Leadership Keys to Success

Restorative Nursing Program

1

Leadership Keys to Success Objectives/Standards

- Understand RNP scope of service
- RNA and RNPC verbalize understanding of their roles and responsibilities to RNP
- Verbalize understanding of admission and discharge criteria
- Review types of documentation forms.

2

Leadership Keys to Success Objectives/Standards (cont'd)

- Review OBRA & Title 22 regulations
- Verbalize effective leadership strategies for the RNP

3

Restorative Nursing Program Definition

- RNP refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psycho-social functioning.

4

Restorative Nursing Assistant (RNA)

- RNA interacts with the residents and provides skill practices in activities that will improve and maintain function in physical abilities and activities of daily living (ADL) and prevent further impairment.

5

Rehabilitation Definition

- Rehabilitation refers to the therapeutic interventions provided by a Licensed Therapist that promote the independence of the chronically ill, disabled and aged with the goal of assisting the resident in becoming a more independent person.

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Scope of service

- Bathing, dressing, grooming
- Toileting
- Oral Hygiene
- Personal hygiene
- Ambulation
- Wheelchair mobility
- Bed mobility

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Scope of service (cont'd)

- Transfer training
- Positioning
- Range of motion
- Bowel & Bladder retraining
- Communication programs
- Exercise programs
- Splints, adaptive/assistive devices
- Dining programs
- Eating & Swallowing

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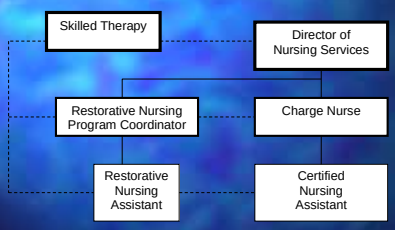
RNP organizational chart



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Roles & responsibilities RNPC

- Provide guidance to the RNA
- Oversight of the RNP
- Review RNA and license nurse supportive documentation
- Coordinating resident RNP services
- Conduct annual RNA performance reviews
- Report to QA&A Committee

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Roles & responsibilities RNA

- Interact and provide RNP services to the resident
- Report problems, changes and needed improvements to the RNPC
- Document resident care
- Communicate and train peer CNAs regarding resident needs

11

Referral pathways

- Skilled therapy
- Nursing
- IDT
- Resident/Family/CNA/RNA/Caregivers

12

Admission criteria

- Skilled therapy program not indicated
- Decline in physical &/or mental functioning
- Change of condition (e.g., unsteady gait, frequent falls, weight loss, pain)
- Potential for improvement with training/retraining (e.g., dining, continence, strengthening exercise, etc.)

13

Assessments

- Functional skills of all residents are assessed at admission
- Reassessed quarterly or with decline in function
- Documented throughout the MDS
  - Function in Section G0110
  - Joint Mobility in Section G0400
  - RNP in Section O0500

14

RNP orders

- Clear & concise
- WHO will provide the service
- WHAT service will be provided
- Frequency
- Duration of order
- Obtain order for discharge

15

RNP orders (cont'd)

- Sample:
  - "RNA to ambulate resident with FWW, FWB, up to 100 ft. 5X/week for 30 days"

16

Documentation process

- Referral form for RNP activities
- Resident Care Plan guidelines for implementing RNP
- RNP Activity Record of treatment provided and resident response
- RNP Summary

17

Documentation
RNP Activity Record

- RNA documents following each activity provided
  - Activity provided
  - Minutes of activity
  - Level of assistance and support
  - Meal intake percentage
  - Initials of RNA providing care

18

Documentation
RNP Summary

- RNA Summary routinely (e.g., daily, weekly, monthly)
  - Activity provided
  - Resident response
  - Outcomes/progress/lack of progress
  - Unusual occurrences
    - Document pain when it occurs, stop the activity & notify nursing/therapy
  - Plan to continue program

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Documentation
Example Weekly Summary

- "Resident maintained skills this week. Complained three times of lack of energy, requiring 5 minute rest. Walked 100 feet with FWW 2/5 days. Resident did not complain of pain. Resident follows swallow protocol when supervised at meals in the dining room."

