Rehabilitation and Restorative Nursing Program Manual

Rehabilitation and Restorative Nursing Program Manual

Section 1

Philosophy and Organizational Structure, Policy and Procedure, Program Overview

Rehabilitation and Restorative Nursing Program

Philosophy and Organizational Structure

The rehabilitation and restorative nursing program is developed to serve as a guide in establishing individualized restorative care to assist each resident in achieving the highest level of self-care and independence possible. Rehabilitative or restorative care 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 psychosocial functioning.

Skill practice in such activities as walking and mobility, dressing and grooming, eating and swallowing, transferring, amputation care, and communication can improve or maintain function in physical abilities and Activities of Daily Living and prevent further impairment.

Resident/family involvement is encouraged in planning, implementing, and setting goals for the resident. Restorative care needs are viewed as part of basic care rather than special care. The establishment of rehabilitation/restorative programs is begun after the interdisciplinary team assesses the resident and identifies the potential for improving functional skills.

Restorative nursing is indicated when the resident displays potential for functional decline following the end of therapy or has achievable goals for functional improvement through rehabilitative or restorative care. Rehabilitation or restorative nursing is essential for carryover of therapeutic teaching. Restorative assessment may occur:

- When there is an assessment due to significant change in status
- Quarterly with assessment process
- On referral from Nursing or Therapy

Each resident enrolled in a rehabilitation/restorative program has measurable objectives and interventions documented in their care plan. The rehabilitation therapist assists nursing in developing and writing measurable objectives/goals and interventions where appropriate.

Implementation of rehab/restorative interventions/direct care is provided by Certified Nursing Assistants, under the supervision of a licensed nurse.

To qualify as a Restorative Nursing Assistant, an individual must be a Certified Nursing Assistant (CNA), have a high interest in rehabilitation and demonstrate good qualities in communication, responsibility and sensitivity. In addition to carrying out resident-specific treatment responsibilities, it is the responsibility of the RNA to, on a daily basis, document the specific tasks completed and to document weekly a summary of each resident's progress, functional status/goal achievement, assistive devices used and the resident's response to treatment.

The RNA will be responsible to report immediately any unusual or unexpected responses of the resident to the charge nurse and/or referring therapist. The RNA should demonstrate care and concern for residents through exercising respect, dignity and a sense of worth in care giving; providing choices to the extent possible; involving the resident in the care planning process; addressing the resident as an equal, avoiding a subservient manner; and providing opportunity for the resident to have some control over his/her life.

A Philosophy of Care Giving

The RNA performs a very significant role in the care giving process. Because the RNA provides a great amount of care, it is essential that care be based on a philosophy that is holistic and humanistic. To provide care in a holistic way means the caregiver accepts the fact that each elderly person has unique characteristics, abilities and interests. Each elderly person is recognized as having a lifetime of experiences different from those of any other person. The combination of these experiences has influenced the person physically, psychologically, socially and environmentally. Everyone is different and requires a variation in response that is unique to that person. When the caregiver provides care in keeping with the uniqueness required for each person, holistic care is given.

Rehabilitation/Restorative Nursing

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 optimal improvement of the resident's physical, mental and psychosocial functioning. Restorative Nursing does not include procedures or techniques carried out by or under the direction of qualified therapists.

Rehabilitation/Restorative care

Refers to nursing interventions that assist or promote the resident's ability to attain their maximum functional potential. These activities are carried out and supervised by members of the nursing staff. Other departmental staff may be assigned to work with specific residents.

Models of Rehabilitation Restorative Nursing

There are two basic models of Restorative Programs, designated staff model and integrated staff model, each delineating who provides restorative services.

- **Designated Staff Model**
    - Designated staff members are specifically assigned to only deliver restorative services
    - Staff members received specialized training in Nursing Rehabilitation techniques (e.g., range of motion, swallowing, ADLs)
    - Job title is frequently used is Restorative Nursing Assistant (RNA)
- **Integrated Staff Model**
    - Restorative programs are integrated into the resident's daily care
    - All staff members caring for a resident are responsible for carrying out restorative services
    - All staff should receive specialized training in Nursing Rehabilitation techniques (e.g., range of motion, swallowing, ADLs)

For both models, specific criteria should be in place for documentation and supervision

- Resident participation and progress must be documented daily
- Monthly progress reports should be completed by the Restorative Coordinator. Ideally, weekly documentation should be completed by the RNA and co-signed by the Restorative Coordinator.
- A Licensed Nurse or Therapist may establish a resident's restorative program
- Each RNA should be supervised by a Licensed Nurse
- Therapists should provide consultation for those restorative programs relating to therapy

Roles and Responsibilities

Restorative Nursing Assistant
The RNA provides the greatest amount of rehabilitative care to elderly residents. It has been estimated that nursing assistants provide at least 90% of the care to residents in nursing homes. Because of their advanced training, RNAs are able to assume a leadership role and set an example to other certified nursing assistants. Their contribution to the care of the elderly is meaningful and valuable because of advanced training beyond that other nursing assistants. Specialized training in rehabilitative care helps the RNA to individualize care, look for innovative ways to assist elderly residents to achieve optimal health and promote improved function and independence of each resident. The trained RNA will carry out each resident's specific restorative program, document progress/changes/declines and report status to the Coordinator.

Nursing
The Licensed Nurse acting as the Restorative Coordinator should supervise delivery of restorative services, manage the program, assist with weekly documentation, and co-sign all progress reports written by RNAs. The Coordinator may choose to establish facility communication systems (e.g., meetings, rounds, referral form) with RNAs and therapists to ensure that any changes in function are addressed and highest functional level is attained and maintained.

Therapy
Therapists in the facility may assist to perform ongoing RNA training, identify appropriate candidates for the restorative program, suggest appropriate treatment interventions/techniques, set resident-specific goals and interventions for the restorative program and assist in monitoring resident progress/decline in the program. When involving therapists in the program, it is important to consult state specific guidelines to ensure compliance.

Policy
It is the policy of this facility that all residents will be screened for restorative care:

- As terminated off active therapy
- When there is a significant change in status
- Quarterly with assessment process
- On referral from nursing or therapy

Rehabilitation/Restorative Nursing is:

- The prevention of secondary complications.
- The restoration of function or partial function.
- Helping residents learn to do for themselves.
- Developing untapped resources.
- Enhancing under-utilized abilities.
- Establishing life patterns within existing limitations.
- Minimizes degrading features (restraints and incontinence).

Rehabilitation/Restorative Nursing programs are designed to create resident independence to improve self-image and self-esteem thereby improving the quality of life.

Program Goals

- To restore function to maximum self-sufficiency.
- To replace hands-on assistance with a program of task segmentation and verbal cuing.
- To restore abilities to a level that allows the resident to function with fewer supports.

Programs

- **Range of Motion**

The extent to which, or the limits between which, a part of the body can be moved around a fixed point or joint. Range of motion exercise is a program of passive or active movements to maintain flexibility and useful motion in the joints of the body.

  - **Active Range of Motion** exercises performed by a resident with cuing or supervision
  - by staff. Exercises are planned, scheduled and documented in the clinical record.
  - **Passive Range of Motion** exercises performed by a staff member or person that has been properly trained.

Splint or Brace Assistance

- **Assistance can be of two types:**
  - The staff provides verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint.
  - The staff has a scheduled program for applying and removing a splint or brace, assess the resident's skin and circulation under the device and reposition the limb in correct alignment. These sessions are planned, scheduled and documented by the clinical record.

Bed Mobility

Activities used to improve or maintain the resident's self-performance in moving to and from a lying position, turning side-to-side and positioning themselves in bed.

Transfer

Activities used to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.

Ambulation Training

Activities used to improve or maintain the resident's self-performance in walking, with or without assistive devices. May include gait training or building of strength and endurance.

ADL Training, Dressing or Grooming

Activities used to improve or maintain the resident's self-performance in dressing, undressing, bathing, washing and performing other personal hygiene tasks.

Eating and Swallowing

Activities used to improve or maintain the resident's self-performance in feeding themselves food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth. Feeding techniques, use or adaptive equipment, proper positioning and cuing are included.

Amputation/Prosthesis Care

Activities used to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis and providing appropriate hygiene at the site where the prosthesis attaches to the body.

Communication

Activities used to improve or maintain the resident's self-performance in using newly acquired functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

Bladder/Bowel Continence

Activities that look at elimination patterns and assist the resident with a decrease in incontinence, prevent complications (i.e. falls, skin breakdown) and ensure resident dignity.

Assessment Process

Resident assessments will include the following:

- Ability to perform activities of daily living.
- Current problems that need addressing.
- Potential for risk to develop a problem in the absence of intervention.
- Need for special equipment or cues to perform tasks.
- Areas of teaching that are needed (energy conservation, work simplification).
- Potential to improve or the need for rehabilitation services to prevent decline.

Screening Instruments - MDS

The MDS provides the staff with information regarding the resident's self-performance deficits and whether restorative interventions would be indicated. The goal of the MDS is to assist the clinician in identifying residents for whom rehabilitative/restorative goals can be reasonable established.

Documentation

Daily Documentation – the staff member that has performed the task as assigned will do daily documentation of the specific restorative nursing interventions. Daily documentation will be completed by using the facility-specific process which may include a flow sheet or electronic medical record documentation. The care plan will be modified when goals are adjusted as necessary.

Program Overview

The strategies incorporated into rehabilitation/restorative nursing practice pervade all aspects of resident care and promote independence, team communication and outcome assessment. Rehabilitation/restorative nursing assistants incorporate these strategies under the supervision of nurses, 24 hours a day, 7 days a week. The program for rehabilitation/restorative nursing is a comprehensive program that includes competency assessment, educational modules, outcome assessment, ongoing tracking and system monitoring. The keys to success for this program are ongoing monitoring, system assessment, and establishment of rehabilitation/restorative nursing as a core element of nursing care within the skilled nursing facility.

Following completion of the curriculum for rehabilitation/restorative nursing, a competency form will be placed in the CNAs personnel file.

Rehabilitation/Restorative Nursing Program Components			
Training Modules	**Participants**	**Strategy**	**Instructor/Facilitator**
Introduction to rehabilitation / restorative nursing	All CNA's	• Lecture • Discussion • Pre and Post-Test	Staff development coordinator or designee
The rehabilitation team	All CNA's	• Lecture • Discussion • Pre and Post-Test	Staff development coordinator or designee
Range of Motion	All CNA's	• Lecture • Discussion • Return Demo • Pre and Post-Test	Staff development coordinator or designee
Splint and Brace Care	All CNA's	• Lecture • Discussion • Pre and Post-Test	Staff development coordinator or designee
Bed Mobility and Transfers	All CNA's	• Lecture • Discussion • Pre and Post-Test	Staff development coordinator or designee
Ambulation Training	All CNA's	• Lecture • Discussion • Return Demo • Pre and Post-Test	Staff development coordinator or designee
Activities of Daily Living	All CNA's	• Lecture • Discussion • Pre and Post-Test	Staff development coordinator or designee
Eating and Swallowing	All CNA's	• Lecture • Discussion • Pre and Post-Test	Staff development coordinator or designee
Amputation and Prosthesis	All CNA's	• Lecture • Discussion • Pre and Post-Test	Staff development coordinator or designee
Communication Strategies	All CNA's	• Lecture • Discussion • Pre and Post-Test	Staff development coordinator or designee
Bladder and Bowel Continence	All CNA's	• Lecture • Discussion • Pre and Post-Test	Staff development coordinator or designee

Section 2

Introduction to Rehabilitation / Restorative Nursing

Objectives:

- To discuss rehabilitation philosophy
- To identify the effects of immobility and physical dependence
- To define rehabilitation
- To list goals for rehabilitation
- To describe the roles of the rehabilitation/restorative nurse and of the rehabilitation/restorative nursing assistant

Content Outline:

- Introduction to rehabilitation/restorative nursing
    - Why Rehabilitation?
    - Hazards of immobility
    - Immobility and Dependence
    - Impact of increased dependence
    - Definition of rehabilitation
    - Goals for rehabilitation
    - Role of the rehabilitation/restorative nurse and of the rehabilitation/restorative nursing assistant

Course Competency:

Each participant will complete a pre-/post-test to validate retention of course content.

Introduction to Rehabilitation/Restorative Nursing

Why Rehabilitation?
Rehabilitation was not needed by ancient cultures
It is necessary today due to technological advances
An individual is more likely to survive a life-threatening injury or illness today than ever before

Hazards of Immobility:

Immobility affects every body system

Musculoskeletal System: Weakness and Atrophy

- **Loss of Strength**
  - Occurs at a rate of 10% a week
  - Recovery possible at only a rate of 6% a week
- **Prevention**
  - Early remobilization

Musculoskeletal System: Contractures

- **Joint of muscle limitation causing decreased range of motion**
  - Trauma and inflammation
  - Spasticity and paralysis
- **Prevention**
  - Flexibility exercises 10 to 15 minutes for 3 or more times a week
- **Correction**
  - Stretching exercises 20 to 30 minutes twice daily

Musculoskeletal System: Osteopenia

- **Osteopenia (bone loss) leads to fractures with minimal movement and exercise**

- **Prevention**
  - Early mobilization

Cardiovascular System

- System wide problems
- Redistribution of body fluids
- Postural hypotension
- Thromboembolus

- **Prevention**
  - Early mobilization
- **Correction**
  - Gradual reconditioning

Integumentary System (Skin)

- **Pressure ulcers**
  - Just 2 hours of pressure may result in tissue damage for an individual with impaired sensation
- **Prevention**
  - Identification of those at high risk
  - Early mobilization

Respiratory System

- **Pneumonia**
  - Caused by decreased airway clearance
  - Caused by pooling of secretions
- **Prevention**
  - Early mobilization

Genitourinary System

- **Calculi**
  - Caused by absorption of calcium (as bone loss occurs)
- **Urinary tract infections**
  - Inadequate bladder emptying, inadequate hydration associated with immobility
- **Prevention**
  - Early mobilization

Gastrointestinal System

- **Anorexia**
  - Caused by decreased metabolism
- **Constipation**
- **Prevention**
  - Early mobilization

Central Nervous System - Hallucinations and disorientation

- **Prevention**
  - Early mobilization

Immobility and Dependence

- **Loss of Mobility**
  - Directly linked with a need for assistance
  - Directly linked with a need to rely on others for daily care
  - Directly linked with a loss of independence

One of the most common fears of older adults is the fear of loss of independence.

Impact of Increased Dependence

- Fear of dependence causes anxiety
  - Loss of function and role
  - Loss of purpose and self-worth
  - Loss of privacy
  - Loss of home and community

Definition of Rehabilitation:
Dynamic process in which a disabled person is aided in achieving optimum physical, emotional, psychological, social, or vocational potential in order to maintain dignity and self-respect in a live that is as independent and self-fulfilling as possible.

Goals for Rehabilitation

- Focus on abilities rather than disabilities
- Make the most of remaining abilities
- Use the creative talents of the rehabilitation team members to design and implement a program
- The resident, family and support are the center of all rehabilitation efforts

Rehabilitation goals are ALWAYS determined through mutual goal setting involving the resident and the team members.

Through the rehabilitation process the resident will:

- Achieve the highest degree of function and self-sufficiency possible
- Maximize quality of life
- Meet the resident's specific needs
- Promote wellness
- Minimize complications

Role of the Rehabilitation/Restorative Nurse

Qualifications

- Education or special training in rehabilitation nursing

Role Characteristics

- Integration of rehabilitation program aspects 24 hours a day, 7 days a week
- Reinforcement of teaching and training completed by other disciplines

Characteristics of the rehabilitation/restorative nurse

- Discharge Planner
- Caregiver
- Confidant
- Case Manager
- Advocate
- Teacher
- Collaborator
- Coordinator
- Liaison
- Leader
- Facilitator
- Researcher
- Consultant
- Encourager
- Educator

Role of the Rehabilitation/Restorative Assistant

Qualifications

- Education or special training in rehabilitation/restorative nursing
- Functions under the direction and supervision of a rehabilitation/restorative nurse

Role Characteristics

- Member of the rehabilitation team
- Promotes carryover of therapeutic teaching by all disciplines
- Provides communication with team members on resident progress and limitations

Post-test
Introduction to Rehabilitation/Restorative Nursing

Name: _____ Title: _____

Social Security: _____ Work: _____

Mailing Address: _____

1. **Rehabilitation/restorative nursing is a key aspect of nursing care. The overall philosophy of rehabilitation/restorative nursing is rest and recovery.**

   True / False

2. **Immobility may be an issue with any chronic illness or injury. Immobility affects the skin and muscle strength but does not have a major impact on other body systems.**

   True / False

3. **Rehabilitation goals are always determined through mutual goal setting involving the resident and the team members.**

   True / False

4. **Rehabilitation/Restorative nursing care is best completed by focusing on rehabilitation program needs 24 hours a day, seven days a week.**

   True / False

5. **The rehabilitation team includes nurses, therapists, rehabilitation/restorative nursing assistants, the patient and family members.**

   True / False

Answer key
Introduction to Rehabilitation/Restorative Nursing

1. **Rehabilitation/restorative nursing is a key aspect of nursing care. The overall philosophy of rehabilitation/restorative nursing is rest and recovery.**

   True / False

2. **Immobility may be an issue with any chronic illness or injury. Immobility affects the skin and muscle strength but does not have a major impact on other body systems.**

   True / False

3. **Rehabilitation goals are always determined through mutual goal setting involving the resident and the team members.**

   True / False

4. **Rehabilitation/Restorative nursing care is best completed by focusing on rehabilitation program needs 24 hours a day, seven days a week.**

   True / False

5. **The rehabilitation team includes nurses, therapists, rehabilitation/restorative nursing assistants, the patient and family members.**

   True / False

Section 3

The Rehabilitation Team

The Rehabilitation Team

Objectives:
To describe rehabilitation philosophy
To describe the purpose of the team approach
To identify members of the rehabilitation team
To identify patterns of communication within the rehabilitation team

Content Outline:
Rehabilitation philosophy
The rehabilitation team
Team members
Team communication
Verbal communication
Written communication

Course Competency:
Each participant will complete a pre-/post-test to validate retention of course content.

The Rehabilitation Team

Rehabilitation Philosophy
Focus on abilities
Resident centered plan
Use of a team approach

The underlying philosophy of rehabilitation is:

Focus on abilities rather than disabilities, and to make the most of the abilities that remain intact.

The Rehabilitation Team

Why a team?

- *No single discipline has the knowledge and expertise necessary to provide all components of the rehabilitation program.*
- All efforts at rehabilitation require integration of the program by the nurse and nursing assistant.
- It is the rehabilitation/restorative nurse and assistant who reinforce teaching and training completed by the other disciplines 24 hours a day, 7 days a week.
- One hour of physical therapy can be undone 23 hours a day – or it can be reinforced 23 hours a day.
- Solid rehabilitation nursing is essential for a successful rehabilitation outcome.

