (i.e. in-depth evaluation)
- Utilize a standardized screening tool to identify potential risk factors (see Fast Facts: Bedfast Overview)
- Based on screening results, perform an in-depth evaluation of the resident or develop a schedule for regular re-screening (See Fast Facts: Evaluation)

CRITERIA FOR DETERMINING BEDFAST

The resident remains in a bed or recliner within his or her room for 22 or more hours per day for at least four days over a seven day period

COMMON ERRORS RELATED TO SCREENING CRITERIA AND CODING THE MDS

- Some common errors which are frequently miscoded as bedfast include:
- Resident is wheelchair-bound - a resident who is wheelchair-bound should not be coded as bedfast, as the definition is limited to bed or recliner use
 - Resident is ambulatory - even if a resident is independently mobile, they could be considered bedfast, and should be coded as such, if they meet the definition of bedfast as stated in the MDS
 - Resident chooses to remain in bed or in a recliner - a resident may desire to remain bedfast despite the best attempts of the facility; however, if a resident meets the bedfast criteria, they must be coded as such



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Shephard, R. Nursing Facility Enhanced Quality Measures: Strategies for Successful Performance, Second Edition. February 2004;107-11. Purchase information available at <http://www.med-pass.com/> Last accessed 6/7/2004.

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FAST FACTS: BEDFAST *Evaluation*

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EVALUATION OF THE BEDFAST

Evaluation of the bedfast resident should include at a minimum:

- Major medical and psychiatric diagnoses
- Current medications
- History of recent acute episode/hospitalization
- Prior mobility status
- Current neurological, musculoskeletal, visual, mental and psychological status

KEY STEPS IN EVALUATION

- Positive screen for risk factors has been performed and is positive
- Resident is coded as bedfast according to Item G6a on MDS
- Referral to MD and/or licensed therapists (PT, OT) for help with evaluation as appropriate
- Identification of factors that may be reversible
- Development of a schedule for on-going monitoring and re-evaluation

COMPLICATIONS AND POTENTIAL REMEDIES

Since the bedfast resident can experience a multitude of complications, it is essential that the multidisciplinary team work together to institute plans of care
Possible complications include:

- Loss of muscle tone leading to orthostatic hypotension - Simple range of motion exercises, and changing the resident's position from supine to erect posture can help stabilize blood pressure as well as keep resident muscle tone stable and joints flexible (helping avoid another complication - contractures).
- Tachycardia, especially among residents who have had a stroke or suffer from cardiovascular problems - Minimize Valsalva maneuver by controlling constipation, assisting in bed mobility as needed, etc.
- For those residents who can move their upper body or lower body, evaluate for ability to use assistive devices to help maintain some self-movement (i.e. overhead trapeze).
- Decrease isolation by allowing for resident interaction with other residents, staff or visitors by moving the resident out of his/her room (if the resident does not refuse) and/or by providing a safe alternative to a recliner chair (i.e. wheelchair, straight chair) for certain hours of the day.



**COMPLICATIONS
AND POTENTIAL
REMEDIES
(CONT.)**

- For residents who refuse to get out of bed or recliner, the facility should make every effort to identify, with the resident and/or family if possible, if there are any underlying causes that can be treated or reversed (i.e. depression, adjustment to nursing home placement, feeling of loss, etc.).
- The facility should provide any care and services needed so that the resident remains at his/her optimum level of function, has opportunities for socialization and has potential complications addressed.

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