20

Documentation
Nurse Weekly Summary

- Licensed Nurse's Weekly Summary of resident progress in RNP
- Ongoing chart reviews/audits to assure compliance/quality

21

Discharge criteria

- Resident meets the goals of the RNP
- Resident refuses consistently &/or lacks motivation
- Resident can't tolerate due to alteration in physical or mental status (e.g., pain, change in medical condition, etc.)
- Resident fails to benefit from the program

22

Documentation
Discharge summary

- MD order
- Treatment program & initial problems
- Highlights of the RNP (e.g., total time period, frequency, interventions & resident response)
- Reason for discharge
- Status at time of discharge & amount of assistance needed

23

Post discharge

- Orient CNAs and Licensed Nursing staff
- Update Resident Care Plan
- Recommend interventions/strategies
- Establish protocol for re-assessment following discharge from RNP
- Maintain functional status

24

Leadership Keys to Success

- Administrative Support
- Training
- IDT process
- Assignments/Schedules
- Documentation
- Resident Care Plan
- Program Management & Supervision
- Continuous Quality Improvement

25

Regulations

- Know the regulations affecting the RNP
- Strive to maintain consistent compliance
- Know your role in the regulatory process
- Regulations influence the quality of care and quality of life of the residents

26

Quality Assurance Performance Improvement (QAPI)

- Systematic approach to monitoring and measuring the success of the RNP
- Assure care and services are maintained at an acceptable level
- Evaluate resident functional status
- Conduct routine chart audits to measure maintenance of functional abilities

27

QAPI (cont'd)

- Use monitor tools
- Interview resident and staff
- Assure ADL Care plans reflect current status of resident
- Report to QA&A Committee

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Demonstrating Clinical Competencies

Show me!

- Post Test

29

Medical Overview

Restorative Nursing Program

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Medical Overview Objectives/Standards

- Understand major muscle groups
- Identify characteristics of normal aging
- Understand common medical problems/pathologies addressed by the RNP

31

Basic anatomy & physiology

- Muscles
- Joints
- Nerves

32

Normal aging

- Aging is a normal process that occurs with the passage of time. Aging past maturity implies a slowing down of biological function.

33

Normal aging (cont'd)

- Biological aspects
  - Skin
  - Skeletal
  - Muscle
  - Nervous system
  - Senses
  - Respiratory system
  - GI system

34

Normal aging (cont'd)

- Psycho-social aspects
  - Sensory changes
  - Psychosocial changes
  - Coping with stress

35

Medical problems/pathologies

- ORIF vs. THR
- CVA (left vs. right)
- Chronic neurological
  - CVA
  - Senility
  - Alzheimer disease
  - Parkinson disease

36

Case studies

- Orthopedic – Mrs. Connelly
- Multiple medical – Tessie Tripper
- Neurological – Mr. Lowe
- Dementia – Mrs. AW

37

Demonstrating Clinical Competency

Cognition, Hearing & Communication

38

Cognition Objectives/Standards

- Verbalize/write examples of a cognitive problem for the middle stage of dementia
- Verbalize/write guidelines for assisting cognitively impaired residents
- Verbalize/write the best environment for working with a cognitively impaired resident
- Identify compensatory strategies for each stage of Alzheimer disease
- Identify cueing systems associated with Alzheimer disease

39

Cognitive disorders

- Cognitive impairment is the decreased ability to mentally process information
- Definitions
  - Cognitive impairment
  - Dementia
  - Memory
  - Direct and indirect treatment
  - Reversible and irreversible

40

Cognitive disorders Classifications

- Reversible
  - Goal is to improve function
  - May return to prior level of function
- Irreversible
  - Goal is to maintain function
  - May not return to prior level of function

41

Cognitive disorders Treatment techniques

- Direct
  - Goal is to improve function
  - Residents with reversible characteristics benefit form this approach
  - Example:"What did you have for breakfast?"

42

Cognitive disorders Treatment techniques

- Indirect
  - Goal is to maintain function, decrease agitation
  - Residents with irreversible characteristics benefit form this approach
  - Example:"Your journal says you had pancakes for breakfast."