Team Members

- Resident, family and support systems
  - Center of the team
  - Must be included in decision making and planning
  - Active participation is essential
  - Successful rehabilitation is possible only with commitment on the part of the resident, family and support system
  - Rehabilitation/restorative nurse and assistant
  - Physician
  - Physical therapist
  - Occupational therapist
  - Speech pathologist
  - Social worker
  - Respiratory therapist
  - Therapeutic recreation specialist
  - Chaplain/Pastor
  - Dietician
  - Psychologist

Team Communication

- Verbal
    - Care management meetings
    - Morning stand up meetings
    - Care planning meetings
    - Therapy treatment demonstrations
- Written Communication
    - Daily documentation
    - Progress notes
    - Resident care plan

Characteristics of Effective Teams

- Informal, comfortable, relaxed atmosphere
- Lots of discussion
- Solid understanding of group tasks and objectives
- Active listening
- Disagreement
- Consensus decision making
- Criticism frequent, frank and comfortable
- Freedom to express feelings, frustrations, ideas
- Action is equated with clear, accepted assignments
- Group takes time to evaluate its efficiency

Post-test
The Rehabilitation Team

Name: _____ Title: _____

Social Security: _____ Work: _____

Mailing Address: _____

1. **The three cornerstones of rehabilitation include: Focus on abilities, resident centered plan, and rehabilitation/restorative nursing delivered care.**

   True / False

2. **A team is nice but not necessary for effective rehabilitation.**

   True / False

3. **Rehabilitation teams achieve successful outcomes through effective communication, which includes the resident and family members.**

   True / False

4. **Effective teams never disagree.**

   True / False

5. **The rehabilitation team includes rehabilitation/restorative nurses, therapists, rehabilitation/restorative nursing assistants, the patient and family members.**

   True / False

Answer key
The Rehabilitation Team

1. **The three cornerstones of rehabilitation include: Focus on abilities, resident centered plan, and rehabilitation/restorative nursing delivered care.**

   True / False

2. **A team is nice but not necessary for effective rehabilitation.**

   True / False

3. **Rehabilitation teams achieve successful outcomes through effective communication, which includes the resident and family members.**

   True / False

4. **Effective teams never disagree.**

   True / False

5. **The rehabilitation team includes rehabilitation/restorative nurses, therapists, rehabilitation/restorative nursing assistants, the patient and family members.**

   True / False

Section 4

Range of Motion

Objectives:

- To describe the need for range of motion
- To define active and passive range of motion
- To demonstrate active and passive range of motion

Content Outline:

- Range of motion: Why is it needed?
- Guidelines for range of motion
- Return demonstrations

Course Competency:

- Each participant will complete a pre/post-test to validate retention of course content.

Range of Motion

Why is it Needed?

Rationale

- To counteract negative effects of immobility and disuse

Definition

Range of motion is the extent to which, or the limits between which a part of the body can be moved around a fixed point or joint.

Range of motion exercise is a program of passive or active movements to maintain flexibility and useful motion in the joints of the body.

Normal Motions of the Body

All motions of the body are described with the body starting in a neutral position. The neutral position is when head and body face forward, feet are straight ahead, and arms are next to the body with the palms facing forward (Figure 1).

Terminology used to describe motions occurring in the upper and lower extremities, neck and trunk are as follows:

Flexion	Bending of the joint
Extension	Straightening of the joint
Abduction	Moving the limb away from mid-line
Adduction	Moving the limb toward mid-line
Internal rotation	Turning the limb toward mid-line
External rotation	Turning the limb away from mid-line
Elevation	Shoulder shrugs
Circumduction	Moving limb in circular pattern
Lateral flexion	Bending to the side by the head or trunk
Lateral rotation	Rotating to the side by the head or trunk
Supination	Turning the palm of the hand upward
Pronation	Turning the palm of the hand downward
Inversion	Turning the foot inward
Eversion	Turning the foot outward
Protraction	Similar to abduction or moving forward, usually associated with scapular motion
Retraction	Similar to adduction or pulling back, usually associated with scapular motion

Basic ROM Terminology

Exercise Classification:

- Passive: Joint motion within unrestricted range, produced by an external force (manual or mechanical) without voluntary muscle activity by the resident
- Active: Any exercise where movement is accomplished by voluntary muscular contraction with or without external resistance

Glossary of Terms and Abbreviations:

- AROM Active range of motion
- AAROM Active assistive range of motion
- DIP Distal interphalangeal joint
- IP Interphalangeal joint
- MP Metacarpophalangeal joint
- PIP Proximal interphalangeal joint
- PRE Progressive resistive exercise
- PROM Passive range of motion
- Prone Lying on abdomen (face down)
- Supine Lying on back (back down)
- WFL Within functional limits
- WNL Within normal limits

ROM Treatment Protocol

- Before performing ROM with a resident, the assistant must know:
    - Diagnosis
    - Medical precautions and contraindications (e.g., no excessive hip flexion or internal rotation)
- Always attempt to position the resident so the part of the body being ranged is waist height and as close to the assistant as possible. This will help to prevent poor body mechanics and potential injury.
    - Positioning the resident properly may involve the use of an adjustable bed or plinth, which can be manually or electrically raised or lowered
    - If this is not possible, position the resident and yourself as best as possible, monitoring your body mechanics throughout the activity
- ROM should be performed to the point of resistance or when a slight stretch is felt
    - Monitor the resident's face for a response, such as grimacing due to pain
      DO NOT FORCE A MOVEMENT
- Each exercise should be performed for 10 repetitions and held for 30 seconds at end range. Follow the program set forth by the therapist as the resident's functional activity tolerance may need to be built up to achieve 10 repetitions.
- Support the extremity or body part throughout range of motion by placing one hand just above the joint and the other hand below the joint.
- Perform each movement slowly to prevent injury to the resident. This will allow the assistant to closely monitor the resident for any signs of pain or discomfort.
- Refer to the program set forth by the therapist. If the resident appears to be unable to safely perform or tolerate the established program due to pain or discomfort, do not proceed with ROM. Notify the nursing staff and the therapist so they can assess the situation.
- When possible, incorporate the range of motion into a resident's bathing or ADL session and teach the resident self-ROM whenever possible.

Sequence of Joint Motion

- **Head and Neck**

- **Shoulder**
  - Flexion – extension
  - Abduction – adduction
  - Internal rotation – external rotation
  - Horizontal abduction – adduction

- **Elbow**
  - Flexion – extension
  - Supinaton – pronation

- **Wrist Joint**
  - Flexion – extension
  - Ulnar deviation – radial deviation

- **Finger Joints**
  - Flexion – extension
  - Abduction – adduction

- **Thumb Joints**
  - Flexion – extension
  - Abduction – adduction
  - Opposition

- **Hip Joint**
  - Flexion – extension
  - Abduction – adduction
  - Internal rotation – external rotation

- **Knee Joint**
  - Flexion – extension

- **Ankle Joint**
  - Dorsiflexion – plantar flexion
  - Inversion – eversion

- **Toes**
  - Flexion – extension
  - Abduction - adduction

Neck

- **Flexion**
  - Starting position: Resident is lying straight out in bed, face up or sitting as straight as possible with his/her head in a neutral (mid-line) position or in as neutral a position as possible with back supported
  - Hand position: Support resident's head in one hand and place the other hand at the base of the head (top of neck). With some elderly residents, you may have to place one hand on the lower jaw, instead of at the base of the head (top of neck), to guide the neck into flexion.
  - Movement: Bend the head forward so chin goes toward the resident's chest
  - Return the head to a neutral position

- **Extension**
  - Starting position: Resident is sitting as straight as possible with his/her head in a neutral (mid-line) position or in as neutral a position as possible
  - Hand position: Place one hand on the resident's forehead and the other hand at the base of the resident's head (top of neck)
  - Movement: Bend the head backward so the top of the resident's head goes down and toward the back
  - Return the head to a neutral position

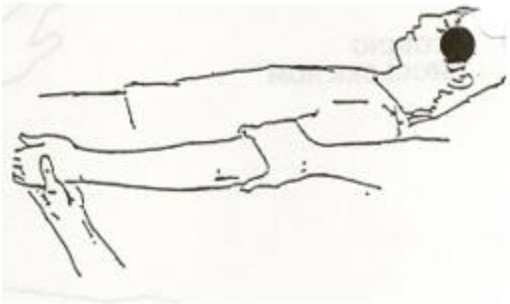
If resident complains of dizziness or lightheadedness with this movement, consult the nurse or therapist immediately as there may be a compression of the vertebral artery.

- **Lateral flexion**
  - Starting position: Resident is lying straight out in bed, face up or sitting as straight as possible with his/her head in a neutral (mid-line) position or in as neutral a position as possible with back well supported
  - Hand position: Place one hand so it cradles one side of the resident's head to help guide it and place the other hand toward the top and to the side of the head
  - Movement: Bend the head toward the side you are cradling and gently push with the other hand, so the ear goes toward the shoulder
  - Return the head to a neutral position and repeat the same steps going to the other side

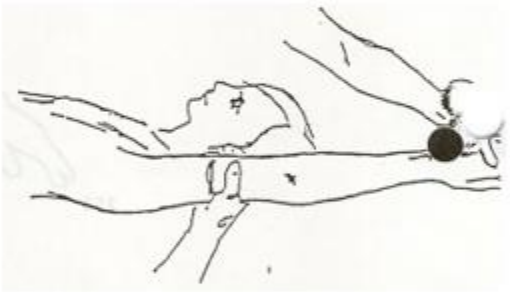
- **Lateral rotation**
  - Starting position: Resident is lying straight out in bed, face up or sitting as straight as possible with his/her head in a neutral (mid-line) position or in as neutral a position as possible with back well supported
  - Hand position: Place one hand so it cradles one side of the resident's head to help guide it and place the other hand on the other side of the head
  - Movement: Rotate the head toward the side you are cradling and push with the other hand, so the chin goes toward the shoulder
  - Return the head to a neutral position and repeat the same steps going in the opposite direction

Shoulder

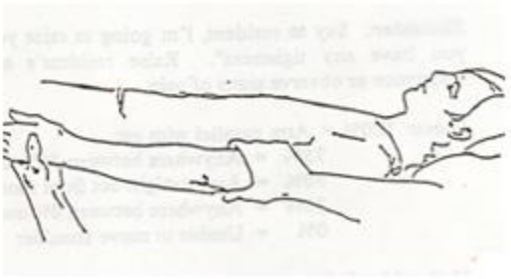
- **Flexion (arm forward)**
  - Starting position: Place resident's arm straight at side with thumb up.
  - Position yourself at resident's side level with his shoulder.



Hand position: Place one hand above elbow.
Hold resident's hand with your other hand.

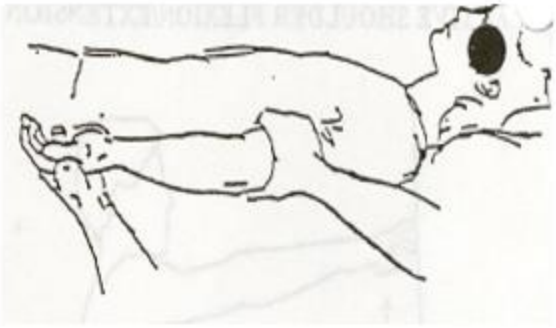


Movement: Lift resident's arm overhead toward the ear.
Keep elbow straight and thumb up.



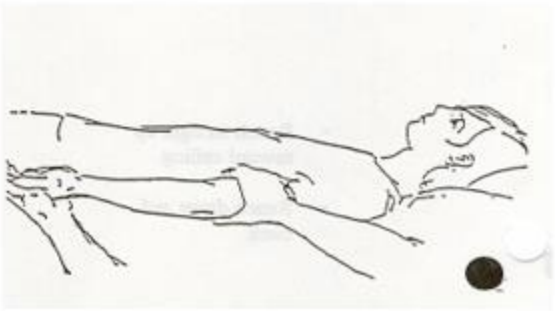
Return resident's arm to starting position, straight at side

Shoulder



Abduction (arm sideward)
Starting position: Place resident's arm straight at side with palm up
Hand position: Place one hand above elbow holding resident's hand with your other hand

Movement: Move resident's arm away from side around toward ear.
Keep elbow straight, palm up and arm parallel with floor.



Return resident's arm to starting position, straight at side

Shoulder

Rotation (turning arm in and out)
Starting position: Place resident's arm at side with elbow bent so fingers are pointing toward ceiling. Position yourself beside resident at the level of the elbow.
Hand position: Place one hand above elbow holding resident's hand with your other hand

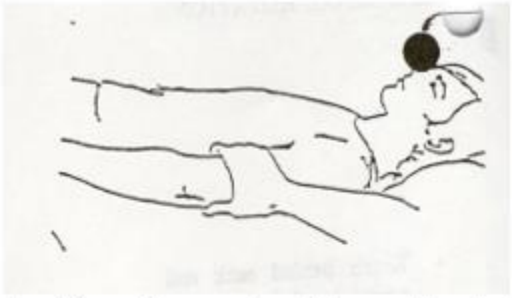
Movement: Turn resident's upper arm so hand moves toward stomach

Turn upper arm so hand moves away from stomach

Return resident's arm to starting position at side with elbow bent

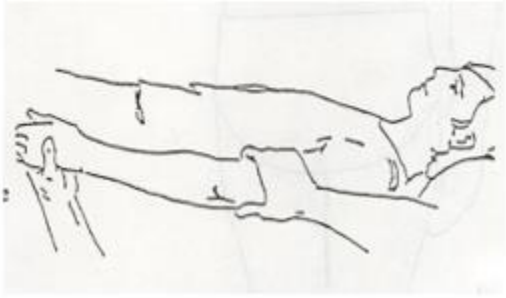
Elbow

- **Flexion: (bending)**
  - Starting position: Place resident's arm straight at side with thumb up



Hand position: Place one hand above elbow holding resident's hand with your other hand

Movement: Bend resident's elbow so hand goes toward shoulder

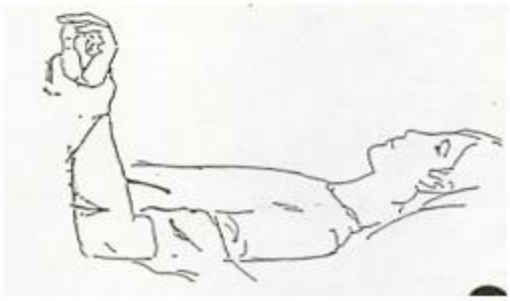


Return the resident's arm to starting position, straight at side

Elbow

Supination and pronation: (forearm turning)
Starting position: Place resident's arm on bed at side with elbow bent so fingers point towards ceiling and thumb points towards shoulder Hand position:
Hold resident's hand with one hand and arm with your other hand

Movement: Turn resident's forearm so palm faces toward him/her



Turn forearm so palm faces away.
Return forearm to starting position

Wrist

- **Flexion and Extension (wrist bending)**
  - Starting position: Place resident's arm at side with elbow bent so fingers point toward ceiling

Hand position: Hold resident's hand with one hand and below wrist with your other hand

Movement: Bend resident's hand backward

Bend hand forward

Return hand to starting position with fingers pointing toward ceiling

Wrist

Ulnar and Radial Deviation (wrist side bending)
Starting position: Place resident's arm at side with elbow bent so fingers point toward ceiling
Hand position: Hold resident's hand with one hand and hold below resident's wrist with other hand

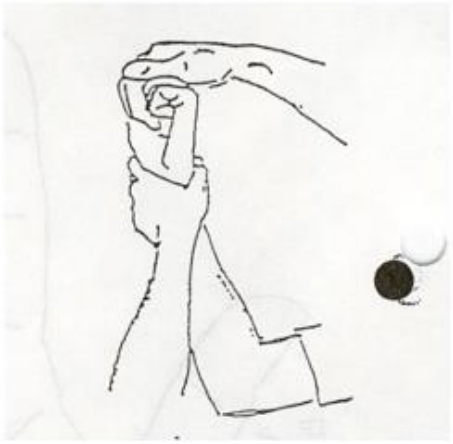
Movement: Bend hand sideways in direction of thumb

Bend hand sideways towards little finger
Return hand to starting position

Fingers

- **Flexion and Extension** (finger bending and straightening).
  - Starting position: Place resident's arm at side with elbow bent and fingers pointing toward ceiling

Hand position: Place one hand palm down over back of resident's hand and support wrist with other hand

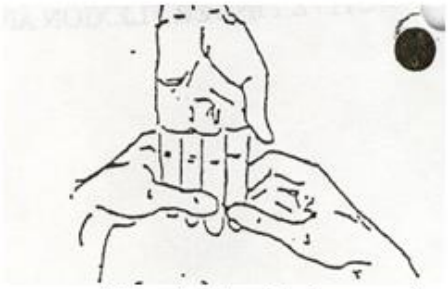


Movement: Help resident make a tight fist Straighten fingers so that hand is flat/open

Abduction and Adduction (finger spreading)
Starting position: Place resident's arm straight at side with palm up

Fingers

1)



Hand position: Hold resident's index finger with one hand and long finger with the other

2)

Movement: Spread resident's fingers apart

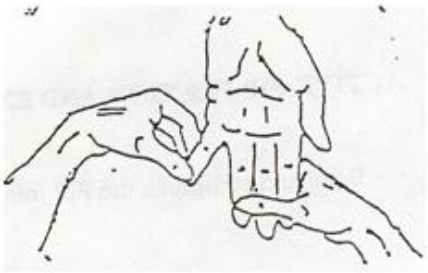
3)

Move fingers together

4)

Grasp resident's long finger and ring finger. Move them apart, then together.

5)

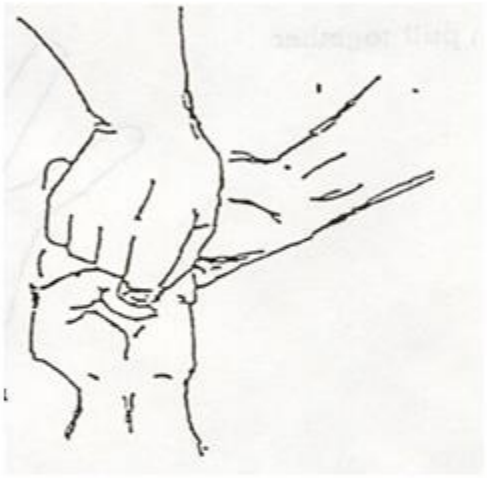


Grasp ring finger and little finger. Move them apart, then together.

