

**Kansas Advocates
for
Better Care**

Promoting Resident-Centered Care and Restorative Care

to enhance resident well-being, and as a means to prevent abuse, neglect and exploitation



Funded by a 2008 Workforce Enhancement in Nursing Facilities grant
from *The Kansas Department on Aging*

Table of Contents

Introduction to Resident-Centered Care	4
• Five core principles	4
What is Resident-Center Care for Older Adults?	6
Culture Change	8
Intersection of Quality of Care with Quality of Life through a Resident-Centered Care Approach	11
Introduction to Restorative Care	14
• Identification of decline - mental, physical, emotional	16
• Appropriate response to decline (engage, report, encourage)	17
• Stress management strategies for residents and caregiving staff	18
Restorative Care Exercises and Indicators	20
• Neck exercises	22
• Trunk exercises	23
• Shoulder exercises	24
• Posture exercises	25
• Foot and leg exercises	26
• Hips exercises	27
• Standing exercises for legs and hips	28
• Hand and finger exercises	29
• Breathing, Balance and Mobility	30
Risk Factors for Predicting Abuse, Neglect and Exploitation	32
Residents and Staff	33
Indicators of Abuse, Neglect and Exploitation	
• Active and Passive Neglect	34
• Psychological Abuse	35
• Physical Abuse	35
• Financial Exploitation	36
• Sexual Abuse	36
• ANE Regulations	37
Resources and Acknowledgments	38

Introduction to Resident-Centered Care

Resident-Centered Care and Restorative Care approaches attempt to break the cycle of dependency and functional decline in nursing homes by addressing individual resident needs. Led by human compassion, facilities are applying common sense approaches to living and caring for elders and to creating long-term care communities where elders choose to live their lives with staff who enjoy assisting them.

Traditional models of nursing home care focus on providing food, shelter and medical attention. But the times they are a-changing. Current residents, their families and certainly the Baby Boomers who will reside in long-term care facilities, desire and are asking for a different approach. Changes center around greater participation by residents in how they live out each day, how they are cared for each day and maintaining maximum independence and choice along the way. Oh yes, and residents want what we all want - relationships and activities that make life worth living - a reason to get up in the morning and to keep on with living. Residents want life in long-term care facilities to be an opportunity to *thrive*, not just survive.

New models in long-term care delivery focus on putting the “HOME” in nursing home. A place where we live comfortably in the familiar, are surrounded by people who care about our well-being, and are able to access things of interest to us in community. Focusing only or even primarily on physical well-being falls far short of how Quality of Care and Quality of Life are now defined. “Person-centered or resident-centered” care are words used to describe this concept.

Nursing homes are changing into personal communities, and away from wards or wings or long hallways. Hopefully they are staffed by familiar caregivers who are there to help their community’s residents live lives of meaning value and joy. Resident-centered homes have private spaces and family places and a chance to continue to live life with some measure of independence and responsibility. Each day is informal, like a day in our own homes, and results in a truly rewarding and satisfying daily life for elders and staff alike. It is not home-like. It is *home*.



Resident-centered care reflects a change of culture. **Culture Change** is a new philosophy that seeks to transform the medical model of care delivery to one that seeks to provide care to elders through a community or relationship-based model of care. It focuses on placing the person before the task in care delivery and empowering caregivers to develop relationships with residents while encouraging residents to develop relationships with each other.

5 Core Principles of Culture Change:

- Respect
- Empowerment
- Community
- Relationships
- Choice

Introduction to Resident-Centered Care

Respect - Each member of your facility's community regardless of their role in the home is part of the care team with valuable ideas and opinions. All have the right to voice views, ideas, and opinions. Each person's views should be heard before decisions are made.

Empowerment - All members of the community, regardless of role in the home, need to feel as though they make a difference. All are recognized as valued, contributing members of the community.

Choice - Residents and workers in long term care communities function best when given a range of options that reflect personal preference. Having residents and/or workers buy into management directed policies is not choice.

Relationships - Relationship building should be an ongoing activity within each home. This includes strengthening the bonds among residents, among workers (at all levels), and between residents and workers.

Community - A primary goal of Culture Change is the ability of nursing homes to evolve from a hospital-like environment to a true community. The phrase, "Would I do this in my own home?" should never be far from your thoughts. Along with medical care, residents' social, emotional, spiritual, cognitive, and cultural needs should receive equal attention. Staff is viewed as complete individuals versus the more traditional view of identifying workers with the tasks they perform.

Change that promotes independence, choice, and empowerment is balanced with organizational and regulatory requirements.

The best way to view Culture Change is as the foundation and building blocks used for giving concrete form to our desire to improve the quality of life for residents and the staff who provide care to them.

The cornerstone of resident-centered care is getting to know a resident so that you understand not only what s/he needs but also how s/he best learns, what s/he likes to eat, what s/he's good at mentally and physically, where s/he could improve mentally and physically. A critical piece of person-centered care is the building of meaningful relationships. We all build relationships throughout our lives, with family, friends, co-workers, and others. The need to be in relationship with others never goes away. When we go to school we look for new friends, when we socialize we look for new friends, when we move to a new home/community we look



for new friends. When we move to a nursing home, we look for new friends in other residents or staff or visitors. The strongest bonds between people grow out of sharing the joyful and the difficult times of life with each other. You will now be the people most often sharing those experiences day to day. As a staff person in a nursing home, you have the opportunity to help older adults develop meaningful relationships in several areas: with Self, with Spirit/God, with new friends, with staff and with the larger community. These relationships will keep an elder's life rich.

"Respect your fellow human being, treat them fairly, disagree with them honestly, enjoy their friendship, explore your thoughts about one another candidly, work together for a common goal and help one another achieve it."

~ Bill Bradley (basketball great, and Senator from New Jersey)

What is “Resident-Centered Care” for Older Adults?

Resident-Centered Care Is About:

- *Building relationships with older adults, and helping residents find common ground for the development of new friendships.*
- *Providing older adults with opportunities to participate in all decisions about their lives.*
- *Encouraging older adults to dream dreams, and achieve goals and desires.*
- *Making sure older adults know about all support, treatment and service options.*
- *Ensuring ways to let older adults express needs, desires and preferences, and to make choices.*
- *Creating opportunities to get feedback from older adults on how things are working, and being responsive to the feedback.*
- *Respecting the dignity and humanity of each older adult.*
- *A decent, kind, and thoughtful way to serve older adults.*
- *Making the lives of older adults and the caregivers who work with them more meaningful.*
- *Making caregiving more rewarding.*
- *Allowing older adults more reasons to feel alive and involved.*

RESIDENT-CENTERED CARE IS ABOUT TREATING OLDER ADULTS THE SAME WAY WE WANT TO BE TREATED.