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Cognitive Disorders Etiology

Diagnosis & Medical Condition	REVERSIBLE (false dementia)	IRREVERSIBLE (true dementia)
Parkinson disease		X
Alzheimer disease		X
Multi-infarct dementia		X
CVA	X	
Urinary tract infection	X	
Depression	X	
Brain tumor	X	X
Alcohol abuse history	X	X

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Cognitive Disorders Specific characteristics

	Parkinson disease, Huntington's chorea, etc.	Alzheimer disease, Pick's disease, etc.
Onset of cognitive deficits	Gradual medical deficit first, then cognitive deficits	Initial problem is intellectual functioning
Language	Normal	Aphasic
Speech	Dysarthric	Normal
Memory	Retrieval problems	Unable to learn
Cognition	Slowed	Poor judgment
Affect	Depressed	Unconcerned
Posture	Stooped	Normal
Tone	Increased	Normal
Movement	Tremor	Normal
Gait	Abnormal	Normal

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Cognitive Disorders
Communication approaches

REVERSIBLE (false dementia)	IRREVERSIBLE (true dementia)
What is today's date?	Today is June 22. Look at your book.
What did you have for breakfast?	Your journal says you had pancakes for breakfast.
No, this is not a restaurant.	Yes, this is a great restaurant, isn't it?
Don't give up. Try again. Lots of practice.	You're right, we should rest.
Why do you need to lock your wheelchair brakes?	Let me lock your brakes for you.
Who visited your yesterday?	Look in your book. See where your son signed.
Could you suggest a better time for your nap?	Time to nap so you're rested for the dance tonight.
No, there is no money. Your son has it at home.	You're right. You have lots of money. It is safe.

46

Alzheimer disease
General guidelines

- Achieve eye contact
- Use touch to gain attention
- Be patient!
- Keep instructions simple and short
- Allow resident time to respond

47

Alzheimer disease
Creating the best environment

- Turn off the TV or radio
- Use adequate lighting
- Have a positive attitude
- Avoid loud spaces if possible

48

Alzheimer disease
Behavior characteristics

- Suspicious
  - "You stole my money."
- Mommy/daddy pattern
  - "Mommy, mommy, mommy."
- Angry/agitated
  - "I hate you. You're stupid. Get out of here."
- Wandering/pacing
  - Caregiver: "Where are you going?"
  - Resident: "I don't know."

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Alzheimer disease
Communication tips

- Guide a conversation to familiar topics
- Be reassuring
- Use short, clear sentences
- Repeat information often
- Allow time for responding

50

Alzheimer disease
Communication behaviors to avoid

- Do not quiz the resident
- Do not correct statements the resident has made even if you know that they are wrong
- Avoid letting frustration or anger enter into your voice

51

Cueing/compensatory systems May include direct and indirect

- Daily Schedule
- Identification Folder
- Memory Wallet
- Monthly Calendar
- Safety card checklist
- Memory Journal

52

Demonstrating Clinical Competencies

Show me!

- Post Test

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Hearing in geriatrics Objectives/Standards

- Verbalize/write compensatory techniques for communicating with a hearing impaired resident
- Understand the difference between sensori-neural and conductive hearing loss
- Identify appropriate wear schedule for a new hearing aid user

54

Hearing in geriatrics
Hearing loss types

- Conductive
  - Outer and middle ear
  - Breakdown in loudness only
- Sensorineural
  - Inner ear or auditory nerve

55

Hearing in geriatrics
Hearing loss types (cont'd)

- Mixed
  - Combination of any of the following: outer ear, middle ear, peripheral
- Central
  - Central nervous system or brain

56

Hearing in geriatrics
Hearing aids

- Check/maintain hearing aid
  - Stethoscope
  - Check batteries
  - Clean with alcohol swab
  - Never use toothpick, needle to clean wax

57

Hearing in geriatrics
Suggestions for communication

- Get the attention of the individual
- Talk naturally but not to fast
- Avoid “ah”, “um”, “well”, “er”, coughs
- Remember that some words are invisible to the lip reader such as “hair” or “egg”

58

Hearing in geriatrics
Gestures

- May be the primary means of communication
- Helpful when working with hard of hearing, aphasic, or cognitively impaired

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Demonstrating
Clinical Competencies

Show me!