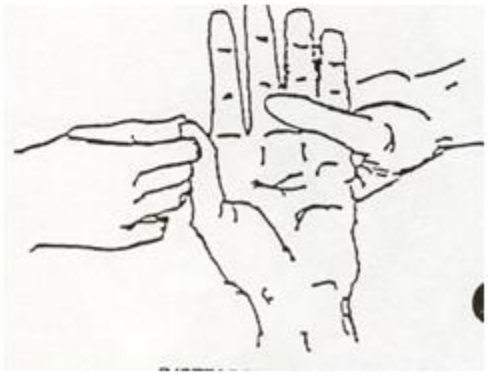
Thumb

- **Flexion and Extension** (thumb bending and straightening)
  - Starting position: Place resident's arm straight at side with palm up

Hand position: Hold resident's hand with one hand and thumb with other hand

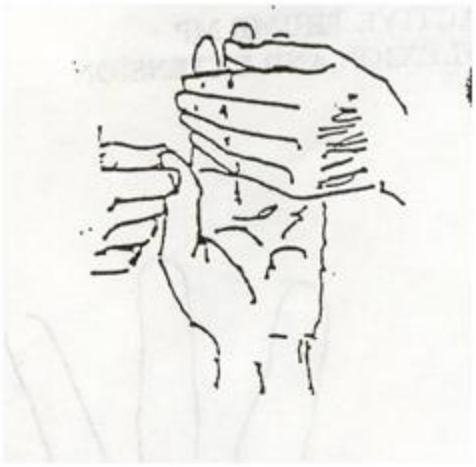


Movement: Bend thumb down into palm of hand



Straighten thumb to "hitchhike" position

Thumb



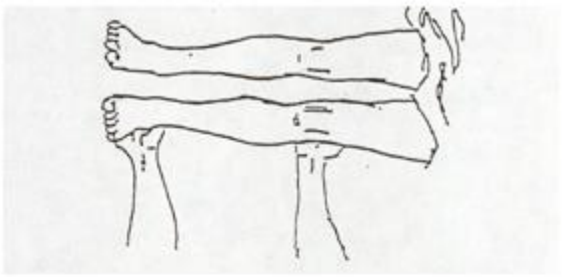
Abduction and Adduction
Starting position: Place resident's arm straight at side with palm up and thumb next to first finger. Hand position: Hold resident's hand in place with one hand and hold base of thumb with your other hand

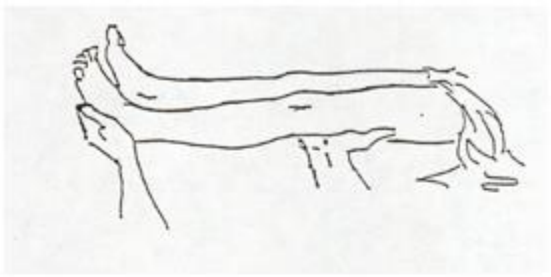
Movement: Move thumb toward ceiling away from palm

Move thumb down to first finger

Hip and Knee

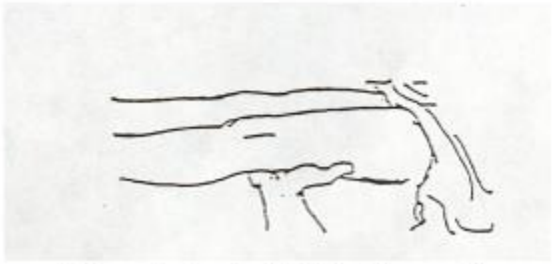
- **Flexion** (hip and knee bend)
    - Starting position: Resident's leg out straight on bed with kneecaps pointing toward ceiling





Hand position: One hand under resident's knee, other hand under heel

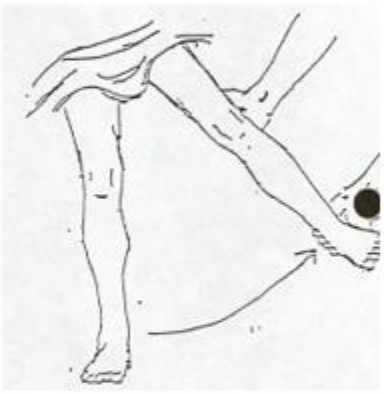
Movement: Bend resident's knee toward chest



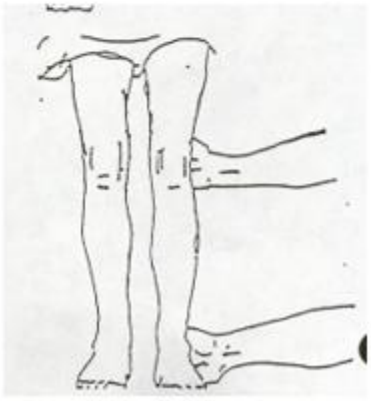
Return leg to straight starting position

Hip and Knee

Abduction (leg to side)
Starting position: Resident's leg out straight on bed with kneecap pointing toward ceiling
Hand position: One hand under resident's knee, other hand under heel

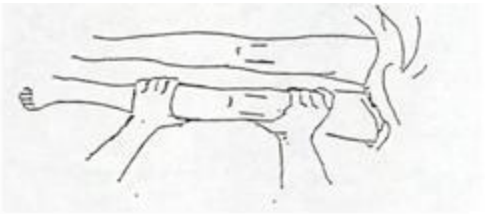


Movement: Move resident's leg away from other leg.
Keep knee straight and toes pointed up (in order to move leg
all the way out to the side, take a step backward).

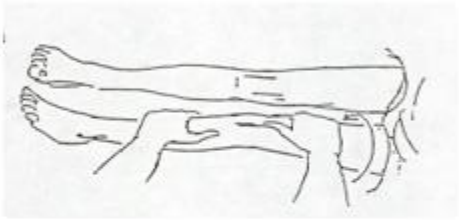


Bring resident's leg into starting position

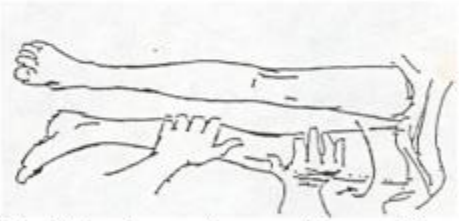
Hip and Knee



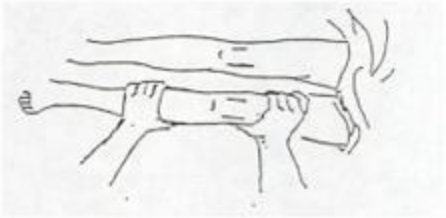
External and internal rotation (leg turning)
Starting position: Resident's leg out straight on bed with kneecap pointing toward ceiling
Hand position: One hand just above resident's knee and other hand just below knee



Movement: Roll entire leg away from you so kneecap turns inward

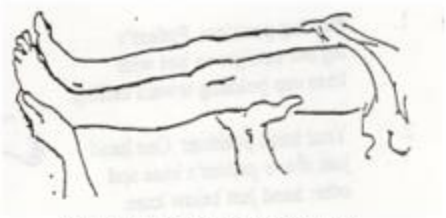


Roll resident's leg toward you so knee points outward



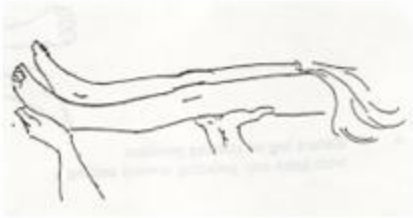
Return leg to starting position with kneecap pointing toward ceiling

Hip and Knee



Straight leg raise (leg up)
Starting position: Resident's leg out straight on bed with kneecap pointing toward ceiling
Hand position: One hand under resident's knee, one hand under heel

Movement: Lift resident's leg up toward chest while keeping knee straight



Bring leg down to starting position on bed

Ankle

- **Dorsiflexion** (foot up)
    - Starting position: Resident's leg straight on bed with toes pointing upward

Hand position: Cup resident's heel in the palm of your hand
with ball of foot resting against your arm. Place other hand on top of ankle.

Movement: Bring resident's foot up by pulling down on heel
and pressing up on ball of foot with your arm

Relax your arm and allow foot to return to starting position

Ankle

Plantar flexion (foot down)
Starting position: Resident's leg straight on bed with toes pointing upward
Hand position: Cup resident's heel in palm of your hand with ball of foot resting against your arm. Place other hand on top of foot just below toes.

Movement: Point resident's foot down by pressing up on heel and down on foot

Bring resident's foot back to starting position with toes pointing towards ceiling

Ankle

Inversion and Eversion (foot in and out)
Starting position: Resident's leg straight on bed with toes pointing upward
Hand position: Hold resident's foot with one hand and ankle with the other hand

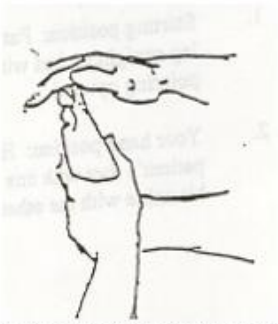
Movement: Turn foot so sole of the foot turns inward

Turn foot so sole of the foot turns outward

Return to starting position with sole of resident's foot toward the end of the bed

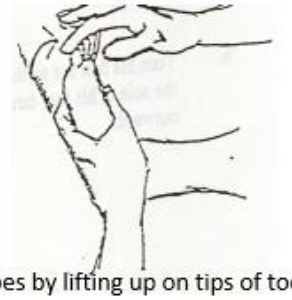
Toes

- **Flexion and Extension** (toe bending and straightening)
  - Starting position: Resident's leg on bed with toes pointing upward



Hand position: Hold resident's foot with one hand
and place fingers of your other hand over tops of toes

Movement: Curl toes down by curling your fingers over them



Straighten toes by lifting up on tips of toes with fingers

Return Demonstrations

Form groups of two or three persons each
One individual will act as the resident
The second individual will complete range of motion following the appropriate sequence
If a third person is included, this person will oversee the process for possible issues
Change roles and repeat the process until all have participated

Post-test
Range of Motion

Name: _____ Title: _____

Social Security: _____ Work: _____

Mailing Address: _____

1. **Range of motion is important only if the resident is unable to move independently.**
   True / False
2. **Active range of motion is done for the resident but is lively in pace.**
   True / False
3. **The sequence of range of motion must not be interrupted but should flow from head to toe.**
   True / False
4. **Range of motion is contraindicated if a resident has spasticity or pain.**
   True / False
5. **Range of motion can be combined with bathing and dressing routines.**
   True / False
6. **Contractures can be prevented**
   True / False
7. **Hand splints, rolls and cones can help to prevent hand contractures**
   True / False
8. **If you feel a spasm during ROM, you should push harder**
   True / False

Answer key
Range of Motion

1. **Range of motion is important only if the resident is unable to move independently.**
   True / False
2. **Active range of motion is done for the resident but is lively in pace.**
   True / False
3. **The sequence of range of motion must not be interrupted but should flow from head to toe.**
   True / False
4. **Range of motion is contraindicated if a resident has spasticity or pain.**
   True / False
5. **Range of motion can be combined with bathing and dressing routines.**
   True / False
6. **Contractures can be prevented**
   True / False
7. **Hand splints, rolls and cones can help to prevent hand contractures**
   True / False
8. **If you feel a spasm during ROM, you should push harder**
   True / False

Clinical Competency Checklist
Restorative Nursing – Active Range of Motion

Employees Name / Credentials: _____

AROM	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Identifies weak or involved side						
Identifies precautions, contractures or pain						
Informs resident in a pleasant manner what is going to happen						
Facilitates all motions correctly						
Ranged each extremity through its end range						
Placed hands correctly						
• Hip						
• Flexion						
• Extension						
• Abduction						
• Adduction						
• Internal rotation						
• External rotation						
• Knee						
• Flexion						
• Extension						
• Ankle						
• Dorsiflexion						
• Plantar flexion						
• Inversion						
• Eversion						
• Toes						
• Flexion						
• Extension						

AROM	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
• Shoulder						
• Flexion						
• Extension						
• Abduction						
• Adduction						
• Internal rotation						
• External rotation						
• Elbow						
• Flexion						
• Extension						
• Forearm						
• Pronation						
• Supination						
• Wrist						
• Flexion						
• Extension						
• Ulnar deviation						
• Radial deviation						
• Fingers						
• Flexion						
• Extension						
• Abduction						
• Adduction						
• Neck						
• Flexion						
• Extension						
• Lateral flexion						
• Lateral rotation						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:**_____

Clinical Competency Checklist
Restorative Nursing – Passive Range of Motion

Employees Name / Credentials: _____

PROM (Passive Range of Motion)	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Identifies weak or involved side						
Identifies precautions, contractures or pain						
Informs resident in a pleasant manner what is going to happen						
Performs all motions correctly						
Ranged each extremity through its end range						
Placed hands placed correctly						
• Hip						
• Flexion						
• Extension						
• Abduction						
• Adduction						
• Internal rotation						
• External rotation						
• Knee						
• Flexion						
• Extension						
• Ankle						
• Dorsiflexion						
• Plantar flexion						
• Inversion						
• Eversion						
• Toes						
• Flexion						
• Extension						

Clinical Competency Checklist
Restorative Nursing – Passive Range of Motion

PROM (Passive Range of Motion)	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
• Shoulder						
• Flexion						
• Extension						
• Abduction						
• Adduction						
• Internal rotation						
• External rotation						
• Elbow						
• Flexion						
• Extension						
• Forearm						
• Pronation						
• Supination						
• Wrist						
• Flexion						
• Extension						
• Ulnar deviation						
• Radial deviation						
• Fingers						
• Flexion						
• Extension						
• Abduction						
• Adduction						
• Neck						
• Flexion						
• Extension						
• Lateral flexion						
• Lateral rotation						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Section 5

Splint and Brace Care

Splint and Brace Care

Objectives:

- To discuss proper application and care of splints and braces

Content Outline:

- Splint and brace care

Course Competency:

Each participant will complete a pre-/post-test to validate retention of course content.

Splint and Brace Care

- Temporary immobilization devices
- Made from a variety and combinations of materials including plaster of Paris, fiberglass, plastic, velcro, cloth and metal
- Individually designed or commercially prepared
- External appliances that
    - Limit motion or weight bearing
    - Protect weak and painful musculoskeletal areas
    - Prevent and correct deformities
    - Reduce axial load
    - Improve function

Types of Braces (orthosis)

- Ankle foot orthosis – short leg brace
- Knee, ankle, foot orthosis – long leg brace
- Hip, knee, ankle, foot orthosis – long leg brace with pelvic band
- Cervical thoracic lumbar sacral orthosis – Milwaukee brace
- Thoracic lumbar sacral orthosis – Boston brace
- Hip abduction orthosis – Scottish Rite brace

Types of Braces (splints)

- Static splints
- Hold the joint in a functional position
- Examples:
- Knee immobilizer
- Wrist immobilizer
- Ankle immobilizer
- Abduction pillow
- Dynamic splints
- Allow the joint to move
- Example:
- Metacarpal-phalanges arthroplasty splint

Assessment

- Skin
    - Inspect for signs of irritation
    - Over bony prominences
    - Around edges
    - Underneath the splint or brace

Assessment frequency

- Check every shift for new splints
    - Check before applying and removing splints
    - Assess a minimum of every 2 hours while splints are on
    - Check for proper fit by observing
    - Correct position of the splint or brace on the body
    - Review the position with the therapist
    - Use a photograph or drawing of the correct position
    - Straps are secure, but not tight
    - The device does not slip down when the resident moves

Resident training should focus on:

- How to apply the device
- How to care for the device
    - Keep it clean and dry
    - Protect the skin by wearing socks, tee shirt, or appropriate cloth material under the device

Notify the physician and therapist if the splint or brace begins to rub the skin or does not fit properly

Assistance can be of two types:

- Where staff members provide verbal and physical guidance and direction that teaches the resident…
    - How to apply for a brace or splint
    - How to manipulate for a brace or splint
    - How to care for a brace or splint

- Where staff members have a scheduled program of…
    - Applying and removing a splint or brace
    - Assess the resident's skin and circulation under the device
    - Reposition the limb in correct alignment
    - These sessions are planned, scheduled, and documented in the clinical record

Post-test
Splint and Brace Care

Name: _____ Title: _____

Social Security: _____ Work: _____

Mailing Address: _____

1. **Each time a splint is applied, the skin should be checked for red areas.**
   True / False
2. **Splint straps should be applied tightly so the splint does not move.**
   True / False
3. **Splints can cause excess pressure over bony areas if not monitored.**
   True / False
4. **Dynamic splints do not allow the joints to move.**
   True / False
5. **Range of motion should be completed each time a splint is applied.**
   True / False

Answer key
Splint and Brace Care

1. **Each time a splint is applied, the skin should be checked for red areas.**

   True / False

2. **Splint straps should be applied tightly so the splint does not move.**

   True / False

3. **Splints can cause excess pressure over bony areas if not monitored.**

   True / False

4. **Dynamic splints do not allow the joints to move.**

   True / False

5. **Range of motion should be completed each time a splint is applied.**

   True / False

Clinical Competency Checklist
Restorative Nursing – Splinting

Employees Name / Credentials: _____

Splinting	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Informed resident in a pleasant manner that it is time to don/doff splint						
Checks precautions prior to application						
Checks wearing schedule prior to application						
Identifies reasons why splint is used						
Completes ROM to affected site prior to splinting						
Identifies purpose and demonstrates donning for each splint						
• Resting hand splint						
• Palm guard						
• Palm guard w/ finger separators						
• Elbow splint						
• Abductor wedge						
• Knee splint						
• AFO						
• Multi-podus boot						
• Isotoner glove						
Doffs splints						
Identifies symptoms of intolerance						
• Skin check						
• Looks for redness						
• Looks for blisters						
• Looks for edema						

Clinical Competency Checklist
Restorative Nursing – Splinting

Splinting	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
Identifies how to store splints						
Identifies how to clean splints						
Replaces worn/soiled						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Section 6

Bed Mobility and Transfer

Bed Mobility and Transfers

Objectives:

- To identify the basic principles of body mechanics
- To review the use of the gait belt
- To define total hip, knee precautions
- To demonstrate bed positioning and bed mobility techniques
- To demonstrate transfer techniques

Content Outline:

- Why use good body mechanics?
- Why use a gait belt?
- Definitions
- Hip Precautions/Knee Precautions
- Bed Mobility
- Transfers
- Return demonstrations

Course Competency:

Each participant will complete a pre-/post-test to validate retention of course content.

Bed Mobility and Transfer

Transfers and bed mobility are a normal part of our daily activities. Going from lying down to sitting edge of bed, rolling, getting in/out of bed, sitting and standing from bed/chairs and toilet are all examples of transfers and bed mobility. Allowing and encouraging a resident to take an active role with transfers will help maintain the highest level of functional independence possible. In this section, we will review the proper techniques for assisting residents to perform transfers and bed mobility safely.

Bed Mobility
Activities used to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side, and positioning him or herself in bed.

General Guidelines

- Tell the resident what you are going to do, as simply and clearly as possible
- Tell the resident what he/she must do
- Utilize assistive devices as needed (bedrails, overhead trapeze, transfer pad)
- Allow the resident to perform as much of the activity as they are able
- Review with resident any precautions

Prone Position (Lying on Stomach)

- Align the resident's head, trunk and feet
- Place a small pillow under the resident's head and neck for comfort
- Assure that the resident's head is flexed slightly; avoid hyperextension of their neck
- Place a pillow under anterior ankles, thighs, and chest for comfort and/or protection
- Arms, flexed resting on pillow
- Alternate arm positions when resident is lying prone
- Both arms flexed
- One arm flexed up; one arm flexed down
- Both arms flexed down at sides to prevent contractures

Side Lying Position

- Keep back straight with knees and hips slightly flexed
- Place a pillow under head, neck, and upper shoulder
- Pull the resident's shoulder slightly forward
- Pull the resident's bottom arm up toward the head of the bed
- Place pillows under upper arm to keep at shoulder level
- Position upper leg bent (flexed) in front of or behind bottom leg to separate skin surfaces
- Place several pillows underneath the groin area to bottom of the foot
- Place pillows behind the back

Dependent Roll

Set-up

- Make sure that the resident has plenty of room on the side direction he/she wishes to roll.

Pre-roll Positioning

- The person assisting positions him/herself on the side of the bed toward which the resident is to roll
- Cross the lower leg farthest away from you over the extremity closest to you
- Cross the arm farthest away from you over the chest, supporting the arm as necessary
- Place one hand on the back of the pelvis and one hand on the shoulder blade.

Roll

- Gently roll the resident toward you onto his/her side
- Encourage the resident to turn his/her head in the direction of the roll
- Position arms and legs with pillows as needed
- Encourage the resident to assist in the following ways:
    - Flexing the opposite hip and knee, placing the foot flat and aiding the roll by reaching forward with the pelvis
    - Turn the resident's head in the direction of the roll
    - If the roll is toward the affected side, have the resident place his/her unaffected arm in the direction of the roll
    - If the roll is toward the unaffected side, have the resident clasp his/her hands together (as in praying), and reach with both arms in the direction of the roll.