- *Every person has strengths, gifts, and contributions to share.*
- *Every person has hopes, dreams and desires to live.*
- *Each person, and those who love the person, are the primary authorities on his or her life.*
- *Every person has the ability to express preferences and to make choices.*
- *A person’s choices and preferences shall always be considered.*
- *Finding the natural supports that help improve the person’s quality of life by:*
 - *Maximizing independence*
 - *Creating connections with others*
 - *Working toward achieving the person’s dreams and goals*
- *Resident-centered care is a continuing process of:*
 - *Listening*
 - *Trying things*
 - *Seeing how they work*
 - *Changing things as needed*



What is “Resident-Centered Care” for Older Adults? (*continued*)

How do we discover the hopes, dreams & desires of older adults?

- Ask!
- Listen:
 - ♥ Believe that the person has something to give and is of value.
 - ♥ Help people discover their gifts.
 - ♥ Listen with an open mind and heart.
 - ♥ Listen to dreams and visions, not just to what is in the present.
 - ♥ Listen without rushing.
 - ♥ Listen to fears and pain.
 - ♥ With no intent to fix or control anyone.
 - ♥ For words that actions may not reveal.
 - ♥ Listen to recognize opportunities.
 - ♥ Knowing that things take time.

Take the time to notice

- ☆ What makes the person happy or sad, angry or fearful?
- ☆ What comforts or calms the person?
- ☆ What triggers difficult behavior?
- ☆ Ask those who know the person best.
- ☆ Share what you learn with others.

Notes

Culture Change/Resident-Centered Care

• Care Practices in nursing homes

The Past - Where we've been	Where we're going	How to get there	Tools for change
1) <u>Institutional model</u> <i>Residents adapt to us.</i>	<u>Resident</u> -driven systems. <u>WE</u> adapt to the Resident.	Create systems to provide individual choice and participation.	<ul style="list-style-type: none"> • Resident makes decisions about: • Waking/sleeping • Meal times • Food preferred • Daily routine
2) Public perception is "Nursing homes are a place to die."	Celebrations that acknowledge resident's ongoing life. Next chapter of a life unfolding	Establish an environment that provides residents and staff the opportunity and resources to thrive, flourish and grow.	<ul style="list-style-type: none"> • Bathing frequency, time & method • Activities of Daily Living (ADLs) • Recreational Activities of Choice
3) Residents need others to "do for" them.	Individuals accept risks, challenge, and choice.	Promote abilities and optimal level of function for all.	<ul style="list-style-type: none"> • Share joyful events • Celebrate all successes • Day-to-day life provides opportunity for meaning & purpose
4) Medical model -- building is hospital-like.	Create the most homelike setting possible.	Support and integrate quality of life with quality of care, focusing on the resident-centered model.	<ul style="list-style-type: none"> • Residents have the opportunity to give, teach, offer, share • Resident can live life and make choices based on individual ability • Consideration of the "whole person" in all decisions - spiritual, mental and physical well-being.

*Don't dwell on what went wrong. Instead, focus on what to do next.
Spend your energies on moving forward toward finding the answer. ~ Denis Waitley*

Culture Change/Resident-Centered Care (*continued*)

• Workplace Practice


The Past - Where we've been	Where we're going	How to get there	Tools for change
5) Assuring Quality	Improving Quality	Customer service and satisfaction approach. Ongoing training for all staff.	<ul style="list-style-type: none"> • Make decisions based on resident surveys and feedback. • Commitment to improving quality. • Look for innovative ways to improve care.
6) It's about doing the job.	Relationship-based practice: it's about what works for the resident and the staff. It's about the person.	Create environment where relationships are important. <i>Care staff, family and resident are the same team</i>	<ul style="list-style-type: none"> • Build meaningful and lasting relationships between staff, residents & family. • Allow consistency in staff assignments. • Staff is visible and known by everyone. • Invest in staff - time, education and commitment to personal goals.
7) The owner, administrator and DON decide how things will be run.	Everyone participates in determining what works and how to change how things will run.	Empower resident and staff to have a voice in improving their home and lives.	<ul style="list-style-type: none"> • Create team driven organizations. • Establish self-managed work teams, for individuals to lead and take greater responsibility. • Promote an environment of decision-making by all team members. • Support a setting where opportunity to better the facility & individual's lives are most important.

Teamwork divides the task and multiplies the success. ~ Author Unknown

Culture Change/Resident-Centered Care (*continued*)

The Past - Where we've been	Where we're going	How to get there	Tools for change
8) Units and departments are separated by role and function.	<p>Integrated work teams.</p> <p>Cross-training of workers.</p> <p>Universal Workers.</p>	<p>Create teams to guide the facility into the best possible care, work, and environmental practice.</p>	<ul style="list-style-type: none"> • Everyone speaks. Everyone listens. • Integrated Care Team-CNAs generate the basis of care plan, and function as equals on the care plan team. • Inclusive decision making process with staff, residents & family.
<p>9) "We've <i>always</i> done it this way!"</p> <p>"We have to do it this way!"</p>	<p>Open to change for a good end result.</p>	<p>Embrace change for positive outcomes.</p> <p>Sharing and learning together.</p>	<ul style="list-style-type: none"> • Engage everyone to develop new ideas for care. • Explore and share the best practices that work. • Teach and lead others within the nursing home community. • Provide training, learning & skill building opportunities. • Create many paths for feedback.

• Environment

<p>10) Hospital environment.</p> <p><i>Alone, cut off, and lonely.</i></p> 	<p><u>HOME</u> Environment.</p> <p>Community and belonging.</p>	<p>Commit to make the current setting less institutional.</p> <p>Provide personal living space, a sense of peace, safety, and community.</p>	<ul style="list-style-type: none"> • Establish a home that provides sense of community, safety and peace. • Support individualized personal environment. • Design for accessibility. • Reduce barriers. • Provide for nature, and natural settings. • Make rooms homelike. • Demonstrate affection, validation, support. • Encourage personal items that reflect individuality. • Provide places for reflection and solitude. • Shift toward neighborhoods & communities.
--	---	--	---

Adapted from <http://dhh.louisiana.gov/offices/publications/pubs-112/How to Implement Culture Change>

Intersection of Quality of Care with Quality of Life through a Resident-Centered Approach

Nursing facilities in Kansas are entrusted and empowered to assist residents with *maintaining* and *attaining* her/his highest practical level of physical, mental, and psychosocial *well-being*. The care plan and comprehensive assessment guides the nursing staff as they provide care and services to each individual. Person/Resident-centered care plans are developed through the participation of the individual, the CNAs that work mostly closely with the individual, the LPNs, RN, DON, and include input from family members and staff who may have helpful information to contribute. The resident's goals are incorporated into the care plan along with those of the care team. Each person's ability to perform activities of daily living (getting in and out of bed, dressing, bathing, eating and using the bathroom) are expected to remain the same or improve with the consistent assistance of nursing staff. The exception to this is when the person's clinical condition creates unavoidable decline.