- Post Test

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Communication
Objectives/Standards

- Verbalize/write communication strategies associated with *left hemisphere* damage
- Verbalize/write suggestions for communicating with *right CVA* residents
- Identify deficits associated with *right CVA* residents
- Understand the use of a communication board.
- Identify compensatory techniques for motor speech disorders

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Communication
Left hemisphere problems

- Aphasia
- Anomia
- Perseverate
- Reading
- Writing speech
- Comprehension
- Math
- May use “yes” and “no” inappropriately
- May not be able to follow directions

62

Communication tips
Aphasia

- Do not talk to the resident as if he/she is a child
- Be aware that resident often performs poorly right after attempting a task that is difficult
- Get confirmation as to whether or not resident is understanding what you say
- Be willing to give up

63

Communication
Right hemisphere problems

- Highly distractible
- Disoriented
- Poor judgment
- Misuses objects
- Repeats same ideas over and over
- Denial
- Confused about space and time
- Perceptual problems
- Left visual loss

64

Communication tips
Right CVA

- Resident should verbalize how to complete a task
- Orient and instruct resident from the right
- Break task into small steps

65

Communication
Motor speech disorders

- Dysarthria
  - Slurred speech
- Apraxia
  - Know what they want to say but the message from the brain does not get through to the tongue and mouth

66

Communication tips
Motor speech disorders

- Allow the resident time to speak
- Use a communication board with the resident
- Let the resident know when you do not understand

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Demonstrating
Clinical Competencies

Show me!

- Post Test

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Demonstrating Clinical Competency

Dysphagia & Eating

69

Dysphagia and Eating Objectives/Standards

- Verbalize/write diagnosis associated with dysphagia
- Identify the stages of a normal swallow
- Verbalize/write common swallowing problems
- Verbalize/write aspiration precautions

70

Dysphagia and Eating Objectives/Standards

- Demonstrate/verbalize/write aids to facilitate a safe swallow
- Identify liquid consistencies
- Demonstrate safe positions for self-feeding
- Demonstrate use of adaptive devices to assist with self-feeding
- Identify two anatomical sites of the larynx

71

Dysphagia Common diagnosis

- CVA
- Parkinson disease
- MS, ALS
- Alzheimer disease
- COPD/CHF
- Cancer
- Changes in personal environment

72

Swallow function stages

- Oral preparatory stage
- Pharyngeal stage and the swallow reflex
- Esophageal stage

73

Swallow function
Normal swallow stages

1. Bolus in oral cavity
2. Bolus conveyed into oropharynx
3. Bolus extends into laryngopharynx
4. Bolus penetrates opened pharyngoesophageal segment
5. Bolus nearly transversed the pharynx
6. Pharynx returned to referenced position

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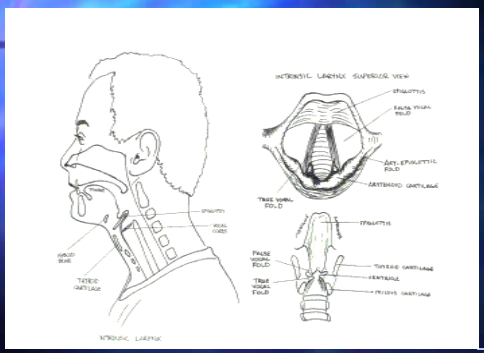
Swallow function & the normal swallow



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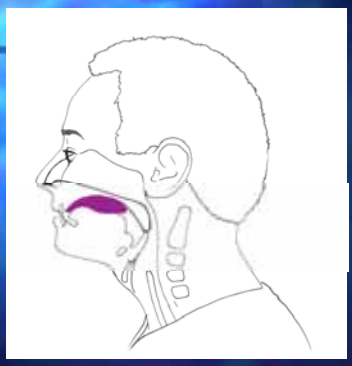
Stage 1: Bolus in oral cavity



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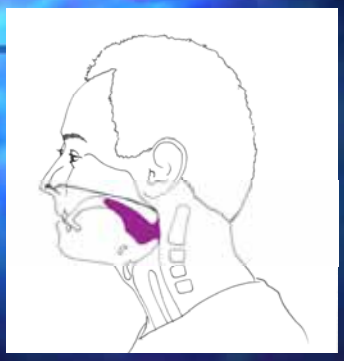
Stage 2 : Bolus conveyed into oropharynx



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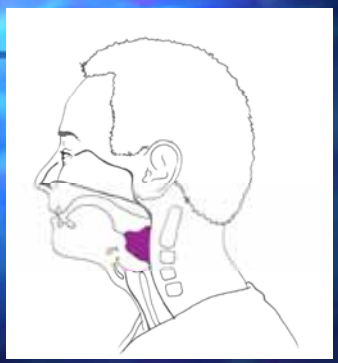
Stage 3 : Bolus extends into the laryngopharynx