Moving Supine To/From Sitting

Set-up

- Make sure that the resident has plenty of room on the side to which he/she wishes to roll

Pre-roll Positioning

- The person assisting positions him/herself on the side of the bed toward which the resident is to roll
- Using good body mechanics, assist resident to flex knees so feet are flat on bed
- Cross the resident's arm farthest away from you over the chest, supporting the arm as necessary
- Place one hand on the resident's tailbone and one hand on the shoulder blade

Sitting

- Gently roll the resident toward you onto his/her side. Assist with one hand guiding legs (ensuring hip precautions if applicable), and the other hand at the resident's shoulder farthest from you to guide trunk. The entire body should roll together (log roll).
- Encourage the resident to turn his/her head in the direction of the roll
- Place the resident's feet over the side of the bed
- Place your arm between the resident's arm and the bed, and place your hand around the resident's shoulder blade
- Have resident push up on elbow and then to hand while swinging his/her legs off the side of the bed
- With one hand, support and guide legs off bed while lifting trunk with the other hand, keeping resident's trunk in alignment with lower body to ensure proper hip precautions
- Gently lift the resident from the side lying position to the sitting position
- Balance the resident in the sitting position
- Encourage the resident to assist in the following ways:
    - Flexing the opposite hip and knee, placing the foot flat and aiding the roll by
    - reaching forward with the pelvis
    - Turn the resident's head in the direction of the roll
    - If the roll is toward the affected side, have the resident place his/her unaffected arm in the direction of the roll
    - If the roll is toward the unaffected side, have the resident clasp his/her hands together (as in praying), and reach with both arms in the direction of the roll.

Scooting Up/Down in Bed

- If the resident cannot help, ask for help from another CAN or nurse
- If the resident is on tube feeding, **do not** put the head of the bed down
- Cross the resident's arms on his/her chest
- Each person assisting takes hold of the sheet or draw sheet as close to the resident's body as possible at the levels of the shoulders and hips
- Ask the resident to hold up his/her head or ask for help from another person to support the resident's head
- Gently lift/scoot the resident up or down in bed
- **DO NOT** pull the resident up by the shoulder

Transfers

Transfer Process

- Before the initiation of a transfer, you must know resident's:
  - Diagnosis
  - Involved or weak side
  - Weight bearing status (if appropriate)
  - Ability to follow instructions
  - Medical precautions or contraindications

Definition:

Activities used to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.

General Guidelines

- Tell the resident what you are going to do, as simply and clearly as possible
- Tell the resident what he/she must do
- Utilize assistive devices as needed (grab bars, walker, cane)
- Allow the resident to perform as much of the activity as they are able
- Be sure the resident is wearing proper shoes
- Be knowledgeable of the amount/type of assistance required and any weight bearing precautions
- Use proper body mechanics
- Transfer to the resident's stronger side (if applicable and able)
- Stabilize or lock all surfaces including wheelchairs and beds
- Equalize heights of surfaces as much as possible
- Remove wheelchair footrests, leg rests, and arm rests if appropriate
- Watch for potential trauma to resident's skin to prevent skin tears
- Assist the resident in the same manner every time
- When two caregivers assist a resident, use a signal to move simultaneously

Sit to Stand Transfer Procedure

- If in bed, have resident sit up with feet over the side of the bed as stated above. When the resident is coming to sitting from supine, have him/her help by pushing his/her body up with the arms. DO NOT allow the resident to hold onto your back or neck for assistance. MONITOR body mechanics.
- Have the resident scoot forward until the feet are flat on the floor
- Position yourself so to assist the resident using good body mechanics (wide base of support, back straight, knee bent). It may be necessary to cross your shin with the resident's afflicted leg (to stabilize leg and lock knee).
- Count aloud with resident to increase participation
- With hands securely on the safety/gait belt, instruct the resident to stand up on the non-involved extremity pushing up from the bed/wheelchair arm rests with both upper extremities if able.
- Have the resident lean forward and push up from the wheelchair armrests with both extremities if able
- Instruct the resident to stand up as straight as possible to assist with maintaining balance. If resident uses an assistive device, have him/her reach for the assistive device once standing erect. DO NOT allow the resident to pull up from the assistive device to achieve standing.

Stand to Sit Transfer Procedure

- Reverse of sit to stand procedure as described above
- If sitting in a wheelchair, make sure breaks are locked prior to transfer
- Remind resident to reach back for surface with both hands before sitting down

Bed to/From Wheelchair

- Bring the wheelchair next to the bed. Position the wheelchair so it is facing the resident's non-involved or stronger extremity. The wheelchair should be as close to the bed as possible, and at a slight angle toward the resident.
- Lock the brakes
- Have resident sit up in bed with feet over the side of the bed as stated above. When the resident is coming to sitting from supine, have him/her help by pushing his/her body up with the arms. DO NOT allow the resident to hold onto your back or neck for assistance. MONITOR body mechanics.
- Lock the bed and position at a height where the resident's feet touch the ground
- Put shoes on the resident's feet
- Secure a gait belt around the resident's waist
- Have the resident scoot forward until the feet are flat on the floor
- Position yourself so you can assist the resident using good body mechanics (wide base of support, back straight, knee bent)
- Instruct the resident to stand up by pushing off of the surface he/she is sitting on and to weight bear primarily on the non-involved extremity once standing. The resident should reach for the far armrest. Make sure your hands are securely on the safety/gait belt.
- Emphasis should be placed on standing up as straight as possible before beginning to pivot toward the wheelchair. It is less energy demanding to stand on a straight knee than it is to stand on a bent knee.
- Pivot the resident toward the wheelchair. This is accomplished by allowing the resident to take small steps. If weight bearing is not permitted on the involved side, then the resident can turn by pivoting or moving the heel in small increments until his/her body is aligned with the wheelchair.
- Have the resident reach for the wheelchair armrests to slowly lower him/herself into the wheelchair.
- To return the resident to the bed from the wheelchair, place the wheelchair so the non-involved leg is next to the bed. Repeat the steps noted above.

Sometimes, due to the set-up of the resident's room or bathroom, it is not possible to place the resident so that the uninvolved side is facing the surface he/she is transferring to. If this is the case, ensure you use a safety/gait belt and make sure the resident stands as upright as possible to allow for the safest transfer possible.

Stand-Pivot Transfers

- Used with residents having the following diagnoses:
    - Amputee
    - Total Hip Surgery
    - Total Knee Surgery
    - Head Trauma
    - Stroke

Transferring with a Sliding Board

- Remove the armrest of the wheelchair at the side facing the resident
- Place one end of the transfer board under the resident's bottom
- Place the other end of the transfer board on the wheelchair
- Help the resident scoot across the transfer board to the wheelchair
- Gently slide the transfer board away from the resident

Transferring with a Walker/Cane

- Secure a gait belt around the resident
- If the resident is in bed lock the bed brakes and lower the bed so that the resident's feet touch the floor
- Put non-skid shoes on the resident's feet
- Tell the resident to place one hand on the walker/cane and push with their other hand from the bed
- Assist with the gait belt as needed
- Tell the resident to stand up
- Once the resident is in the standing position, have him/her place his/her other hand on the walker/cane
- Help the resident turn with the walker/cane so his/her back is facing the chair
- Have the resident reach back for the chair with one hand at a time, lean slightly forward and begin sitting in the wheelchair

Why Use Good Body Mechanics?

- Using body mechanics principles will help you and the resident to:
    - Conserve energy
    - Maintain muscle tone and joint mobility
    - Prevent injury

Basic Principles

- When moving or lifting heavy objects remember to:
  - Keep a straight back with pelvis level, and head up
  - Reason: Increased lordosis or kyphosis (rounding of the back) will increase the chance of back injury. A straight back will keep the center of gravity over the base of support and align the spine in the most appropriate way to prevent vertebral disc injury. Keeping the head up helps to maintain a straight back.

- Keep feet apart for wide base of support
  - Reason: Broadens the base of support making it easier to maintain balance while lifting

- Bend the knees and lifting with the legs, not the back
  - Reason: Bending the knees before lifting lowers center of gravity which provides increased stability and helps use quadriceps (thigh muscles) to do the lifting instead of relying on back muscles

- Hold the load/resident close to the body
  - Reason: The load becomes part of body mass, decreasing effects of gravity and decreasing the lever length of the arms. The load (resident) will be "lighter" if held away from the body, increasing control of the load. For example, hold a two-pound weight out to the side of your body. Notice how heavy it becomes. Now hold it close to the body. Notice how light it becomes.

- Utilize safety equipment such as gait belts/lift sheets whenever possible
  - Reason: By using safety equipment appropriately, the assistant and the resident will be safer and less likely to be injured. Such equipment often decreases the amount of stress on the body (as well as the resident's body) and provides an effective way to maintain control of a resident while lifting or transferring.

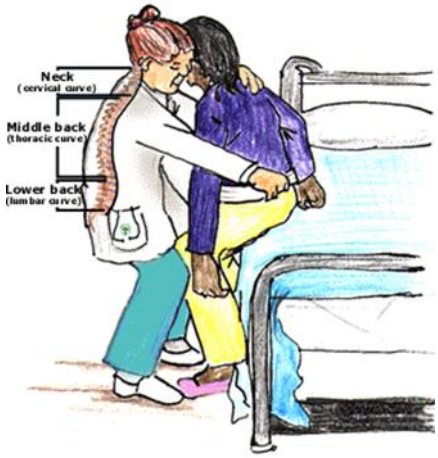
- Turn by shifting foot position instead of rotating your spine
  - Reason: By moving your feet, you prevent twisting of the spine while lifting. Twisting with a heavy load may cause a back injury.

- Lift alone only if you have no doubt about your ability to do so – if you have any doubts, get help!

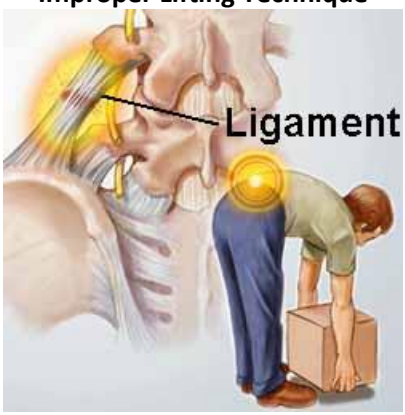
- Work the whole body together as a unit for maximum efficiency.
  - Reason: This will set the trunk muscles to immobilize the spine to enable arms and legs to do the lifting.

- Remember to use a safety/gait belt or lift sheet whenever possible to assist with lifting.

Proper Lifting Technique



Improper Lifting Technique



Note: From SpineUniverse.com. "Spinal Structures and Body Mechanics," Tips 1-3.

Why Use a Gait Belt?

Safety/gait belts should be used whenever a resident is assisted with transferring or walking. A safety/gait belt can help prevent injury to the resident caused by pulling on arms or underarms, as well as by falls. They also prevent the caregiver or assistant from being injured.

Remember: Safety/gait belts can be a benefit only if the assistant's hands are ON the belt! Do not assume there is adequate time to "grab" onto the belt if the resident should need assistance – it will be too late!

Placement

- Greet resident by name and identify self
- Explain the procedure to the resident to reduce anxiety and increase cooperation.
- Apply the safety/gait belt while the resident is in a sitting position. If the resident is unable to sit, apply the safety/gait belt while the resident is lying down. Be sure the belt is not twisted.
- Safety/gait belts should be applied around the resident's waist, just above the resident's hips and well below the ribs. Occasionally, this may be prohibited due to a feeding tube or incision. In these cases, place the safety/gait belt around the chest under the arms, above the breasts.
- Place the belt around the resident's waist with the buckle on the weaker side.
- Safety/gait belt should be snug. A good guide is to be able to insert no more than 2 fingers underneath the gait belt.
- Safety/gait belt will become looser when the resident stands up or does transfer. It will need to be re-adjusted once the resident stands.

Use in Transfers

- Bend your arms, keeping your elbows at your side with palms up.
- Place both hands under the belt, one on each side of the patient's waist.
- Protect the resident's skin from the buckle with your hand.
- Lift with your knees when moving the resident from sitting to standing.
- DO NOT HAVE THE RESIDENT PLACE HIS/HER ARMS OR HANDS AROUND YOUR NECK DURING THE TRANSFER.
- If the resident is sliding out of the chair, simply grasp the belt (if 2 people are assisting, one person assists on each side of resident) at the back of the resident, place arm under thigh and, on the count of three, lift and swing the resident back into chair.

Use in Ambulation

- Stand slightly behind and to the weaker side of the resident
- Use one hand to assist the resident's balance and confidence by placing it on the resident's shoulder. Do not hold on to the arm – if a fall occurs, this could cause serious injury.
- Your other hand should be grasping the gait belt from behind and underneath to provide safe ambulation. When held in this position, the assistant's arm is in a better mechanical advantage and is stronger.
- If the resident totally loses his/her balance, and a fall is eminent, the safety/gait belt can be used to "break" the fall and prevent injury to the resident. Simply grasp the safety/gait belt while maintaining good body alignment: knees bent with feet 12" apart. Pull the resident toward you to prevent the fall or to gently control the resident's descent.
- When necessary, two people may use the safety/gait belt. Each person stands on opposite sides of the resident and grasps the belt as previously described.

Contraindications to the Use of the Gait Belt

A gait belt is indicated for most all weight bearing transfers and gait activities. However, contraindications to the use of a gait belt may be as follows:

- Ostomies
- Fractured ribs
- Cardiac/respiratory disease
- Abdominal surgery
- Severe degenerative disease of the spine

Figure 1: Safety/gait belt with added handles

Figure 2: Gait training belt

Note: From Sammons Preston Roylan Catalog. "Skil-Care™ Belt Handles" & "Gait Training Belt," Bolingbrook, IL: Sammons Preston Roylan.

Definitions

Levels of Weight Bearing:

Level	Abbreviation	Definition
Full Weight Bearing	FWB	The resident places all his/her weight on the affected joint.
Non- Weight Bearing	NWB	The resident does not put any weight on the affected joint.
Partial Weight Bearing	PWB	The resident places 25% of his/her bodyweight on the affected joint during mobility tasks.
Toe Touch Weight Bearing	TTWB	The resident places approximately 10-15% of his/her body weight on the affected joint. (The toe touches the floor surface during walking on the affected leg.)
Weight Bearing as Tolerated	WBAT	The resident places as much as is tolerated on the affected leg.

Hip Precautions/Knee Precautions

Hip Precautions

- Avoid flexing the leg/hip beyond the normal sitting position (90 degrees)
- Do not sit in deep chairs
- Use an elevated toilet seat
- Do not leave the resident sitting for periods longer than an hour
- Do not position the leg with toe pointing inward while the leg is flexed or straight
- Keep the leg positioned with the foot facing forward or out to the side
- Do not cross the resident's legs while sitting or lying down
- Use a pillow placed between the legs or an abduction device to keep the hip positioned correctly
- When rolling a resident on his/her side, place a pillow or abduction pillow between the resident's knees
- Turn the resident on his/her back, or unaffected side
- Do not let the resident bend forward during transfers, when sitting in a wheelchair, pulling on pants or tying shoes
- Report the following changes to the nurse:
- Increased swelling of the leg with the incision
- Increased redness or discoloration of the hip
- Increased pain at the hip
- Increased drainage from the incision line
- Complaints of dizziness, chest pain, or shortness of breath
- Odor from the incision
- Changes in skin color
- Increased perspiration

Knee Precautions

- Do not place a pillow behind the knee while lying in bed
- Place pillow behind calf
- Instruct the resident to wear a knee immobilizer if ordered by the physician
- Instruct the resident to avoid sitting with knees flexed or extended for more than one hour
- Report the following changes to the nurse:
- Increased complaints of pain behind the knee or calf
- Increased swelling of the knee with the incision
- Complaints of dizziness, chest pain, or shortness of breath
- Odor from the incision
- Changes in skin color
- Increased perspiration
- Increased drainage from the incision

Return Demonstration

- Form groups of two or three persons each
- One individual will act as the resident
- The second individual will complete each bed mobility and transfer activity
- If a third person is involved, this individual with oversee the process for possible issues
- Change roles and repeat the process until all have participated

Post-test
Bed Mobility and Transfer

Name: _____ Title: _____

Social Security: _____ Work: _____

Mailing Address: _____

1. **You should use your back muscles to lift heavy objects.**

   True / False

2. **Using a gait belt may help to prevent injury to a resident or to you.**

   True / False

3. **Partial weight bearing means that the resident can place as much body weight as is tolerated on the affected leg.**

   True / False

4. **You should remind the resident with recent hip surgery not to cross their legs while sitting or lying down.**

   True / False

5. **When rolling a dependent resident in bed, the resident's head should be positioned toward the opposite direction of the roll.**

   True / False

6. **You should always transfer to the resident's stronger side.**

   True / False

7. **It is not necessary to be concerned with the weight bearing status of a resident with a fracture while doing a transfer**

   True / False

8. **The resident should scoot forward in the wheelchair before attempting to stand up**

   True / False

9. **To assist the resident in doing a transfer, it is acceptable for the resident to hold around your neck**

   True / False

10. **To transfer from the bed to the wheelchair, the resident should reach for the armrest of the wheelchair before standing up**

    True / False

11. **When lifting, it is important to hold the object as close to your body as possible**

    True / False

12. **When lifting, it is important to keep your feet close together so you can maintain your balance**

    True / False

Post-test
Bed Mobility and Transfer

1. **You should use your back muscles to lift heavy objects.**

   True / False

2. **Using a gait belt may help to prevent injury to a resident or to you.**

   True / False

3. **Partial weight bearing means that the resident can place as much body weight as is tolerated on the affected leg.**

   True / False

4. **You should remind the resident with recent hip surgery not to cross their legs while sitting or lying down.**

   True / False

5. **When rolling a dependent resident in bed, the resident's head should be positioned toward the opposite direction of the roll.**

   True / False

6. **You should always transfer to the resident's stronger side.**

   True / False

7. **It is not necessary to be concerned with the weight bearing status of a resident with a fracture while doing a transfer**

   True / False

8. **The resident should scoot forward in the wheelchair before attempting to stand up**

   True / False

9. **To assist the resident in doing a transfer, it is acceptable for the resident to hold around your neck**

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10. **To transfer from the bed to the wheelchair, the resident should reach for the armrest of the wheelchair before standing up**

    True / False

11. **When lifting, it is important to hold the object as close to your body as possible**

    True / False

12. **When lifting, it is important to keep your feet close together so you can maintain your balance**

    True / False

Clinical Competency Checklist
Restorative Nursing – Body Mechanics

Employees Name / Credentials: _____

Mechanics	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Uses safety equipment (lift sheet, gait/safety belt)						
• Keeps back straight						
• Keeps head up						
• Maintains wide base of support						
• Bends knees before lifting						
• Holds object/resident close to the body						
• Does not hurry through task						
• Lifts with legs not back						
• Pulls objects instead of pushing						
• Does not twist back when lifting						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Clinical Competency Checklist
Restorative Nursing – Bed Mobility

Employees Name / Credentials: _____

Bed Mobility	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Identifies weak or involved side						
Identifies precautions, weight bearing status or strength prior to transfer						
Informs resident in a pleasant manner what will happen						
Starts with bed flat, in low position, with siderails down						
Resident instructed to bend hips and knees so that feet are flat on the bed						
Resident instructed to drop knees to one side						
Resident instructed to roll onto side						
Assistance is given with one hand on shoulder blade and one on pelvis						
Resident instructed to push up to sitting using arms						
Assistance is given with one hand under upper back and one around knees						
Resident is supported in sitting position until position maintained independently						
Good body mechanics used at all times						
Follows same procedures for scooting in bed, rolling to opposite side						

Clinical Competency Checklist
Restorative Nursing – Bed Mobility

Bed Mobility	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
Identifies cases where 2 people are needed						
Identifies and demonstrates use of trapeze for bed mobility						
When assisting, supports resident at shoulders and pelvis, does not allow resident to hold onto the neck						
Identifies and demonstrates use of bed rails for mobility						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Clinical Competency Checklist
Restorative Nursing – Transfers

Employees Name / Credentials: _____

Transfers	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Identifies weak or involved side						
Identifies precautions, weight bearing status or strength prior to transfer						
Informs resident in a pleasant manner what is going to happen						
Uses a safety/gait belt correctly						
Wheelchair placed correctly so resident can lead with strong leg						
Wheelchair brakes are locked						
Helps resident scoot forward so feet touch floor						
Has resident lean forward and push down with hands on surface to stand up						
Resident instructed to stand straight						
Resident instructed to pivot to wheelchair and all precautions are carried out						
Resident instructed to move backward until he feels chair touching backs of legs						
Resident instructed to reach for wheelchair armrest prior to sitting down						
Resident instructed to bend knees while lowering to the chair						
Good body mechanics used at all times						

Clinical Competency Checklist
Restorative Nursing – Transfers

Transfers	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
Follows same procedures for bed, chair, toilet transfers						
Identifies cases where 2 people are needed						
Identifies and demonstrates use of sliding board for transfers						
When assisting, supports resident around the trunk or with gait/safety belt, not holding under the arms						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Section 7

Activities of Daily Living

Objectives:

- To identify and learn to use common adaptive devices used for self-care activities
- To describe adaptive techniques used for self-care activities

Content Outline:

- Adaptive Equipment
- Adaptations for residents with limited range of motion
- Adaptations for residents with problems of coordination
- One-handed dressing techniques

Course Competency:

Each participant will complete a pre-/post-test to validate retention of course content.