Never do for others what they can do for themselves. **Restorative care** activities can be passive or active. Either type of restorative care can be done with a resident based upon the judgment of and under the supervision of a licensed nurse and does not require a specific physician's order.

Active restorative care is done when you remind the resident to do certain activities that help with **range of motion, balance, strength and/or mobility**. This is often done while you or the resident is accomplishing other things. For example you are walking down the hall and you notice that a resident is sitting in a chair but her head is leaning heavily toward her shoulder. You step into her room, greet her, make clear eye contact with her and suggest that if her neck is going to hold up the weight of her impressive intellect that she might want to straighten her spine and neck. Encourage her to do five chin tucks (see page22).

Passive restorative care is when you assist someone in completing an activity for **range of motion, balance, strength or mobility**. Passive restorative care can be provided by nurses or CNAs at the order and under the supervision of a licensed nurse. An example might be that in Mr. Juarez' plan of care he has identified that he wants to strengthen his lower body to facilitate his getting in and out of bed alone. So while he's in bed or sitting in a chair, position yourself at his feet and suggest that he lift his leg and bend his knee toward his chest to the point of comfort and push against your outstretched hands while you offer gentle resistance, holding to the count of three.

A lot of us don't like exercise, so it is often helpful to tie the activity that you are suggesting or assisting with to the person's increased level of functioning.

Helpful communication techniques:

- Position yourself in front of the person you're talking with.
- Make direct eye contact.
- Place yourself at their eye level.
- Use gestures if helpful for the person's understanding.
- Treat as an equal.
- Make directions simple, do one part of a task at a time.
- Always show respect.
- Create a calm environment. Turn off TV or radio.
- Use humor and appeal to their sense of humor.

Intersection of Quality of Care with Quality of Life through a Resident-Centered Approach (*continued*)

- Encourage independence.
- Assess for changes daily.
- If a decline becomes permanent, change what you do to help **facilitate independence** in every way that you can. It will lessen your workload and it will provide opportunities to continue functioning at the person's highest level. Always **be positive** and **praise** the person for her/his successful attempt or completion of a restorative care activity. It will make her/him more confident in her/his abilities, promote a sense of positive self worth and encouragement for succeeding at higher levels of challenge.

Quality of Care State and Federal regulations give clear guidance on what the *quality of a person's care* will be, including the need for:

- Care and services that maintain or improve a person's level of functioning.
- Care and services that provide care for persons unable to complete needed tasks on her/his own.
- Bathing, skin care, cleanliness and control of body odor.
- Ensuring that dentures and the oral cavity are clean.
- Dignified dressing and grooming.
- Availability of food and drink to maintain hydration, usual body weight and nutrition.
- Monitoring and appropriate intervention for persons at risk of malnutrition.
- Care that ensures continence, unless prohibited by a clinical condition.
- Care that ensures the integrity of skin and avoids the development of pressure ulcers.
- A hazard-free environment to avoid injury.

Quality of Life is important to all of us, including individuals whose current home is in a nursing facility. Over a lifetime, we each discover the routines that promote our best functioning. We find we have distinct preferences for bedtime, rising time, number of sleep hours; foods and times to eat, amounts and how often we eat; what colors we look best in, what we like to wear; whether we have a small group of close friends or love to meet new people all the time; want a set routine or like for things to change often. This is true for every person who calls a nursing facility *home*.

Person/Resident-centered care **does not add** more to your workload. Person/Resident-centered care simply **allows each resident to choose** or have significant choice in how s/he lives each day in her/his home. When she rises, what he wears, what food has appeal for breakfast or lunch or dinner, who would she like to interact with, how does he choose to occupy his time, does she have an appointment with a hair stylist, would he like a shower, bath or washcloth bath at the sink...*these are some of the choices that make us feel that we have a positive or negative quality of life*. If a resident is not able to tell you her/his preferences, it is important to find out from a family member what the resident's routines were when they were living on their own. Being able to choose our own routines, engage in activities that we enjoy or that interest us, eat food that we find appetizing, build friendships with persons who we find appealing are all important ingredients for the quality of life we'd like to have.

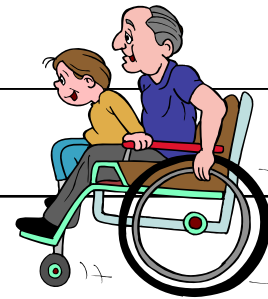
Intersection of Quality of Care with Quality of Life through a Resident-Centered Approach *(continued)*

It's not only about living or dying but about thriving!

How satisfied would you be with your life if you got up when someone else told you to, dressed in what someone else had laid out for you, ate what other people thought was tasty at a time that someone else chose and had available to do only what someone else had arranged for you? How motivated would you be to carry on? For most of us, this situation would not be appealing.

*To thrive, each human being needs something to do,
someone to love, and something to hope for.*

Notes



Alone we can do so little; together we can do so much. ~ Helen Keller

Introduction to Restorative Care

Restorative care does refer to activities that promote older adults' ability to **adapt** and **adjust** to living as independently and safely as possible. Restorative care does not refer to activities carried out by or under the direction of a physical therapist. Restorative care includes walking and mobility exercises, dressing, personal/self care, eating, swallowing, transfer and communications skills. Active or passive movement by a resident that is incidental to dressing, bathing, etc., does not count as part of a formal restorative care program. Restorative care focuses on remaining strengths and abilities, not limitations, creating short-term, moderate and realistic/achievable goals, modifying the environment to enable success (mirrors, set-ups, etc), using assistive devices to enhance self-care abilities (weighted cups, special tooth brushes, suction cup on bottom of cosmetics).

The ultimate goal is to maintain each person at her/his highest level of functional ability. What that level of functional ability is, of course will be different for each older adult. Once a skill is learned the older adult will need to use it or lose it.