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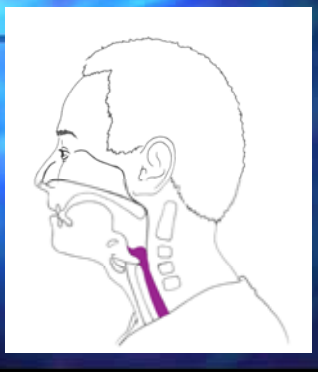
Stage 4 : Bolus penetrates opened pharyngoesophageal segment



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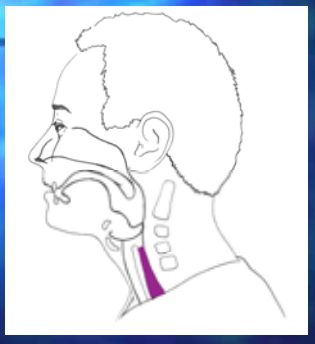
Stage 5 : Bolus nearly transversed the pharynx



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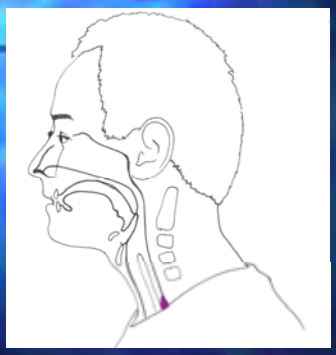
Stage 6 : Pharynx returned to referenced position



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Swallowing
Common problems

- Resident reports difficulty with swallowing
- Spitting food out
- A wet or gurgly voice
- Coughing and/or choking
- Spilling food or liquid from the mouth
- Watery or tearing eyes

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Swallow function
Eating and safety strategies

- Techniques to help improve the swallow
  - Chin tuck
  - Alternate liquids with solids
  - Clear oral residue with tongue and/or finger
  - Use a straw
  - Remain upright at a 90° angle
  - Food texture and liquid modifications

83

Swallow function
Suggestions and aids

- Position upright with head tilted slightly forward
- Take small bites of food, one bite at a time
- Provide frequent verbal instructions while eating

84

Swallow function
Suggestions and aids (cont'd)

- Follow any precaution signs noted in resident's care plan or room
- Alternate sips and bites
- Management of impaired swallow requires patience and discipline

85

Swallow function
Food textures

- Food Textures
  - Puree
  - Ground
  - Mechanical Soft
  - Liquids
    - Thick – nectar, honey, pudding consistency
    - Thin – water, juice, soda, coffee

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Swallow function
Foods that may present difficulty

- Mixed textures
- Stringy textures
- Floppy textures
- Small, hard textures
- Thin liquids
- Foods with tough skins
- Foods that fall apart in the mouth
- Dry sticky foods

87

Swallow function and self feeding
Proper positioning

- Resident in Bed
- Resident in Geri-chair
- Resident in wheelchair at the table
  - Table height at waist
  - Food within 12-inch reach (knees under table)
  - 90° at hips, knees and ankles
  - Feet supported, flat on the floor

88

Adaptive equipment

- These devices can facilitate independence in self feeding
  - Utensils
    - built up, angles, weighted, cuff
  - Plates
    - lip, scoop, partitioned, guard, dycem
  - Beverage cups
    - nosey, two handled

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Self feeding
Other considerations

- Visual changes
  - Food contrast of color
  - "Clock" position of food on plate
  - Verbal cues and directions
- Neglect
  - Lay out of place setting
  - Position of caregiver
  - Verbal cues and directions

90

Dining environment Considerations

- Quiet location
- Good lighting, no glare
- Everyday table settings
- Seating arrangement per personality
- Regular chairs if possible
- Food choice and presentation
- Celebrations

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Demonstrating Clinical Competencies

Show me!

- Safe feeding positions
- Liquid consistencies
- Adaptive feeding devices
- Swallow aids
- Post Test

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Demonstrating Clinical Competency

Joint Mobility

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Joint Mobility Objectives/Standards

- Identify purposes for RNA to perform ROM
- Verbalize & demonstrate passive, active/assisted ROM
- Identify contraindications for PROM
- Identify reasons for the RNA to assist in a routine exercise/maintenance program

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Joint Mobility Objectives/Standards (cont'd)

- Verbalize indications & contraindications for routine exercises
- Identify/verbalize major muscle groups
- Demonstrate resistive exercise for the upper and lower extremities
- Demonstrate method to reduce edema
- Demonstrate self ROM technique
- Demonstrate correct application of a splint