Activities of Daily Living

The purpose of the Restorative Activity of Daily Living (ADL)/Grooming Program is to provide residents with an opportunity to attain or maintain their highest level of independence in performing ADLs. ADLs may include bathing, dressing and undressing, grooming and hygiene, oral care and accessory dressing. Repeated practice of ADLs improves the resident's self-esteem and dignity as the resident achieves more independence and proficiency in performance of self-care tasks.

Activities including repetition, physical or verbal cueing, and task segmentation provided by any staff member or volunteer under the supervision of a licensed nurse may quality as training and skill practice in rehabilitation nursing.

Dressing or grooming: Activities used to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

Treatment Ideas

Light Hygiene

ADL Skill	Selected Activities	Materials
Oral Care	• Set up • Provide instruction • Practice skills • Clean up • Insert dentures • Soak/clean dentures • Brush teeth • Floss teeth • Use mouthwash • Gargle	• Water • Glass • Toothbrush • Toothpaste • Denture brush and receptacle • Denture adhesive • Denture cleaner • Dental floss • Mouthwash • Adaptive equipment
Washing Hands and Face	• Set up • Provide instruction • Practice skills • Clean up • Nail cleaning	• Basin of water • Washcloth • Soap • Nailbrush • Wash mit • Towel
Lotion, Perfume/Cologne, Aftershave	• Apply lotion to hands and upper arms • Apply deodorant or powder • Stress benefit from sensory stimulation, touch and smell	• Lotion • Perfume • Cologne • Aftershave • Deodorant • Bath powder

Grooming

ADL Skill	Selected Activities	Materials
Shaving	• Set up • Provide instruction • Practice skills • Clean up • Clean electric razor • Charge electric razor	• Electric razor • Pre-shave • Shaving cream • Standard safety razor • Towel • Water • Aftershave
Nail Care	• Set up • Provide instruction • Practice skills • Clean up • Safety awareness	• Emery board • Nail polish remover • Cotton balls/Q-tips • Nail polish/topcoat • Nail brush • Clippers • Lotion • Pumice stone • Toe separators • Trash can
Hair Care	• Set up • Provide instruction • Allow resident to choose supplies • Practice skills • Comb/brush hair • Style hair • Apply gel/mousse/hairspray • Clean up	• Comb • Brush • Mirror • Pins • Clips • Ribbons, hair elastics or flowers • Gel/mousse/hairspray • Curlers
Make-up	• Set up • Provide instruction • Allow resident to choose supplies • Practice skills • Clean up	• Blush • Eye shadow • Mascara • Base/foundation • Eye liner • Eyebrow pencil • Lipstick/gloss • Powder • Make-up brushes

Upper and Lower Extremity

ADL Skill	Selected Activities	Materials
Dressing	• Retrieve items from closet • Set up • Provide instruction • Allow resident to choose items • Introduce adaptive equipment • Practice donning and doffing clothing	• Sweater • Jacket • Pants • Blouse • Pullover shirt • Bra/underwear/undershirt/boxers • Skirt/dress • Housecoat • Pajamas • Dressing stick/reacher • Button hook/zipper pull
Footwear Dressing	• Retrieve items • Set up • Provide instruction • Allow resident to choose items • Introduce adaptive equipment • Practice donning and doffing footwear	• Socks • Shoes • Velcro closure shoes • Slippers • Sock aid • Long handled shoe horn • Elastic shoe laces • Dressing stick
Accessory Dressing	• Set up • Provide instruction and demonstration • Allow resident to choose and retrieve items • Practice tying, fastening and buckling	• Jewelry (earrings, necklace, pin) • Scarves • Ties • Belts • Ribbons/bows • Hats • Purses • Button/snap/zipper board

Adaptive Clothing/Dressing Suggestions for those with Limited Range of Motion or Coordination

- Use front opening garments, one size larger than needed and made of fabrics that have some stretch.
- Use larger buttons or zippers with a loop on the pull-tab
- Replace buttons, snaps and hooks with Velcro
- Wrinkle free clothing
- Clothing that is easily cleaned
- Pants with elastic waists
- Suspenders
- Elastic thread for buttons
- Pull tabs on zippers
- Sew loops/tabs onto clothing to allow use of dressing stick
- Slip-on shoes or sneakers with Velcro closures.
- Replace regular shoelaces with elastic shoelaces or other adapted shoe fasteners that can be left tied all the time
- "Tube" socks
- Adaptive equipment to make self-dressing easier (e.g., dressing stick, button hook, elastic shoelaces, long handled shoehorn, Reacher, sock aid)
- Plan adequate dressing time so that the resident does not feel rushed
- Use bras with front openings or Velcro replacements.
- To avoid falls, dress while sitting on bed, in wheelchair, or in chair with arms.

Adaptations for Hygiene and Grooming

- A handheld showerhead on flexible hose for bathing and shampooing hair can eliminate the need to stand in the shower and offers the user control of the direction of the spray. The handle can be built up or adapted for limited grasp.
- A long handles bath sponge/brush can allow the user to reach legs, feet and back. A wash mitt and soap on a rope can aid limited grasp.
- Long handles on comb, brush, toothbrush, lipstick, mascara brush and safety or electric razor may be useful for limited hand to head or hand to face movements.
- Electric toothbrushes may be easier to manage for oral hygiene.
- A short Reacher can be used to reach toilet paper.
- Dressing sticks can be used to pull garments up after using the toilet.
- Safety rails can be used for bathtub transfers and safety mats or strips can be placed in the bottom of the shower.
- Attach toiletries (shaver, lipstick, toothbrush, etc.) to a cord if the resident often drops objects.
- Use weighted wrist cuffs for applying lipstick, for shaving, etc., to help hold hand steady.
- Use a suction brush attached to the sink for nail care or denture care.
- Use soap on a rope. Hang soap on a rope around the resident's neck or over a bathtub fixture for easy reach.
- Glue an emery board to a small piece of wood and fasten it to the tabletop to file nails.
- Use large size roll-on deodorant.
- Use a bath mitt that holds the soap in it.
- Use non-skid mats to prevent falls.

Adaptive Equipment

Button Hook/Zipper Pull (Figure 1)

- Used to pull up or down by hooking the end of the zipper.
- The large end is slipped through the buttonhole and attaches around the button.
- Pulling the loop through then pulls the button through the buttonhole.
- Used with residents with decreased hand grasp, limited use of hand, or a decrease in fine motor skills.

Dressing Stick (Figure 2)

- Used to pull or push clothing up the leg or arm, over the shoulder.
- Ideal for residents with decreased hip flexion or limited upper extremity movements, i.e., pulling clothes up after using the toilet.

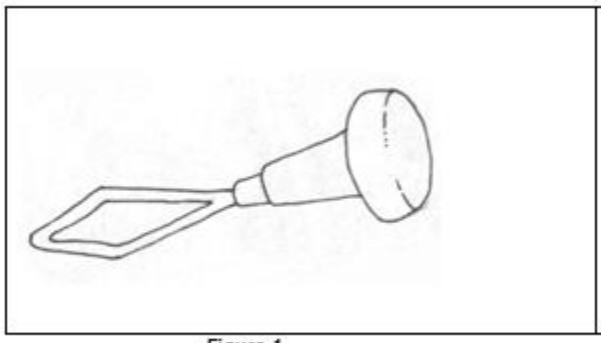


Figure 1

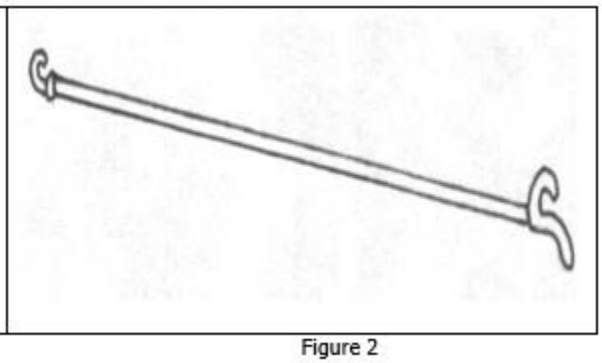


Figure 2

Elastic
Shoe Laces (Figure 3)

- Utilized to convert “tie up“ shoes into “slip on” shoes
- Helpful for residents who cannot or should not bend over or cross legs

Long-Handled Shoe Horn (Figure 4)

- Utilized for putting on shoes
- Helpful for residents who cannot or should not bend over or cross legs

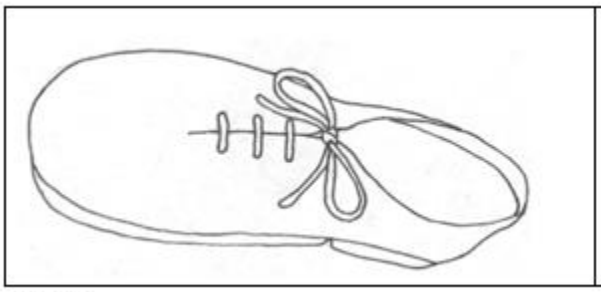


Figure 3

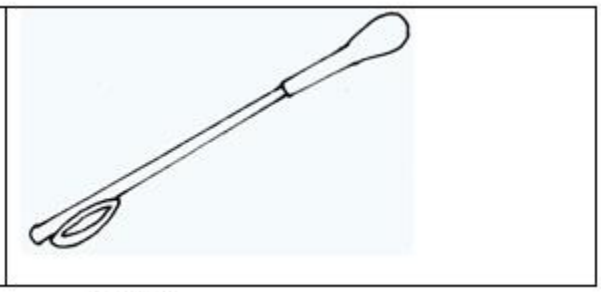


Figure 4

Reacher (Figure 5)

- Used to assist with dressing or picking up objects and grasping the clothing with the clawed end.
- Helpful for residents who cannot or should not bend over or reach above head (e.g., hip surgery)

Sock Aid (Figure 6)

- Used to apply socks or pantyhose by sliding sock or stockings over the aid and pulling the sock aid up the foot.
- Helpful for putting on socks for residents who cannot or should not bend over or cross legs

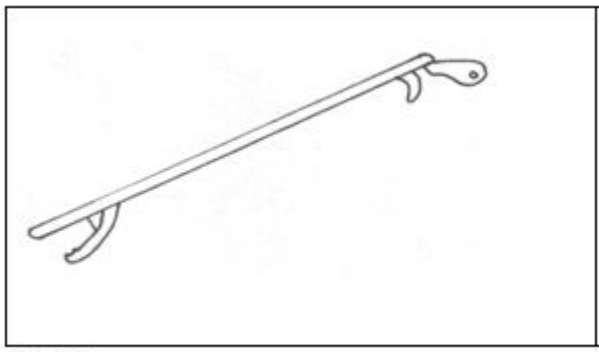


Figure 5

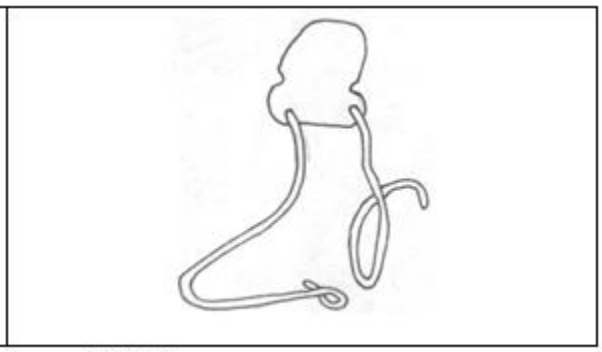


Figure 6

Long Handled Bath Sponge

- Used with a resident who has decreased hand function or arm range of motion.

Suction Denture Brush

- Used to assist residents in cleaning dentures or fingernails.
- Suction cup fastens dentures to the sink to allow for one-handed scrubbing.

Comb and Brush with Built-up Handles

- Used with residents who have weak grasps.
- Built-up foam covers handles.

Universal Cuff

- Used with residents who have weak grasps.
- Makes it possible for the resident to perform hygiene skills such as combing hair or brushing teeth.

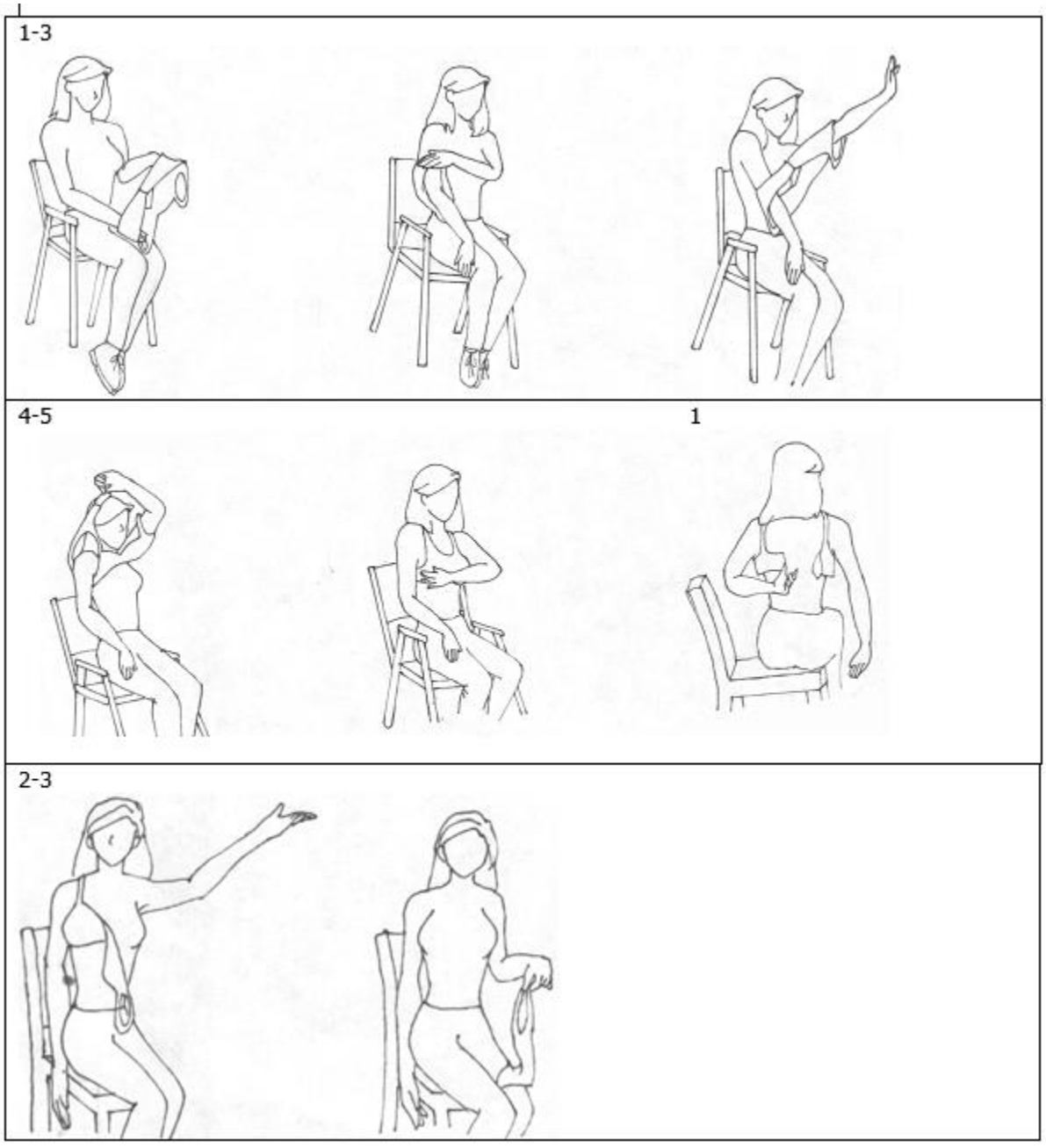
One-Handed Dressing Techniques

Putting on a Bra (dressing)

1. Hook bra and position in front of body
2. Place affected arm through shoulder strap and pull up to or above elbow.
3. Place unaffected arm through shoulder strap and pull up to or above elbow
4. Hook back strap with thumb and pull over head like a jersey
5. Adjust as needed

Removing a Bra (undressing)

1. Unhook fastener with unaffected arm
2. Shake strap off of unaffected arm
3. Use unaffected arm to take strap off affected arm