All staff can participate in encouraging residents in optimal functioning. Staff will engage with residents based on staff's level of knowledge of each individual. Change begins with you, and what matters is what you do from this moment forward.

Role of caregiver:

- Observe what older adult can do
- Modify environment to enhance older adult's functional abilities
- Provide appropriate assistive devices
- Provide appropriate verbal and physical prompts
- Model or demonstrate self-care activity for older adult with short, clear directions
- Praise attempts and successes
- Be aware of the older adult's level of fatigue (use gait belt, or place wheelchair nearby to avoid falls)

Promote Success

Prepare older adult for activity: minimize distractions, make sure older adult has hearing aid in and glasses on before beginning activity. Restorative activities can be general or task specific. Both are helpful and build confidence and function.

Mobility is critical for all personal care functions. Mobility in the upper body is required to complete ADLs: eating, bathing, grooming, dressing and toileting. Mobility in the lower body is required to complete ADLs: toileting, transfers, walking, dressing and movement. To safely accomplish restorative care, the exercise space should be clear of obstacles, well-lighted (reduce glare), shoes and clothing that assist with stability and flexibility, and assistive devices as needed.

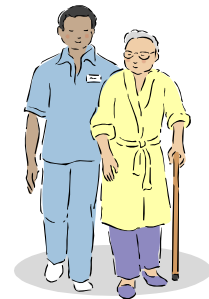
“Our residents don't live in our facility, we work in their homes.” Quote from nursing home staff-person.

Restorative Care *(continued)*

Maintain Maximum Function - Identifying Decline

Learning to identify when a resident begins to decline - mentally, physically, or emotionally - is critical to maintain his/her well-being. All staff have varying degrees of contact with individual residents. Use the following criteria to guide you in your observations.

- Has she had more difficulty than usual getting dressed in the morning or undressed at night?
- Has he lost strength or range of motion in his upper body (arms, neck, etc.) or lower body (back, legs, feet, knees, etc.)?
- Does she have a hard time getting in and out of her shower or bathtub?
- Is it difficult for him to get in or out of bed, or up or down from a chair?
- Has she not been walking as much or as far as she usually does?
- Does he have a difficult time getting off of or on to the toilet?
- Is it difficult for her to use her hands for tasks such as opening lids, buttoning blouse, writing, cutting food, or picking up things?
- Does he leak urine or frequently not make it to the toilet?
- Are her hands or wrists starting to look deformed?
- Does he often get short of breath or overly exhausted during activities such as walking, cooking, dressing or bathing?
- Does she ever cough when drinking liquid?
- Has his vision become worse, making it more difficult to enjoy the things he likes to do?
- Does she have a new need for any adaptive equipment, such as a walker, wheelchair, grab bars, toilet riser, bath bench, reacher, sock aide, etc.?
- Does he ever have difficulty swallowing pills?



Resource: Modified version of Lawrence Therapy Services Screening Tool.

Restorative Care *(continued)*

Appropriate staff response to noticed resident decline.

- Observe
- Engage
- Share
- Empower
- Restore

Observe Look at the resident's movements, listen to what s/he says to gather information.

Engage Talk with the resident, gently inquire about what you've noticed.

Share Discuss what you've noticed and learned with other team members. Report and record.

Empower the resident to act on his/her own behalf.

Restore maximum functioning, with or without assistive devices.

Encouragement - an important ingredient in success.

- Great job.
- Keep up the good work.
- It's wonderful to see all you've accomplished.
- Look how strong you are getting.
- Wow, you are amazing.
- Look at your steady gains.
- Don't worry - everyone has an off day.
- You're going to give me a workout.
- Look at how well you're doing this.
- You've really improved.
- That's a great stretch.
- I bet it feels good to be able to ...
- Very impressive!

Success builds confidence.

Restorative Care (*continued*)

Stress management for residents and staff

Three of the best stress coping techniques are:

- Deep breathing
- Exercise
- Supportive relationships

All three are key parts of a resident-centered and restorative care approach. As you enhance resident well-being, you will also enhance your personal well-being.

Stress management strategies

Life strategies:

- Eat a well-balanced diet; reduce or eliminate caffeine.
- Get enough sleep (6-8 hours); take naps.
- Exercise regularly (1/2 hour, 3-4 times a week).
- Schedule leisure activities; develop a hobby.
- Do not rely on cigarettes, drugs or alcohol.
- Do something to unwind between work and home.
- Learn about meditation and relaxation exercises and build them into your life.
- Seek professional help if your stress-related symptoms just won't go away.

On the job strategies:

- Walk away from the situation (only if the resident is safe).
- Ask a co-worker for help.
- If you see negative or escalating interactions, approach quietly and ask if you can help.
- Count to ten.
- Take three deep, slow breaths.
- Sit down (this is especially helpful if you cannot leave the resident's room).
- Discuss the problem with a co-worker or supervisor.
- Repeat a saying in your mind that helps you to stay calm (a prayer or song).
- Limit overtime.
- Remember, it is often the situation that is the problem. Try not to personalize.
- Work with your supervisor to rotate assignments of residents whose care is difficult.
- Schedule time off.

Special connections-residents and staff

Each of you have worked or will work with older adults with whom you share a special bond. It may be a bond of the heart, a shared interest, humor, or history. Making a point to have regular interaction with her/him will contribute to a positive view of life.

The Abuse Prevention Project - Philadelphia, PA. © CARIE 1999

Communication & Observation

Preventing abuse, neglect and exploitation (ANE) of frail elders requires more than merely learning about the legal definitions and examples. ANE can be avoided by using a compassionate approach to frail elders, so that any interactions are initiated from the point of view of the frail elder. Observe the frail elders' behaviors; their behaviors are ways of expressing what they are experiencing and feeling.

Communication as a means to prevent ANE

- Look at the resident; make eye contact and block out other distractions.
- Acknowledge what the resident says.
- Focus on the resident's needs, not on your own needs.
- Use a gentle touch to gain the resident's attention or offer support. Accept the same from residents.
- Approach the resident in a slow, non-hurried manner from the front.
- Call residents by names they prefer.
- Encourage residents, even if s/he can't talk.
- Avoid talking over a resident to talk with someone else.
- Be respectful of residents' belongings and space.