95

Range of motion (ROM) Purpose

- Maintain or increase joint motion
- Decrease/prevent contractures
- Maintain strength if active/resistive
- Increase functional use if active
- Decrease c/o pain due to stiffness or immobility

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ROM
General considerations

- Resident should be comfortable/relaxed
- EXPLAIN what you are doing, and why
- Assist only as the resident needs
- Hold the body part secure and gently
- Do NOT grasp a painful joint
- Start with large joints and progress to smaller joints
- Monitor pain – ROM should not be painful

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Passive range of motion (PROM)
Contraindications

- Extreme pain upon movement
- Bony blockage with movement
- Severe crepitation with movement
- Recent fracture
- Joint inflammation
- Any contraindication in the chart noted by the MD or therapist

98

ROM
Types & definitions

- PROM
  - 100% caregiver
- A/A ROM
  - Part resident, part caregiver
- AROM
  - 100% resident

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ROM
Types & definitions (cont'd)

- Resistive
  - Active motion with weights, Theraband, pulleys, exercycle, etc
- Functional
  - Active use during ADL's
- Self ROM
  - Resident uses a strong arm to assist a weaker arm

100

Assisted exercise

- Objectives
  - Maintain and/or improve ROM and strength
  - Decrease pain
  - Improve balance, gait and transfers
  - Improve automatic functional independence and mobility
  - Promote independence, well-being and quality of life

101

Routine exercise program
Indications

- Increased muscle strength/ROM
- Increased aerobic capacity
- Reduce risk of CVA
- Appetite stimulation
- Fall prevention

102

Routine exercise program Contraindications

- Heart signs – marked SOB, chest pain
- Sharp/intense joint pain
- Change in speech pattern
- Acute deep vein thrombosis (DVT)

103

Splinting indications

- Protect the skin, joints and muscles
- Manage/prevent contractures
- Protect a damaged or healing joint
- Support weakened muscles
- Prevent muscle shortening/tightening

104

Hand care

- Soak and range programs
  - Decreases tone, swelling and pain
  - Ensure to dry thoroughly
- Edema reduction
  - Elevation

105

Splint program
Areas to monitor

- Check skin for any signs of pressure
  - Marking, redness, discoloration or swelling
- Look at all points of contact
  - Bony prominences, web space, areas below straps
- Straps should allow 2 fingers to pass between strap and skin (or stockinet)

106

Demonstrating Clinical Competencies

Show Me!

- Passive range of motion (PROM)
- Active assisted range of motion (AAROM)
- Resistive exercise
- Edema reduction method
- Post test

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Demonstrating Clinical Competency

Functional Mobility

Mrs. Connelly - an orthopedic case study

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Functional Mobility -- Ortho Objectives/Standards

- Demonstrate orthopedic dressing technique with adaptive devices for lower body dressing
- Demonstrate use of gait belt
- Define therapy assist level terms
- Define weight bearing status
- Demonstrate and verbalize precautions for THR and ORIF

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Functional Mobility -- Ortho Objectives/Standards

- Demonstrate safe transfers
- Demonstrate appropriate us of assistive devices
- Demonstrate assisted ambulation with device and weight bearing limits

110

Basic rules of body mechanics

- Assess the situation first
- Get close to the object to be moved
- Let your legs do the work, not your back
- Use a wide base of support
- Push – don't pull
- Turn – don't twist your body

111

Gait belt Purpose

- Provide safety during mobility
- Provide appropriate “handle” for assisting movement or mobility of resident
- Improve mechanical advantage and control of the resident’s body during mobility
- Prevent injury to the resident or staff

112

Gait belt Contraindications

- Abdominal aortic aneurysm
- Severe heart or breathing problems

113

Gait belt Precautions

- PEG tubes
- Colostomy bags
- Recent abdominal surgery
- Recent back surgery or fractures
- Recent rib fractures
- Heart or breathing problems

114

Gait belts
Hands on assistance

- Secure around the resident's waist
- Fit snug to prevent slipping with use
- Keep buckle away from bony areas
- Use for transfers, gait, or repositioning

115

Levels of assistance

- Descriptions of a *resident's ability* to perform a task:
  - Independent
  - Set-up assist
  - Supervised
  - Contact guard
  - Min assist
  - Mod assist
  - Max assist
  - Total assist/dependent