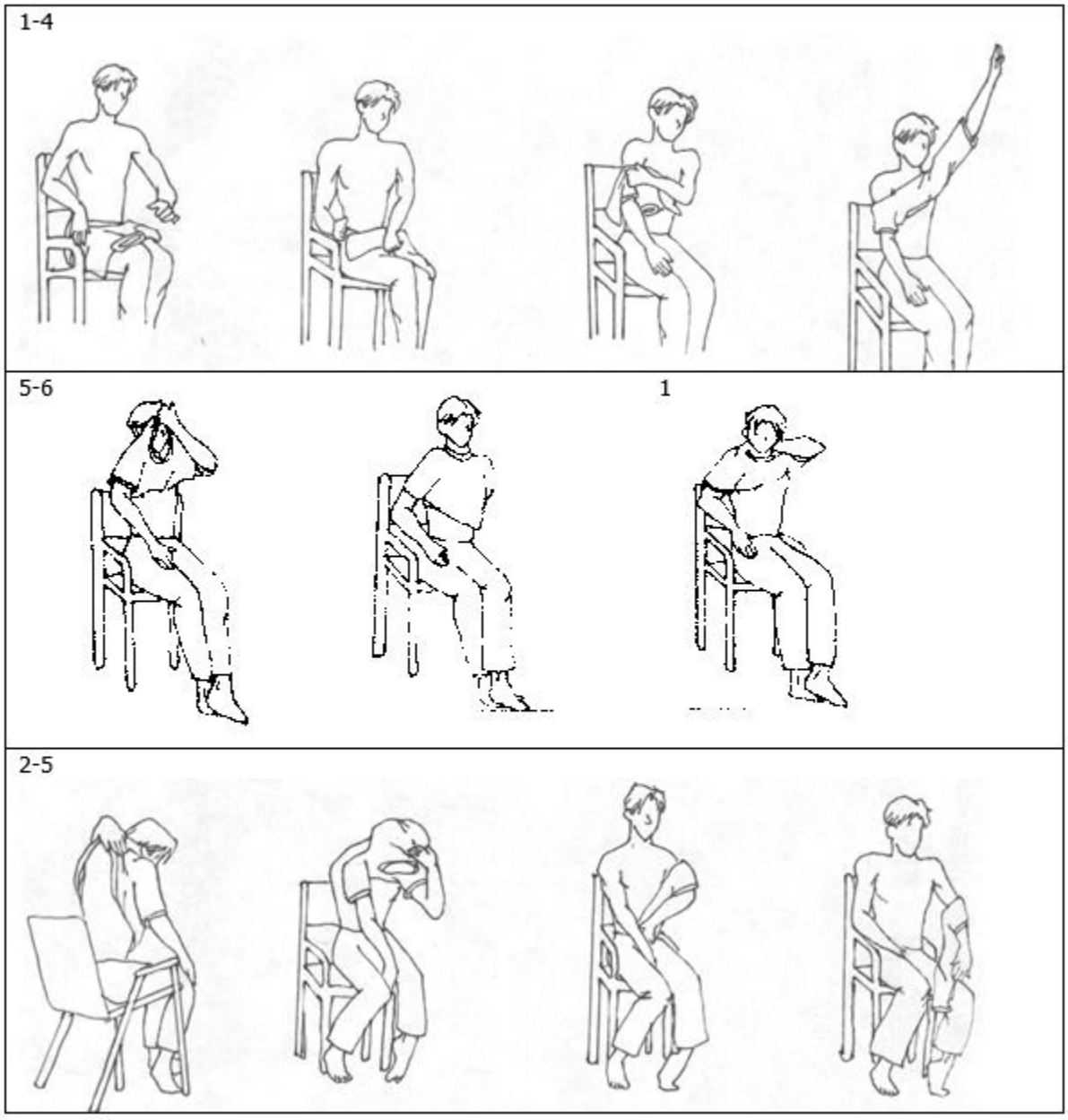


Putting on a Pullover Shirt (dressing)

1. Place shirt on lap with the neck towards the knees and the front facing down
2. With unaffected arm, gather shirt from the bottom to the shirt sleeve of the affected arm
3. Pull the gathered sleeve onto the affected arm and up over the elbow
4. Place the unaffected arm through the remaining sleeve
5. Hook the neck and bottom of the shirt with thumb and pull over the head
6. Pull the shirt down and adjust

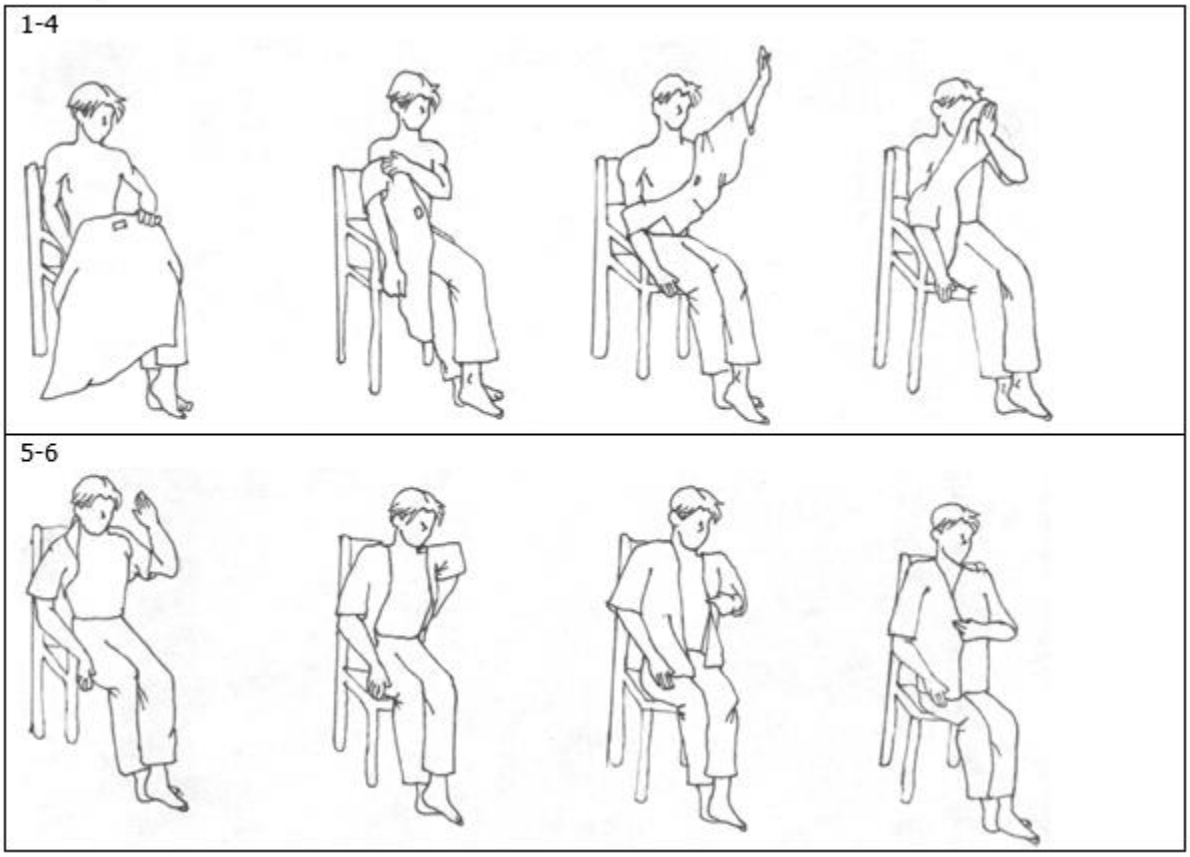
Removing a Pullover Shirt (undressing)

1. Lean forward and gather the shirt with the unaffected arm from behind the unaffected shoulder
2. Duck and pull shirt off the head
3. Use the unaffected arm to pull the shirt sleeve off the affected arm
4. Shake the shirt off the unaffected arm



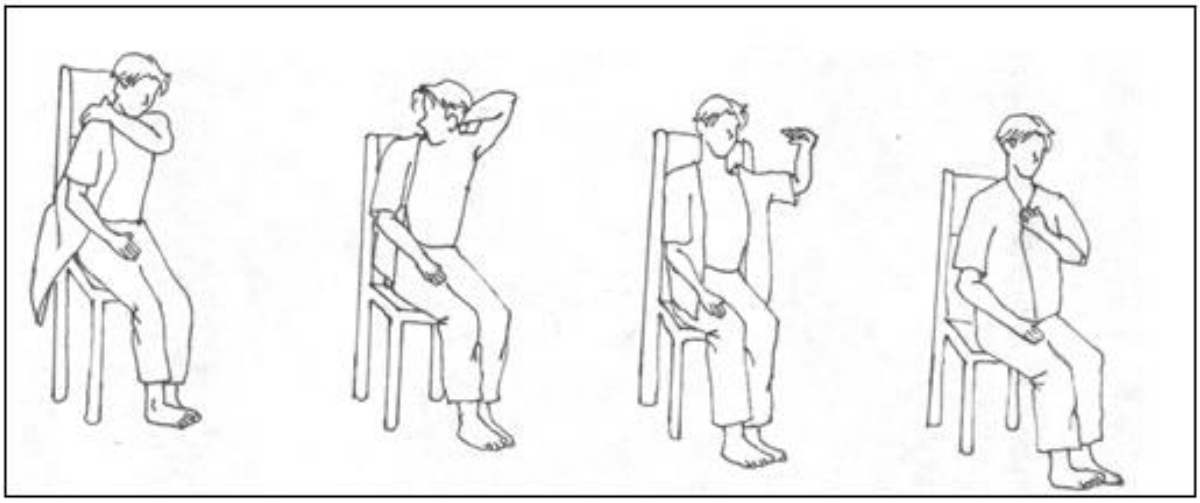
Putting on a Front Opening Shirt – Technique #1

1. Place shirt on lap with bottom of shirt at knees and label facing up
2. Pick up affected hand, place through sleeve. Use unaffected hand to pull sleeve up the arm and past the elbow.
3. Place unaffected arm through remaining sleeve
4. Hook the shirt from collar to the bottom. Lean head forward and pull over head.
5. Drop the shirt down the back, reach behind and pull the shirt tail down
6. Adjust the shirt and button the buttons



Putting on a Front Opening Shirt – Technique #2

1. Pick up affected hand, place through sleeve. Pull shirt up over elbow to shoulder.
2. Grasp the top of the collar on the unaffected side and hold tightly. Lift the shirt up and around the back to the unaffected side.
3. Place unaffected arm through sleeve
4. Adjust the shirt and button the buttons



Removing a Front Opening Shirt/Blouse

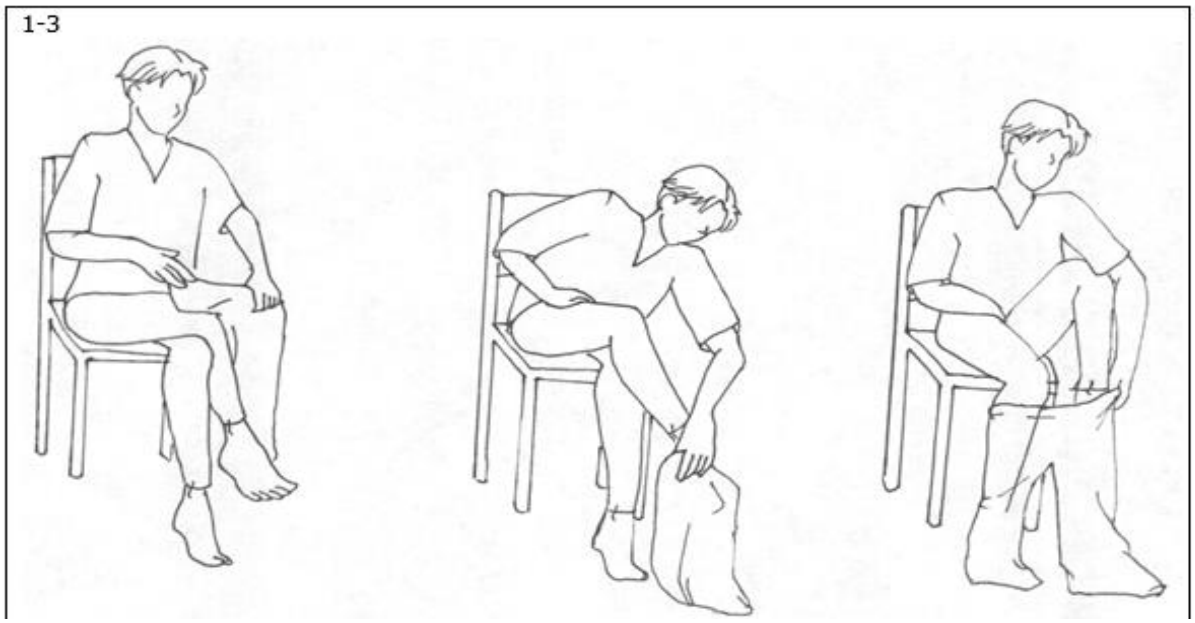
- Unbutton shirt/blouse.
- Lean forward.
- Gather the material up behind the neck by using the strong hand, then pull shirt over the head.
- Remove sleeve from the strong arm and then the affected weak arm.

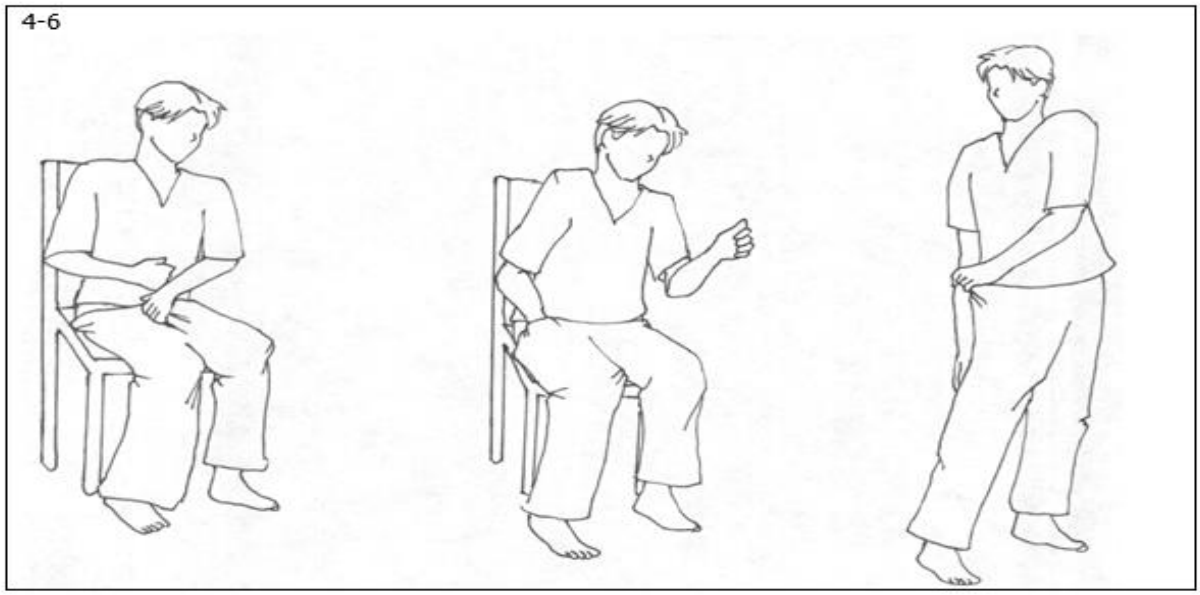
Removing a Front Opening Shirt/Dress

- Tell the resident to unbutton shirt.
- Tell the resident to use the unaffected hand and push shirt off the affected shoulder.
- Tell the resident to grasp the middle of front edge of shirt and pull it out to the side, pulling the shirt off unaffected shoulder.
- Help the resident to raise unaffected arm out of the sleeve.
- Tell the resident to use the unaffected hand to grasp the cuff of the right sleeve and pull from the affected arm.

Putting on Pants from Sitting (dressing)

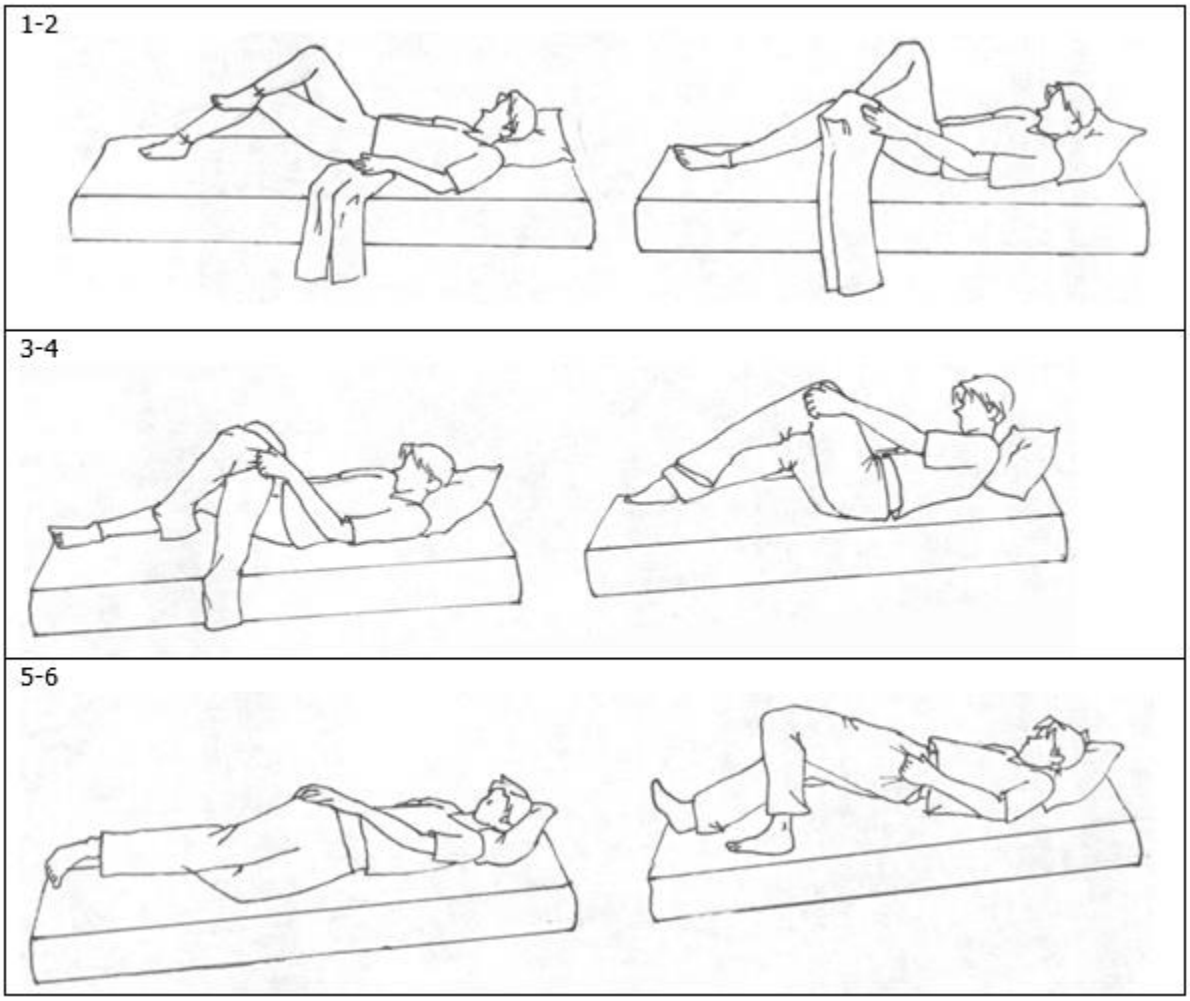
1. With unaffected arm, pick up affected leg and cross over on top of unaffected leg. Gather pants with unaffected arm.
2. Bend and pull pants on to affected leg, up to the knee
3. Uncross the affected leg. Put unaffected leg into the other pant leg.
4. Remain sitting. Pull pants up the knee and onto the hips as far as possible. Lean from side to side in chair, pulling pants up with unaffected arm while lifting hips.
5. To prevent pants from falling while standing, place affected hand in pant pocket or inside of pants. If suspenders are used, pull them onto the shoulder prior to standing.
6. With feet spread apart, stand and pull pants over the hips. Fasten the pants in sitting or standing position, as resident is able.





Putting on Pants from Lying (dressing) – for those with poor balance

1. With unaffected leg, hook the ankle of affected leg up over the knee on the unaffected leg. Bend unaffected leg so that it pulls affected leg up to within reach of unaffected arm.
2. Reach with unaffected arm and place pants onto the affected foot
3. Work the pants up to the knee
4. Straighten unaffected leg and remove from under affected leg while holding on to pants. Place unaffected leg in remaining pant leg.
5. Work the pants up over the hips by rolling from side to side and pulling with the unaffected arm
6. If able, bend the unaffected leg, pressing down with the foot and shoulder while raising both hips from the bed (bridging). Fasten trousers.