Observe Behaviors

If you observe **new onset** or a **change in behavior**, watch for underlying causes such as:

- Drug toxicity
- Eyes/ears, sensory impairment
- Metabolic disturbance or endocrinopathy
- Emotional disturbances, especially depression
- Nutrition deficiency
- Tumors, trauma to the head
- Infection
- Arteriosclerosis, including vascular disease
- Share what you observe with responsible team members.



Coming together is a beginning. Keeping together is progress. Working together is success. ~ Henry Ford

Restorative Care Exercises

Maintenance: 15 minutes of the following activities help maintain individual functioning. The total time can be completed in one sitting or in five-minute blocks. The following exercises can help improve upper and lower body strength, mobility and flexibility.

Key for use with exercises

VIP (Very Important for Posture) - This exercise will help maintain or improve posture.

Osteoporosis - this exercise may be helpful in preventing osteoporosis.

ROM (Range of Motion) - This exercise will improve or maintain joint range of motion or flexibility.

Strength - This exercise will help increase or maintain muscle strength. Muscle strength can occur if a ROM exercise is done against gravity, if the muscle is held tightly contracted for six seconds.

Endurance - This exercise helps decrease muscle tension. It's good to incorporate deep breathing when doing relaxation exercises.

ADL (Activities of Daily Living) - These are sample activities of daily living that may be improved by doing this exercise.

Notes

Upper Body & Trunk

Jaw exercises

Position: Lying, sitting or standing.

Jaw Open Wide (jaw range of motion)

- Open mouth slowly
- Hold three seconds
- (NOTE: A three-finger opening is functional)
- Say out loud: "A E I O U"

Indications

- ADL - eating, yawning, laughing
- Voice and swallowing

Precautions

- Joint surgery



Jaw forward (jaw range of motion)

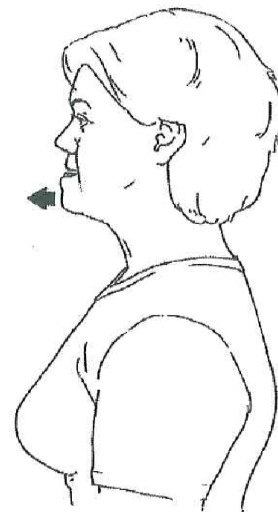
- Move lower jaw forward (careful not to jut neck out)
- Hold three seconds
- Relax

Indications

- ADL - eating, yawning, laughing

Precautions

- Joint surgery



Upper Body & Trunk

Neck exercises

Position: Lying, sitting or standing erect with arms relaxed at sides or in lap.

Chin Tucks (axial extension)

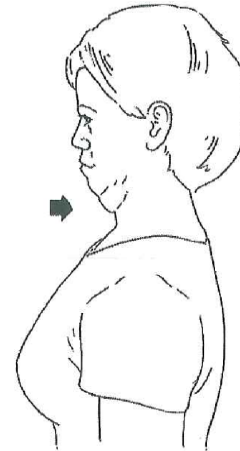
- Look straight ahead
- Glide neck back to make a double chin
- Hold three seconds
- Relax

Indications

- VIP
- Osteoporosis
- ROM

Precautions

- Dizziness
- Neck Pain



Head Turns (rotation)

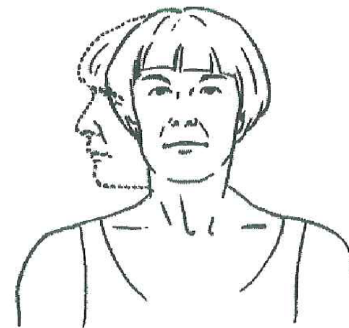
- Look straight ahead
- Turn head to look over shoulder
- Hold three seconds
- Return to front
- Repeat to other side

Indications

- ROM
- Relaxation
- ADL-driving, dressing, cleaning

Precautions

- Dizziness
- Neck pain



Upper Body & Trunk

Trunk Exercises

Position: Sitting or standing.

Side Bends (lateral flexion)

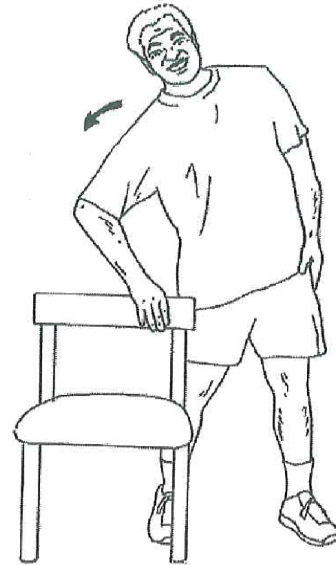
- Hold on to back of chair if standing
- If sitting, hold on to the arm of the chair
- Lean trunk sideways, slowly bending at the waist
- Repeat to other side

Indications

- ROM
- Strength
- ADL - reaching to floor or under table

Precautions

- Osteoporosis
- Balance
- Back pain



Side Bend with Overhead Arm (shoulder flexion/lateral trunk flexion)

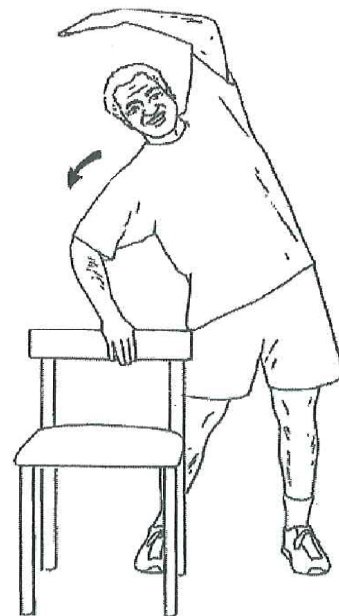
Same as **Side Bend**, except raise one arm overhead as you bend to opposite side.

Indications

- ROM
- Strength

Precautions

- Osteoporosis
- Back pain



Upper Body & Trunk

Position: Lying, sitting or standing.

Shoulder Circles (scapular range of motion)

- Move shoulders slowly in a circular motion (forward, up, back and around)
- Arms at sides and facing forward, lift shoulders toward ears with inhale
- Hold for up to five seconds
- Exhale and relax shoulders back down.