116

Positioning of residents
Do's

- Change position at least every 2 hours
- Follow Therapist instructions for positioning/body alignment
- Encourage the resident to help move his body into different positions
- Provide ROM with repositioning
- Make sure residents hips are level when sitting

117

Positioning of residents
Don'ts

- Avoid lying on open areas
- Avoid tight, binding bed linens at feet
- Do not grasp sore muscles or joints
- DO NOT LIFT OR PULL ON ARMS
- Avoid letting the head slump or drop to the side, back or front
- Avoid lying on tubing

118

Pressure Areas
Risk factors

- Pressure
- Friction
- Sheer
- Moisture
- Incontinence
- Immobility
- Nutrition

119

Major Pressure Areas

- Most common areas of pressure
  - Sacrum
  - Coccyx
  - Buttocks
  - Heels
  - Greater Trochanter - hips

120

Positioning devices

- Lap tray
- Cushions
- Upper extremity supports – slings, troughs, lap buddy

121

Bed positioning
Hip fractures

- Total Hip Precautions must be followed AT ALL TIMES – everyone is responsible for these precautions
  - No hip flexion beyond 60-90 degrees
  - No hip adduction
  - No hip internal rotation

122

Positioning
Total Hip Replacement (THR)

- THR Precautions -- Primarily a posterior approach:
  - No hip flexion beyond 60-90 degrees
  - No hip adduction
  - No hip internal rotation
- THR Precautions -- Anterior approach
  - Restrictions are the opposite of the posterior approach

123

Supine positioning THR

- Trunk in straight alignment
- Head supported on a pillow
- Arms in comfortable position
- Abductor pillow in place for legs
- Heels floated

124

Sidelying positioning THR

- Trunk in straight alignment
- Head supported on a pillow
- Arms in a comfortable position
- Sidelying on the uninvolved side or Sidelying on the involved side after staples are out
- Abductor pillow strapped in place

125

Supine to sit THR

- Bend uninvolved leg and bridge to edge of bed – lower uninvolved leg to the floor
- Prop up on elbows if possible
- Caregiver cradles involved leg with one arm, and the other arm blocks across the resident's waist and grasps the draw sheet
- Pivot around to the edge of the bed
- Lower feet to the floor

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Wheelchair Positioning

- Safety
- Proper set up of wheelchair
- Proper alignment of resident
- Footrest legrest position
- Repositioning

127

Transfers
OSHA Guidelines 2009

- OSHA recommends, “Manual lifting of residents be minimized in all cases and eliminated when feasible.”

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Transfers
With Rehab residents

- Purpose:
  - Increase strength and endurance skills through practice
- Candidates:
  - Rehab residents who have NOT reached a plateau in their skills and are expected to improve
  - Rehab residents with limited assist, CGA and/or supervised assist levels

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Transfers
With Non-Rehab residents

- Purpose:
  - Maintain and/or improve functional level of transfer
- Candidates:
  - Non-Rehab residents who are not expected to significantly improve in their skill level
  - Non-Rehab residents with total dependent assist typically use a sling mechanical lift
  - Non-Rehab residents with extensive assist level typically use a weight-bearing mechanical lift or a sling mechanical lift

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Transfers
Hip fractures

- Total hip replacement precautions must be followed AT ALL TIMES, until discharged by the MD
- Observe weight bearing limitations for ORIF residents AT ALL TIMES, until discharged by the MD

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Ambulation
Precautions

- Safe equipment is a must
- Check rubber tips for wear
- No loose hardware
- Check gait belt for wear
- Make sure the resident has safe shoes, proper clothing, glasses and/or hearing aids as needed

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Ambulation
Observe for…

- Chest pains
- Shortness of breath (SOB)
- Dizziness or faintness
- Unusual weakness
- Rapid ⬆ or ⬇ in heart rate
- Change in skin color (pallor)
- Sudden onset of heavy sweating

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Ambulation
Assist levels

- Maximum (Max)
  - Resident needs 75% or more assistance
- Moderate (Mod)
  - Resident needs 25-75% assistance
- Minimum (Min)
  - Resident needs 25% or less assistance

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Ambulation
Assist levels (cont'd)

- Contact Guard Assist (CGA)
  - Resident needs hand contact/cues/no weight bearing assistance
- Stand-by/Supervised Assist (SBA/S)
  - Resident needs supervision/cues/no hands on
- Independent (I)
  - Resident is independent with or without devices

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Ambulation
Weight bearing definitions