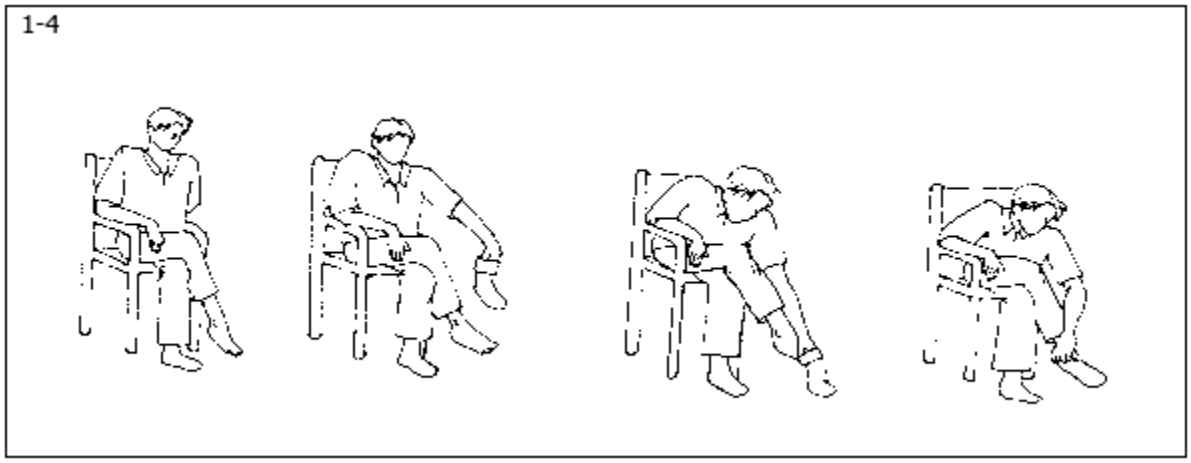


Taking off Trousers/Pants

Resident unfastens trousers and works them down past his hips as far as possible.
If standing balance is poor: Tell the resident to lie down on the bed, unfasten trousers/pants. Bend strong knee and hip pushing strong foot against bed to raise hips. Push pants down below hips.
Sit on side of bed. Push pants leg off with strong leg.
Cross weak leg and pull pants off weak leg.

Putting on Socks (dressing)

Sit down. Cross affected leg over unaffected leg. Roll or gather the sock to within several inches of the toe.
Open the sock with the unaffected hand by placing thumb and first 2 fingers inside the stocking and spreading fingers apart
Place sock over the toes and over the foot as much as possible
Pull the sock on over the foot



Taking Off Socks/Stockings

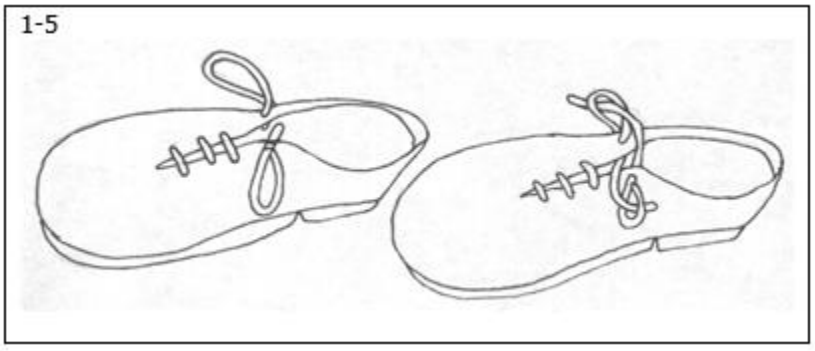
- With strong hand, cross weak leg and remove sock.
- Cross strong leg and remove the other sock.
- Cross strong leg so that foot is free and in easy reach of strong hand. Use strong hand, pull other sock over strong foot in same manner.

Putting on Shoes (dressing)

1. Sit down. Cross affected leg over unaffected leg. Hold tongue of shoe and place over toes.
2. Adjust shoe and hold heel of shoe to pull over heel
3. Tie according to one-handed shoe tieing instructions

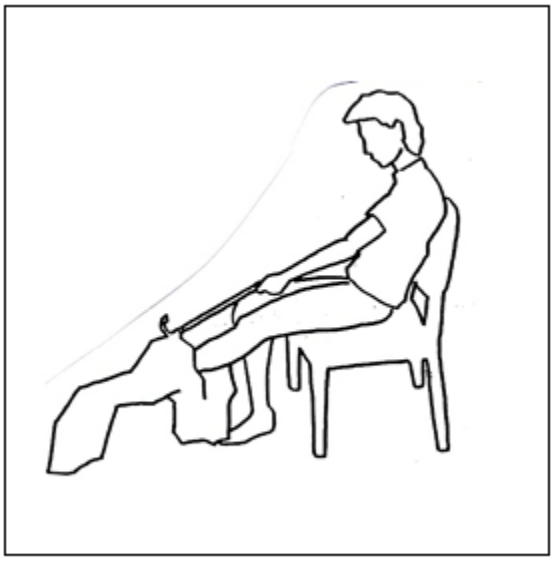
One-handed Shoe Tie

1. Lace up the shoe in a traditional manner to the last hole
2. On the last hole, go back through the hole on the same side to form a loop with a tail on each side
3. Take the tail on one side and pass it through the loop on the opposite side
4. Pull tails, one at a time, to tighten
5. Once the lacing is tight, tuck the extra lacing into the instep of the shoe



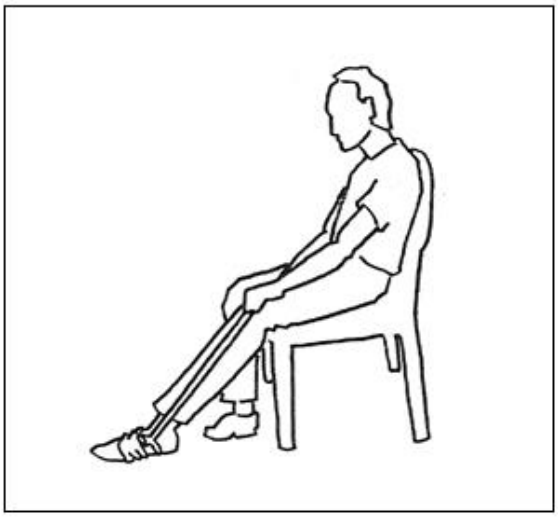
Dressing with a Reacher or dressing stick

- Sit on the side of the bed or in a chair
- Use the dressing stick to catch the waistband of the underwear or pants
- Lower the stick to the floor and slip the pants over the affected or weaker leg first
- Insert other leg
- Pull pants over knees
- Stand using walker for balance and pull pants over hips
- When taking pants off, start with the unaffected or stronger leg



Using a sock aid

- Slide the sock over the sock aid making sure the heel of the sock is at the back of the plastic and the toe of the sock is tight against the end
- Holding on to the cords, drop the sock aid on to the floor in front of the foot
- Insert the foot into the sock
- Using the cords, pull the sock over the foot
- To remove socks, use a dressing stick or Reacher to push the sock off the foot



Post-test
Activities of Daily Living

Name: _____ Title: _____

Social Security: _____ Work: _____

Mailing Address: _____

1. **A resident that had recent hip surgery may need to use a Reacher to assist with dressing.**

   True / False

2. **Residents with limited range of motion should wear garments that you pull over the head.**

   True / False

3. **You should instruct the resident with problems of coordination to stand up when dressing.**

   True / False

4. **Use front opening garments for residents with problems with coordination or limited range of motion.**

   True / False

5. **Residents are not able to dress themselves using one-handed techniques.**

   True / False

6. **Weighted wrist cuffs may help hold a resident's hand steady while shaving.**

   True / False

7. **If set-up properly and oriented to the surroundings, it is possible for a resident with dementia to independently complete ADL tasks.**

   True / False

8. **Water temperature should be checked before completing hygiene/grooming tasks to ensure a resident is not burned.**

   True / False

9. **The RNA should allow a resident only 2 attempts to complete ADLs independently. After attempts, the RNA should step in and complete tasks for the resident.**

   True / False

Answer Key
Activities of Daily Living

1. **A resident that had recent hip surgery may need to use a Reacher to assist with dressing.**

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2. **Residents with limited range of motion should wear garments that you pull over the head.**

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   True / False

Clinical Competency Checklist
Restorative Nursing – ADL Grooming

Employees Name / Credentials: _____

ADL/Grooming	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Informed resident in a pleasant manner that it is time to get dressed/undressed						
Checks precautions prior to dressing						
Checks that resident has necessary toiletries and adaptive equipment						
Identifies safest place for dressing (lying in bed, edge of bed, wheelchair)						
Identifies adaptive equipment and demonstrates use						
• Button hook						
• Dressing stick						
• Elastic shoelaces						
• Long handled shoehorn						
• Reacher						
• Sock aid						
• Long handled sponge						
• One handed wash mit						
• Suction brush						
• Built up handles						
Basic dressing techniques						
• One handed pullover shirt						
• One-handed button-down shirt						
• Pants from sitting position						
• Pants from lying position						
• Socks/shoes						

Clinical Competency Checklist
Restorative Nursing – ADL Grooming

ADL/Grooming	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
Instructions/techniques						
• Cues for energy conservation						
• Follows hip precautions						
• Verbal cues						
• Hand over hand assist						
• Tactile cues						
• Visual demonstration						
• Allows extra time for independence before lending physical assist						
• Ensures safety						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Section 8

Eating and Swallowing

Objectives:

- To define dysphagia
- To list the 4 stages of swallowing (3 traditional and 1 additional)
- To identify signs and symptoms of a swallowing disorder
- To identify the most serious complication of a swallowing problem
- To describe proper positioning for feeding
- To identify adaptive feeding equipment

Content Outline:

- Definitions
- Dysphagia
    - Four stages of swallowing
    - Signs and symptoms of eating or swallowing problems
    - Aspiration pneumonia
- Special diets for residents with swallowing problems
- Techniques for improving swallowing and eating
- Resident positioning for swallowing and self-feeding
- Selecting and using adaptive equipment during self-feeding

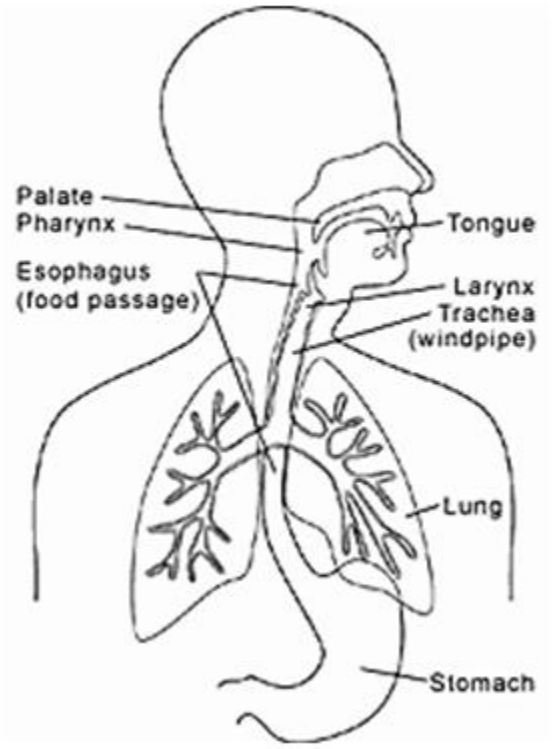
Course Competency:

Each participant will complete a pre-/post-test to validate retention of course content.

Eating and Swallowing

The ability for people to feed themselves is often the last self-care task they can perform. Many residents lose their self-feeding and/or swallowing abilities due to illness, progressive disease or aging and require special setup or assist. Safe swallowing is important for residents to stay healthy, maintain ideal body weight and prevent aspiration pneumonia, dehydration, development of pressure sores, loss of balance and falls. It is very important to preserve these skills.

Important Physical Structures for Swallowing



Note: From National Institutes on Health. "How Do We Swallow?"
Bethesda, MD: National Institute on Deafness and Other Communication Disorders.

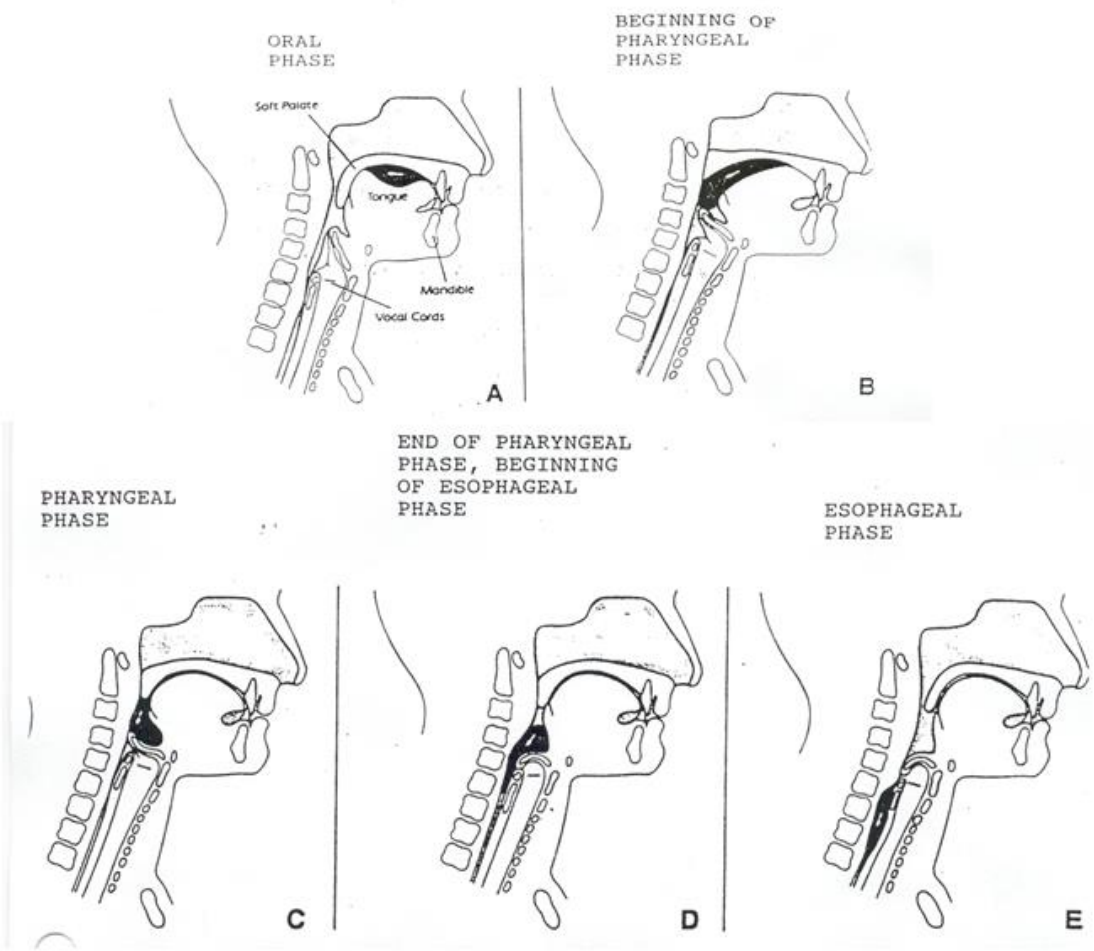
Structure	Description
Hard Palate	The roof of the mouth
Soft Palate	Soft rear portion of the roof of the mouth
Tongue	Used to form the bolus (ball of chewed food) and to propel the bolus to the back of the mouth
Pharynx	Upper throat space
Larynx	Voice box
Adam's Apple	The prominent lump at the front of the neck, which can be seen/felt approximately 2 inches below the chin. It should move upward each time the resident swallows. It is also called the "larynx" or "voice box". It can be felt by placing fingers on the neck/throat to confirm resident swallowed
Trachea	Pathway for air to the lungs or "windpipe"
Esophagus	Pathway for food to the stomach; when not in use, it is collapsed against itself

Term	Definition
Aspiration	The breathing in of food or other substances into the lungs. This is VERY serious and frequently results in pneumonia.
Aspiration Pneumonia	Inflammation and/or infection of the lungs caused by inhaling food, liquid or other substance. A serious condition, it may occur before, during, or after the swallow, require hospitalization or result in death.
Bite Reflex	Automatically biting or clenching the spoon with one's teeth.
Dry Swallows	Swallowing when food is not present in the mouth.
Dysphagia	Difficulty with swallowing. Some residents may have difficulty with swallowing liquids, others may have trouble with textured food, and d some may have difficulty swallowing any type of food or liquid.
G-tube (Gastrostomy Tube)	Feeding tube inserted directly into the stomach through the stomach wall. Used to feed a person who is unable to safely consume food and/or liquids and/or medications by mouth.
MBS (Modified Barium Swallow)	Test used to assess the passage of substances during a swallow.
NG tube (Nasogastric Tube)	Feeding tube inserted into the nose and running down the throat, into the stomach. Used to feed a person who is unable to take food by mouth.
NPO	Nothing by mouth
Paralysis	Numbness in a limb, lips, tongue, palate, etc. which may prevent a resident from being able to self-feed or swallowing a regular diet.
PO	By mouth
Pocketing	Keeping food in the cheeks when attempting to swallow. The resident may not be able to sweep away food in the cheeks because of weakness in the tongue or cheeks.
Reflux	Return of food or liquid to the throat from the stomach.

Self-feeding	The ability to feed oneself, with or without adaptive equipment.
Silent Aspiration	Food or liquid entering the airway or lungs without producing any symptoms of disturbance such as coughing or struggling behavior.
SLP	Speech Language Pathologist
Tongue Thrust	Extending the tongue beyond the front teeth and out of the mouth each time a resident takes a bite of food.
Upper Extremity	The left or right arm.
Visual Field	The area that the resident is able to see when looking straight ahead.
WNL	Within Normal Limits

Four Stages of Swallowing

- Oral Preparatory Phase
  Acceptance of food into the mouth and the chewing, tasting and manipulation of the food into a bolus (ball of chewed food) in the oral cavity
- Oral Phase
  Tongue moves bolus back to the pharynx
- Pharyngeal Phase
  Swallow reflex is triggered; bolus moves through pharynx to esophagus
- Esophageal Phase
  Bolus moves through esophagus to stomach



Logemann, J. A. (1983). Evaluation and treatment of swallowing disorders.
Journal of the National Student Speech Language Hearing Association, 12, 38-50. Used with permission.

What is Dysphagia?

- Dysphagia is a swallowing disorder in which an individual demonstrates difficulty moving food from mouth to stomach, including food acceptance and recognition.
- Some individuals may be completely unable to swallow, leading to the need for alternative feeding methods, while others may only have difficulties with lip closure and/or leakage of liquids, foods or saliva from the lips.
- An impairment in any or all stages of swallowing
- Results in reduced ability to obtain adequate nutrition by mouth
- Often requires therapist intervention

What Causes Dysphagia?

- Any condition that weakens or damages the muscles and nerves used for swallowing, affects coordination and/or limits sensation may cause dysphagia, such as:
    - Multiple Sclerosis
    - Dementia
    - Parkinson's disease
    - Stroke/CVA
    - Head injury
- An infection or irritation can sometimes cause narrowing of the esophagus.
- Cancer of the head, neck or esophagus may cause swallowing problems.
- Sometimes specific cancer treatment can cause dysphagia.
- Injuries of the head, neck and chest
- Congenital abnormalities of the swallowing mechanism (e.g., cleft palate)

Special Diets for Residents with Swallowing Problems

- Verify the correct diet
- Check the card that comes with the food on the tray, the resident's name and the name band
- Check that the card and the food on the tray is the correct diet and consistency

International Dysphagia Diet Standardization Initiative

The International Dysphagia Diet Standardization Initiative (IDDSI) is a global standard with terminology and definitions to describe texture modified foods and thickened liquids used for individuals with dysphagia of all ages, in all care settings, and for all cultures.