Indications

- ROM
- VIP
- Osteoporosis

Precautions

- None



Hug yourself (combination elbow flexion/shoulder horizontal movements)

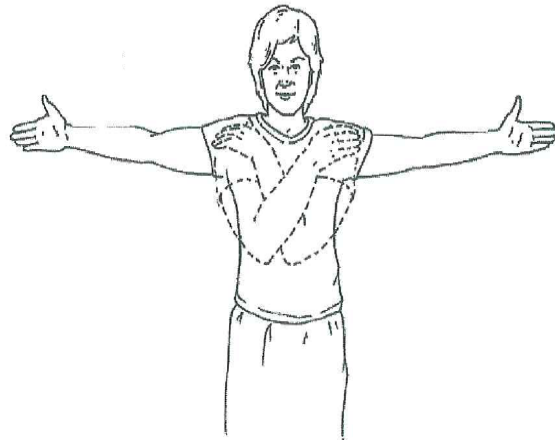
- Position arms out as in drawing
- Bring arms together, touching opposite shoulder as a hug
- Repeat with other arm on top

Indications

- ROM
- ADL - Eating, dressing

Precautions

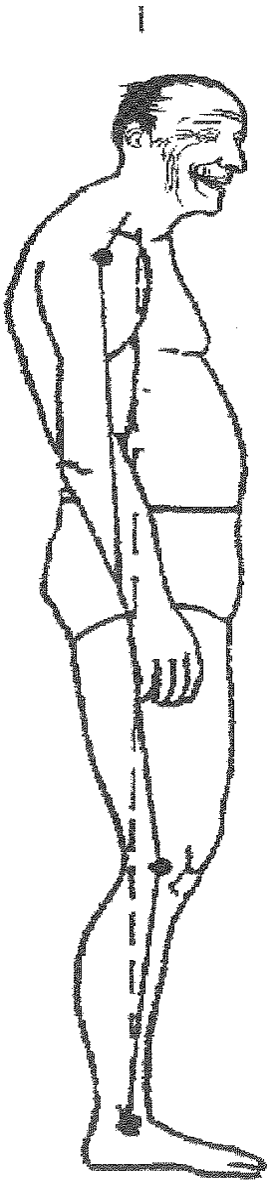
- None



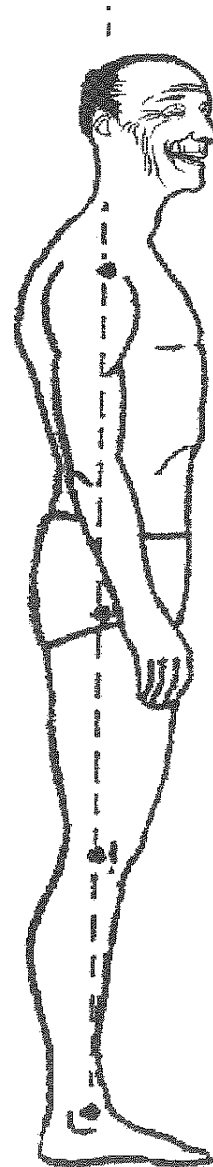
Exercises for Whole Body

Posture Exercise

A good way to practice posture is to position yourself up against a sturdy wall. Follow the guidelines below, while imaging yourself getting taller, as if someone had a string attached to your head and are pulling you upwards.



1. Stand up tall against the wall.
2. Roll your shoulders slightly backwards.
3. Elevate your chest.
4. Tighten your abdominal muscles.
5. Tighten your buttocks.
6. Keep your knees parallel to each other.
7. Support weight equally on both feet.
8. Stretch trunk upwards.
9. Are you getting any taller?
10. Do several times a day.



Legs, Feet and Hips

Foot/Leg Exercises

Position: Sitting or lying.

Ankle Circles

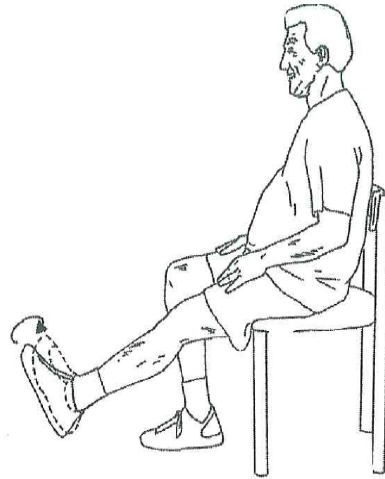
- Sit up straight, one foot extended in front
- Turn sole of foot in and out
- Move foot around in a slow, large circle
- Change directions

Indications

- ROM
- Improves circulation
- ADL - walking, stair climbing, balance.

Precautions

- None



Caterpillar (toe flexation)

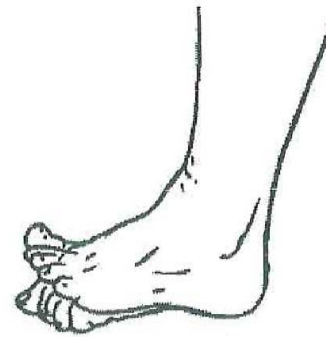
- Curl toes down
- Hold three seconds
- Lift toes up
- Hold three seconds
- Variations: gather a towel with your toes or pick up marbles with your toes.

Indications

- ROM
- Strength
- ADL - Walking (helps arch support)

Precautions

- Joint surgery



Legs, Feet and Hips

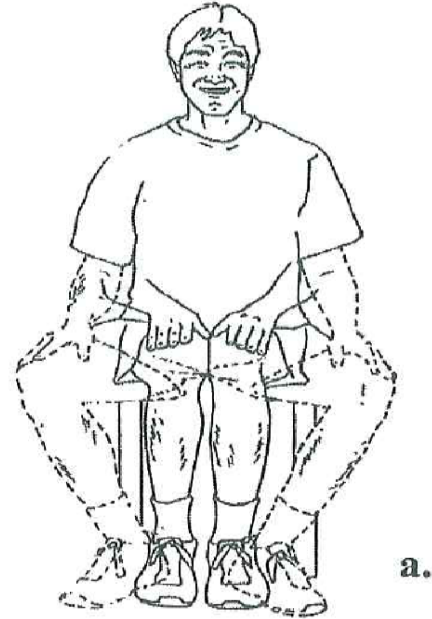
Hip Exercises

Position: Sitting

Spread Eagle (hip abduction)

Version A

- Sit up straight
- Spread knees apart
- Hold three seconds
- Bring knees together



Version B

- Sit up straight
- Lift one foot two inches off floor
- Move that leg slowly out to the side
- Return to center
- Repeat on other leg

Indications

- ROM
- Strength
- ADL - Bathing, in/out of car

Precautions

- Joint surgery



Hips and Legs

Standing Exercises (full weight-bearing)

March (hip/knee flexion)

- Stand holding on to chair
- Alternate lifting knees up and down as if marching in place