- FWB
  - Full weight bearing
- WBAT
  - Weight bear as tolerated
- PWB
  - Partial weight (25-75%)
- TDWB
  - Touch down weight (10%)
- NWB
  - Non weight bearing (0%)

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Ambulation
Gait sequence

- With all gait patterns, sequence is:
  1. Assistive device
  2. Weaker leg
  3. Stronger leg

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Dressing techniques
Post hip surgery (THA or fracture)

- Remember total hip precautions
- All positions that force the head of the femur against surrounding muscles should be AVOIDED
- Dress the operated leg first
- Use appropriate adaptive devices
- Undress the operated leg last

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Adaptive devices Ortho

- Long-handled shoe horn
- Reacher
- Dressing stick
- Sock aid
- Long-handled sponge
- Raised toilet seat

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Pacing for low endurance

- Identify early signs of fatigue
  - Breathing – SOB, ↑ rate
  - Cooperation
  - Judgment
  - Pace
  - Balance

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Demonstrating Clinical Competencies

Show Me!

- Orthopedic dressing technique
- Gait belt use
- Precautions for THR and ORIF
- Safe transfers using assistive device
- Assisted ambulation with device and weight bearing restrictions
- Post Test

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Demonstrating Clinical Competency

Functional Mobility

Mr. Lowe - a neurological case study

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Functional Mobility -- Neuro Objectives/Standards

- Demonstrate upper-body dressing technique with a hemiplegic resident using adaptive equipment
- Demonstrate self range of motion techniques
- Demonstrate splint application
- Identify major pressure risk areas for positioning a hemiplegic resident

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Functional Mobility -- Neuro Objectives/Standards

- Demonstrate bed and wheelchair positioning
- Demonstrate safe transfers
- Demonstrate wheelchair set-up and safety
- Demonstrate ambulation techniques using assistive devices

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Positioning
Hemiplegic tone and spasticity

- Conditions that can increase tone
  - Pain
  - Emotion
  - Noise
  - Poor Positioning
- Proper Positioning can reduce tone
  - Increase comfort
  - Increased function

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Positioning and protecting
Hemiplegic shoulder

- Never pull on the hemiplegic arm
- Do not hold the hemiplegic arm as the only point of support
- Never reposition the patient by lifting under the arms
- Always support the arm in sitting or lying – never allow it to dangle

146

Self Range of Motion

- Overhead
- Lateral Chop
- Pronation / Supination

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Positioning
Hemiplegic resident

- Bed positioning
- Wheelchair positioning

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Transfers
Hemiplegic or weak resident

- Caregiver assists with gait belt
- Resident should assist when possible
- Make sure to block the resident's weak knee or knees
- Protect a weak/paralyzed arm with your arm/hand
- Have the resident reach back for the chair or surface they are going to sit on, if possible

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Transfers

- One-person partial transfer
- Sliding board transfer

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Ambulation
Hemiplegic resident

- Gait belt
- Assistive device
- Prescribed technique
- Precautions/safety

151

RNP ambulation
Admission criteria

- Increase activity tolerance
- Decrease level of assistance needed
- Improve gait pattern
- Resident skill level requires the specialized skills of an RNA

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RNP ambulation
Discharge criteria

- Decline in functional progress due to
  - Pain or marked fatigue
  - Change of medical condition
  - Decline or change in cognition
  - Decline in gait skills
- Falls & need for Therapy intervention
- Plateau of skills – CNA can follow

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Dressing techniques Adult hemiplegia

- Do not rush, allow yourself and the resident time to complete the activity
- Set the resident up in a safe position with the garments laid out [usually on the affected side]
- Dress the affected side first
- Undress the affected side last
- Complete the activity with success

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Adaptive devices Neuro

- Raised toilet seat
- Button hook
- Built-up handles (hairbrush)
- Universal cuff
- Suction cup (denture brush, fingernail brush)

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Demonstrating Clinical Competencies

Show Me!

- Upper body dressing technique with adaptive equipment
- Self range of motion
- Splint application
- Pressure risk areas for positioning
- Bed positioning

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Demonstrating Clinical Competencies

Show Me!

- Wheelchair set-up and safety
- Wheelchair positioning
- Sliding board transfer
- One-person partial assist transfer
- Ambulation techniques using assistive devices
- Post test

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Remember….

“Activity strengthens. Inactivity weakens.”

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