Indications

- ROM
- Strength
- Endurance
- ADL - Walking, climbing stairs
- +Weight

Precautions

- Balance
- Joint surgery



Back Leg Lift (hip extension)

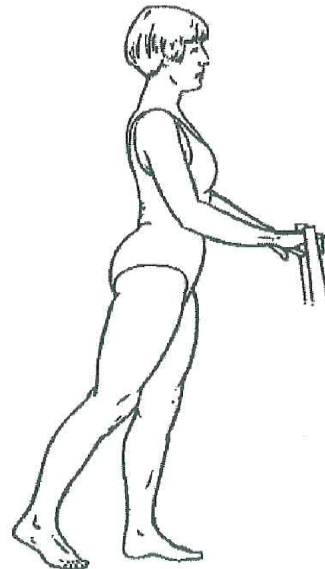
- Stand straight, holding on to chair
- Slide one foot back (keeping foot flexed) until only the tip of the toes are on the floor
- Return and repeat with the other leg (motion should occur at the hip, not the low back)

Indications

- ROM
- ADL - Walking
- +Weight

Precautions

- Joint surgery
- Balance



Hand/Finger Exercises

Finger Exercises

Position: Lying, sitting or standing.

Thumb Bend (thumb flexion)

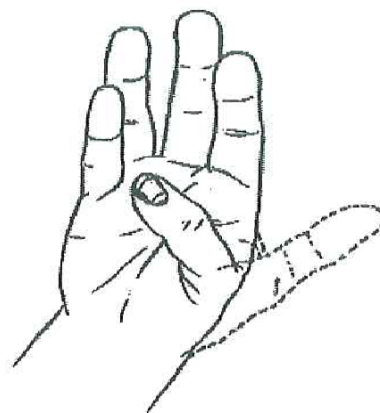
- Open hands, fingers relaxed
- Reach thumb across palm toward base of little finger
- Hold three seconds
- Stretch thumb out again

Indications

- ROM
- ADL - grasping, picking up objects

Precautions

- None



Finger "Os" (opposition)

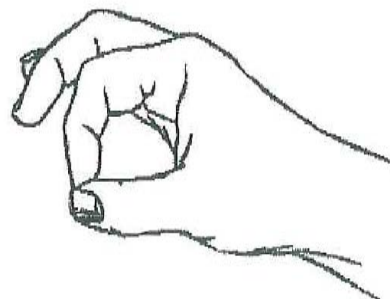
- Open hand wide, fingers apart
- Touch tip of thumb to tip of index finger (make an "O" shape)
- Repeat with each finger

Indications

- ROM
- ADL - grasping, picking up objects

Precautions

- None



Breathing, Balance & Mobility

Active Breathing

- Lie, sit or stand with feet shoulder width apart, arms at sides
- At inhale, lift arms straight up from sides as high as comfortable
- Hold for up to five seconds
- Exhale, lowering arms to rest at sides
- (Inhale deeply through nose, exhale fully through the mouth)
- Do deep breathing several times a day to improve oxygen level to all cells



Heel Raises (sitting or standing while holding stable object for balance)

- Feet flat on floor, shoulder width apart
- Lift heel from floor, putting foot into tip-toe position
- Hold up to five seconds
- Lower heel to floor
- Repeat with other foot



Knee Slides (sitting or standing while holding stable object for balance)

- Feet flat on floor, shoulder width apart
- Bend knee, lifting foot off floor and knee toward ceiling
- Hold up to five seconds
- Lower foot to floor
- Repeat with other leg



Chair Dips (sitting in weighted stable chair. If using wheelchair, BOTH LOCKS ON)

- Sit in chair facing forward, palms down on chair arm
- Push up with arms, standing only far enough to straighten elbows
- Hold up to five seconds
- Lower to sitting position



Risk Factors for Predicting Abuse and Neglect

Working as a team helps prevent abuse, neglect and exploitation (ANE) of residents. Be aware of the things that can trigger stress and anger and find ways to relieve those triggers before feelings escalate. All staff have the responsibility to protect and intervene to prevent ANE, or if you suspect ANE has happened.

The following have been identified as the **six major risk factors** most commonly leading to abusive behavior on the part of nursing facility staff:

Major Risk Factors:

Short Staffing: Short Staffing means that staff does not have enough time or support to do the job of caregiving. As a result, caregivers must often give up the most rewarding aspects of their jobs - meaningful exchanges with residents - and focus instead on the tasks of care. This can lead to poor coping skills, and not seeing the person, only seeing what must be done.

Attitude: Viewing residents not as individuals, but as burdens or tasks to be dealt with, or as children in need of discipline.

Burnout: Working in a nursing facility is often emotionally and physically strenuous. As a result, nursing facility staff experience very high levels of burnout.

Conflict: Few people are trained to manage the high degree of conflict that sometimes occurs in nursing facilities. Conflicts with residents are commonplace. Lack of conflict management skills increases the likelihood of inappropriate responses toward residents.

Disruptive and Aggressive Resident Behavior: Nursing facility staff are at significant risk of abuse from residents. In one study, 89% of nurses and nursing assistants interviewed said they had been insulted or sworn at by residents; 87% had been pushed, grabbed, or pinched; 70% had been hit or had an object thrown at them; and 47% had been kicked or bitten. Without adequate training on why such behaviors occur and how to deal with them, staff and residents are both more vulnerable.

Lack of Supervision: Some staff are more apt to commit abusive acts if they believe the quality of their work is not being monitored or that they need not be concerned with consequences from their actions.

Adapted from the American Health Care Assn. training publication "Keeping Nursing Facility Residents Safe," pp. 22, 23.

Additional Risk Factors for ANE

Residents at Risk for Being Abused

- ⇒ abuse others
- ⇒ insult staff or other residents
- ⇒ show demanding or critical behaviors
- ⇒ don't want or accept help from staff
- ⇒ "undo" staff help
- ⇒ may have specialized care issues
- ⇒ show self-pitying behaviors
- ⇒ can't verbalize that they have been abused
- ⇒ may be passive & not functioning at capacity
- ⇒ don't "listen" to staff
- ⇒ would not be expected to notice if things were missing, etc.
- ⇒ are agitated, confused or resist care

Additional Risk Factors: Staff Who May React Abusively

- ⇒ have worked too much overtime
- ⇒ are under stress in their personal lives
- ⇒ are drug and/or alcohol abusers
- ⇒ have low self-esteem
- ⇒ do not get along well with co-workers
- ⇒ take things personally
- ⇒ omit breaks/lunch, etc.

Staff Who May Be At Risk for Being Abused

- ⇒ tend to rush residents who are cognitively impaired
- ⇒ approach agitated residents with a loud, overly cheerful manner
- ⇒ do not use calm, friendly, non verbal-approaches
- ⇒ are rough in giving care
- ⇒ are impatient
- ⇒ may appear "threatening" to residents

From CARIE, 1999: p. 43; 46.

Definitions & Indicators that ANE may have occurred

Active Neglect: The willful deprivation of goods or services which are necessary to maintain physical or mental health.

Examples of Active Neglect

- Purposefully withholding food or other items
- Not assisting a resident whom you know needs help with feeding
- Knowingly postponing incontinent care to take a break
- Not delivering mail or messages promptly to a resident
- Sitting at the nurses station and ignoring a call
- Just about anything that an individual postpones or does not do because of some personal activity such as a break or personal call

Passive Neglect: The deprivation of goods or services which are necessary to maintain physical or mental health, without conscious intent to inflict physical or emotional distress.

Examples of Passive Neglect

- Forgetting to keep the water pitchers full so residents can drink freely
- Not adhering to facility safety precautions
- Telling a resident you will return in 5 minutes and forgetting to do so
- Leaving a resident on the toilet and forgetting to return
- Forgetting to put in a resident's dentures, hearing aid or glasses
- Forgetting to help a resident with eating
- Leaving someone unattended due to high number of residents in the area

Indicators that Neglect (Active or Passive) May Have Occurred

- Loss of weight
- Dirt under fingernails; matted hair; body odor; heavily soiled or stained clothing
- Reduced ability to walk
- Skin breakdown
- Psychological indicators including withdrawal, sudden or unexplained changes in behavior, new or unexplained depression, or agitation, anger, demanding behavior

Definitions & Indicators that ANE may have occurred

Psychological Abuse: The threat of injury, unreasonable confinement and punishment, or verbal intimidation and humiliation which may result in mental anguish, such as anxiety or depression.

Examples of Psychological Abuse

- Resident told to have bowel movement in diaper rather than toileting
- Leaving resident on bedpan for an extended period of time
- Threatening the resident with punishment if she/he does not behave
- Talking to resident as if she/he was a child
- Talking about resident as if she/he was not there
- Yelling or screaming
- Using demeaning language or ridicule
- Confining resident unnecessarily
- Prohibiting free choice
- Not allowing resident to participate in activities
- Using silence - Ignoring resident's questions, comments
- Exposing resident with no precautions for privacy

Indicators that Psychological Abuse May Have Occurred

- Recent or sudden changes in behavior
- Seemingly unjustified fear
- Unwarranted suspicion
- Unwillingness to communicate
- Denial of situation
- New or unexplained depression
- Lack of interest
- Change in activity level

Physical Abuse: The infliction of injury, unreasonable confinement or punishment with resulting physical harm.

Indicators that Physical Abuse May Have Occurred

- Bruises, skin tears, swelling, limbs looking out of place
- Change in walking, standing or sitting ability
- Scratches, tears or irritation around the genitalia
- Marks, welts, burns, teeth marks, cuts or scratches
- Withdrawal, change in behavior, unusual fear
- Unexplained depression, denial of situation

Definitions & Indicators that ANE may have occurred

Financial Exploitation: An improper course of conduct with or without informed consent of the older adult that results in monetary, personal or other benefit, gain or profit for the perpetrator or monetary or personal loss for the older adult.

Examples of Financial Exploitation

- Stealing or helping oneself to any of the resident's possessions without permission
- Not treating reports of theft seriously
- Borrowing from one resident for another resident without permission
- Not returning proper change to resident after making purchases
- Forcing resident to tip

Indicators that Financial Exploitation May Have Occurred

- Missing clothing
- Missing valuables
- Missing food or other personal belongings
- No spending money

Sexual Abuse: Sexual contact that results from threats, force or the inability of the person to give consent, including but not limited to assault, rape and sexual harassment.

Examples of Sexual Abuse

- A resident of either gender fondling a confused fellow resident
- Staff member intimately touching resident during bathing
- Any sexual activity that occurs when one or both parties cannot or do not consent

Indicators that Sexual Abuse May Have Occurred

- Scratches, tears, irritation and swelling around the genitalia
- Changes in walking or sitting ability
- Abnormal discharge
- Psychological indicators, including withdrawal, depression

Resources & Acknowledgments

Kansas Department on Aging Hotline: 800-842-0078
To report suspected abuse, neglect and exploitation of residents in adult care homes

State Long-Term Care Ombudsman: 877-662-8362
For assistance with concerns/problems with adult care homes

Kansas Advocates for Better Care: 800-525-1782
<http://www.kabc.org>

Promoting Excellent Alternatives in Kansas nursing homes (PEAK)
<http://www.agingkansas.org/CultureChange/PEAK/peak.htm>

*We gratefully acknowledge the following businesses
for providing information for this publication:*

Lawrence Therapy Services, Laura Bennetts & Kim Hoffman 785-842-0656
2200 Harvard, Suite 101, Lawrence, KS 66049
<http://www.lawrencetherapyservices.com/home.htm>

Neu Physical Therapy Services, Lydia Neu 785-842-3444
1305 Wakarusa Dr, Lawrence, KS 66049

Tauy Creek Publishing, Sharon Magee-Minor OTR/L 785-594-3454
taucreek@netks.net

Sources and disclaimer

Information contained within this publication is from individuals and businesses, as well as state government sources. This publication could contain inaccuracies or typographical errors, and is provided without warranty of any kind, either express or implied.

For the complete version of Kansas regulations, see http://www.agingkansas.org/ProviderInfo/regs/reg_index.html

Notes



About Kansas Advocates

Founded in 1975 as *Kansans for Improvement of Nursing Homes (KINH)*, Kansas Advocates for Better Care continues to be the only statewide consumer-based non-profit organization working to improve the quality of long-term care in Kansas.

This 501(c)(3) organization is supported entirely by membership dues, contributions, sales from consumer information products, and grants for special projects. Members and contributors receive newsletters with news about licensed adult care homes throughout Kansas. The volunteer Board of Directors includes consumers, health care providers and business leaders from across the state.

Special thanks to the Kansas Department on Aging for funding this project.

Kansas Advocates for Better Care
913 Tennessee, Suite 2 Lawrence, Kansas 66044
Lawrence phone: 785-842-3088
Toll-free: 800-525-1782
Email: info@kabc.org
Website: <http://www.kabc.org>