The IDDSI framework consists of a continuum of 8 levels (0-7). Levels are identified by text labels, numbers, and color codes to improve safety and identification. The standardized descriptors and testing methods will allow for consistent production and easy testing of thickened liquids and texture modified foods.

Liquids are tested through a gravity flow test. Remove the plunger from a 10ml slip tip syringe, cover the nozzle with your finger, and fill with 10ml of the liquid. Release the nozzle and start the timer. After ten seconds, the amount of liquid remaining will tell you the classification of your liquid:

- 0-1 ml for thin (Level 0)
- 1-4 for slightly thick (Level 1)
- 4-8 for mildly thick (Level 2)
- 8-10 for moderately thick (Level 3)
- 10 for extremely thick (Level 4); Level 4 should be tested by the IDDSI fork-drip/spoon-tilt tests.

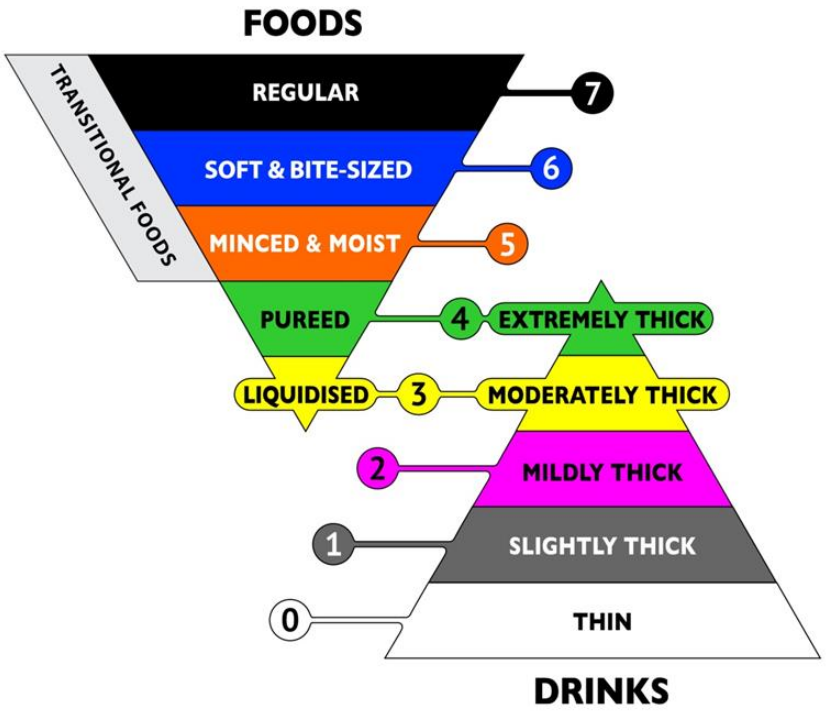
Solids are measured through the fork drip test (Levels 3 and 4 liquids can also be tested through the fork drip test)

- Level 3 (Liquidized or Moderately Thick liquids) should drip slowly or in dollops/strands through the tines/prongs of a fork.
- Level 4 (Puree food or Extremely Thick liquids): a small amount may flow through and form a tail below the fork, but it does not dollop, flow or drip continuously through the fork prongs.

Levels 4 and 5, materials should not be sticky. This can be tested with a spoon tilt test- the sample should be cohesive enough to hold its shape on the spoon but must slide or pour off the spoon if the spoon is tilted or turned sideways or shaken lightly.

- Level 5 Minced and Moist foods, particles of food should fit between the tines/prongs of a standard metal fork for adults, or the size of the child's fifth fingernail for children.
- Level 6- Soft and Bite-sized recommends maximum food size of 1.5 cm x 1.5 cm (the entire width of a standard fork.

Softness/hardness of food can be tested with the Fork pressure test. Press the fork into the food sample by placing the thumb onto the bowl of the fork until blanching is observed which pressure is consistent with tongue force used during swallowing.



Dysphagia diet

- Diets are likely given different names at different facilities
- The resident's physician orders special diet considerations

Common stages of diets:

- Stage 1. Pureed
- Stage 2. Pureed/Ground
- Stage 3. Ground
- Stage 4. Mechanical Soft
- Stage 5. Regular

Common stages of liquids:

- Thin (regular)
- Nectar thick (like processed syrup)
- Honey thick (like honey or buttermilk)
- Pudding thick (like pudding in a pudding pack, sticks to spoon without running off)

Symptoms of a swallowing disorder may include one or more of the following:

- Decreased recognition of eating environment/situation/specific foods
- Decreased desire to eat in front of or with others
- Difficulty opening mouth for food acceptance
- Decreased physiological responses to food and/or liquids
- Recent diet changes
- Difficulty in chewing, excessive chewing
- Excessively long mealtime (45-60 minutes)
- Unusual posture during mealtime
- Difficulty managing saliva
- Excessive drooling, especially immediately after eating
- Food or liquid leaking from mouth
- Nasal regurgitation (food or liquid coming out the nose during swallow)
- Food remaining on tongue after swallowing
- Pocketing of food on one side or both sides of the mouth or tongue
- Spitting out food after chewing
- "Holding" food or medications in the mouth
- Refusing to swallow
- "Refusing" foods of different textures
- Difficulty starting a swallow
- Facial grimacing
- Gagging
- Complaining of pain or "something stuck" during or after swallow
- Coughing or choking before, during and/or after eating or drinking
- Watery eyes and/or reddened face while eating or drinking
- Attempts to clear throat during eating or drinking
- Difficulty or inability to breathe while consuming meals, snack or nutritional supplement
- Needing to swallow two or three times "to get all the food down"
- "Wet" voice after eating or drinking
- Excessive mouth movement during chewing and swallowing
- Increased body temperature of unknown cause
- Pneumonia or chronic respiratory distress
- Unexplained weight loss
- Gastro esophageal reflux
- Unable to keep food in mouth
- Unable to drink
- Unable to move food or liquids backward to swallow
- Food is not chewed enough to swallow
- Unable to complete meals

Techniques for Improving Swallowing

- Tell the resident who you are and what you will be doing
- When feeding, if possible, sit down on a chair in front of the resident
- Resident should be positioned according to the instructions of the SLP and may need to be repositioned during the meal. Unless otherwise noted, residents are generally positioned upright with head in the neutral position.
- Describe the menu
- Tell the resident when the feeding utensil is near his/her mouth
- Present food at the mouth level so the resident does not need to lift his/her head while eating
- Do not use a straw unless instructed by therapy
- Tell the resident to take small bites and sips
- Place food on the strong side of the mouth
- Ask the resident to dry swallow to clear food lodged in the throat (as frequently as instructed by therapy)
- Alternate solids and liquids
- When feeding the resident, place the utensil gently on the mid-portion of the resident's tongue
- When the resident is swallowing, ensure that his/her lips are closed
- Give the resident regular, verbal cues
- To reduce confusion, place only one dish in front of the resident at a time
- After eating, have the resident remain sitting up for at least 30 minutes
- Check for pocketing. Food in mouth may need to be cleared prior to the next presentation.
- Do not use a syringe to feed
- Before and after each meal, the caregiver should provide complete oral care to ensure no food is in the mouth
- Resident may be safe to eat only foods and liquids of specific textures, be certain to check the diet order before feeding:
- Resident may not be safe to use a straw
- Ensure dentures fit well. The resident may eat better without the dentures or denture adhesive may be used to improve chewing.
- Allow adequate time for eating

Definition

Activities including repetition, physical or verbal cueing, and task segmentation provided by any staff member or volunteer under the supervision of a licensed nurse may quality as training and skill practice in rehabilitation nursing.

Eating or swallowing: Activities used to improve or maintain the resident's self-performance in feeding one's self food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

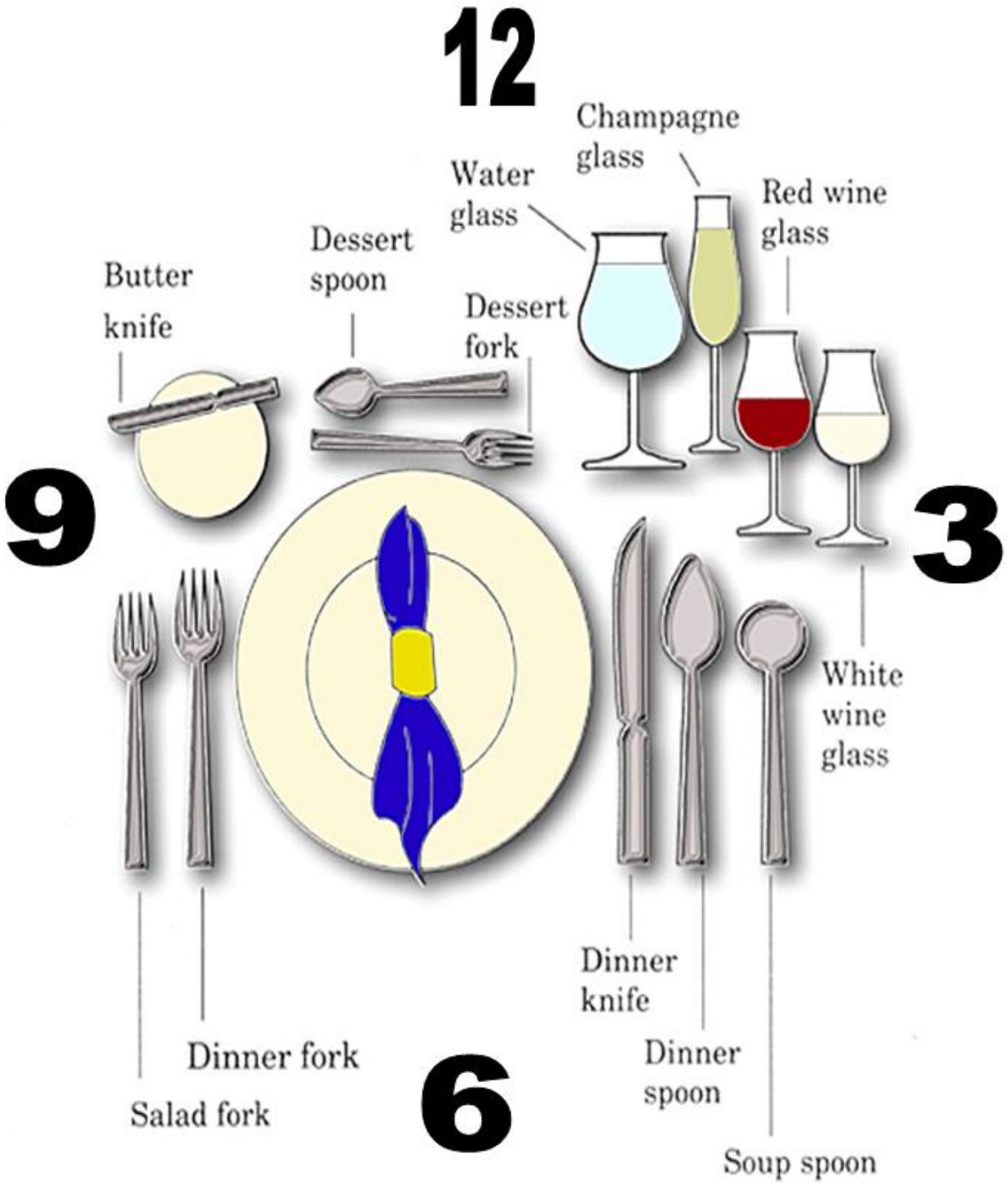
Techniques for Improving Self-Feeding

- Use a pleasant voice to greet residents by name and inform them it is mealtime
- Check to see that residents have their dentures, eyeglasses or any necessary adaptive equipment before transporting them to the dining room. If residents are able to walk or wheel to the dining room, allow them to do so and offer assistance as needed.
- Assist residents to achieve correct positioning (see photos below):
    - Transfer to regular chair if possible
    - Ensure hips and knees are positioned at 90-degree angles (or as close as possible)
    - Ensure feet are flat on the floor or on foot pedals
    - Position the resident as close to the eating surface as possible
    - Ensure the table is positioned at elbow height
    - Encourage the resident to bring his head slightly forward
    - Position the resident so he is facing the table squarely
- Present food, describing what items are on the plate
- Set up food according to therapist recommendations, or resident preference
    - Remove plate from tray if possible (trays give a cafeteria appearance, and are often too big and cumbersome for the table)
    - Arrange the food in an appetizing or restaurant style format
- Allow the resident time to set up his/her own plate of food such as cutting food, pouring beverages, seasoning food or buttering bread. If he/she has difficulty, assist in set up of the tray.
- Use the "clock" method to set up food for those visually impaired to assist in locating food items (see diagram below). When setting up the clock program, ask the resident the preferred placement of food items. Stay consistent with food placement. For example:
    - Meat or entrée at 4:00
    - Vegetable at 1:00 – 2:00
    - Potato at 10:00
- Place a towel or napkin in the resident's lap to protect clothing. Avoid using bibs as this can be degrading for the elderly population.
- Ask the resident if there is anything else, he/she needs
- Encourage the resident to independently self-feed without rushing and allowing rest breaks when needed
- If a resident has made an effort to self-feed, but now seems tired, assist with the remainder of the meal. Attempt to make the meal as pleasant as possible.
- Incorporate adaptive equipment and specific feeding techniques as outlined by the referring OT or SLP. Frequently used adaptive equipment includes:
    - Finger foods
    - Plate guard
    - Scoop dish
    - Dycem place mats
    - Utensils with built up handles
    - Weighted utensils
    - Swivel utensils
    - Rocker knife
    - Quad grip or universal cuff utensils holder
    - Nosey cup
    - Sip control cup
    - 2-handled cup

- For a neurologically impaired resident with perceptual deficits, other special arrangements may improve the self-feeding abilities. Food placement may be:
    - To the affected side (to increase visual scanning)
    - To the unaffected side (to increase self-feeding independence and facilitate efficient oral clearance)
    - Within the resident's visual field
    - With pressure added from utensil (to increase sensation on the tongue)
- For a confused resident, presentation of one food item at a time or use of finger foods may be effective methods for the resident. If the resident seems distractible or has a short attention span, it may be best to position so he/she cannot observe other people. If easily distracted by noise, it may be necessary to work individually in a quiet room.
- Provide a pleasant eating environment. Mealtime is a social time. It is important to normalize the meal for residents. It is a proven fact that a pleasant environment directly affects the success of self-feeding. Have a newspaper on hand to incorporate discussion of current events.
- Residents should be seated with people they enjoy being around to encourage socialization. Try to group resident with similar difficulties together, such as those using adaptive equipment, those who eat only finger foods (sandwiches, fresh fruit, crackers, etc.), or those with impaired coordination who are messy eaters.
- A specific area should be designated for the Restorative Dining Program, and it should be:
    - Quiet with low stimulation
    - Well lit
    - Separate from other diners, if possible
    - Equipped with tables of the correct height to accommodate wheelchairs
    - Able to accommodate family/visitors
    - Decorated with contracting tablecloths and utensils to facilitate visual/perceptual skills for all residents

Resident Positioning for Swallowing and Self-Feeding

- Arrange for the resident to eat meals out of bed whenever possible
- Use pillows, wedges, or lap tables to assist the resident in maintaining the proper position
- Place the resident's arms on the table or tray-assure proper shoulder positioning
- Adjust the table height to reach between the resident's waist and mid-chest
- Place food within a 12-inch reach
- When the resident is ready to eat, have the resident place his/her head slightly forward
- Always check:
    - Positioning of resident
    - Positioning of the eating surface
- To protect the resident from choking, check with the speech/language pathologist or occupational therapist to see if these special positions are recommended:
    - Have the resident turn his/her head to the weak side
    - Have the resident tilt his/her head toward the strong side


12
Champagne glass
Water glass
Red wine glass
Dessert spoon
Butter knife
Dessert fork
9
3
White wine glass
Dinner knife
Dinner spoon
Soup spoon
Dinner fork
Salad fork
6

Correct Dining Position

- Hips back in chair
- Seated upright or flexed slightly forward
- Slight head flexion may assist in closing airway during swallow
- Elbows supported on chair or table
- 90-degree knee flexion
- 90-degree ankle flexion with feet supported on floor or footrest
- Close proximity to table

Incorrect Dining Position

- Table too high
- Not seated close to table
- Not facing table
- Head straining forward
- Sliding forward in chair
- Feet unsupported

Selecting and Using Adaptive Equipment During Self-Feeding

- Use adaptive equipment to:
    - Assist in self-feeding
    - Increase independence
    - Help with safe swallowing
    - Decrease the chance of choking
    - Choose adaptive equipment for residents with:
    - Limited range of motion
    - Upper extremity weakness
    - Poor coordination
    - Paralysis, especially one-sided
    - Blindness
    - Swallowing problems

Residents with Decreased Strength:

- If the resident's pinch or grasp is limited:
    - Select built-up or enlarged handles on utensils
    - Temporarily built-up handles with a washcloth, foam rubber, or
    - Other material wrapped around the handle and secured
    - Use commercial utensils with plastic handles
    - Utensils should be lightweight to reduce resistance
- Types of adaptive equipment for these residents may include:
    - Universal Cuff
    - Use a universal cuff (utensil holder) when the resident cannot grasp or pinch.
    - The cuff fits around the palm and has a pocket where the utensil is inserted.
- Lapboard/Elevated Table
    - Use a lapboard or high table to support the arm.
    - The height should be adjusted to just below the shoulder.
    - As arm strength increases, lower the lapboard or use a lower table.
- Spork
    - This utensil combines the bowl of a spoon with the tines of a fork.
    - It eliminates the need to switch utensils.
    - It is used with a cuff or splint.
- Sandwich Holder
    - This utensil holds the sandwich and has a handle.
    - Use when a resident cannot pick up a sandwich.
- Cups or Mugs
    - When the resident has difficulty holding a cup, select a mug with a T-shaped handle or a handle long enough to accommodate all four fingers.

Residents with Poor Coordination:

- Select a cup that has a sipping spout to prevent spills
    - Prepare the resident's food before he/she attempts to self-feed
    - Cut into small pieces
    - Butter toast, rolls, etc.
    - Mix the milk in cereal, etc.

Residents with Paralysis, Tremors or Range of Motion Deficits:

- Rocker Knife
    - Use to stabilize and cut meat and other foods.
    - This utensil has a sharp curved blade that cuts when rocked over the meat.
- Dycem
    - Non-skid surface that prevents dishes from sliding
    - Useful for one-handed self-feeding
    - Wet towel or wet sponge-cloth will work too
- Plate Guard
    - Use to prevent food from being pushed off the plate when scooped.
    - Attach the plate guard to the left of the plate for a right-handed resident, or to the right for a left-handed resident.
- Utensils
    - Use utensils weighted for stability.
    - Use enlarged handles to assist with the resident's grasp.
    - Plastic-coated utensils will protect the resident/s teeth.
    - Nosey Cup
    - Use a nosey cup to compensate for decreased neck extension
    - Be sure that cut out faces away from the mouth

Residents Who are Blind:

- Tray set-up
    - Tell the resident where each item is placed on his/her tray as he/she explores the placement of dishes, glasses, utensils with his/her hands.
    - Allow him/her to explore the location of the food by using the fork to taste the food.
    - Tell the resident to distinguish salt from pepper by taste.
    - Tell the resident to find the edge of the food with the fork.
    - Tell the resident to move the fork one bite size inward on the meat/food.
    - Tell the resident to cut the food, keeping the knife in contact with the fork.

Metal Plate Cuff

Universal Cuff

Clear Plastic Plate Guard

Universal Cuff

Snap-on Plastic Plate Cuff

Wrist-Supported Universal Cuff

Nosey Cup

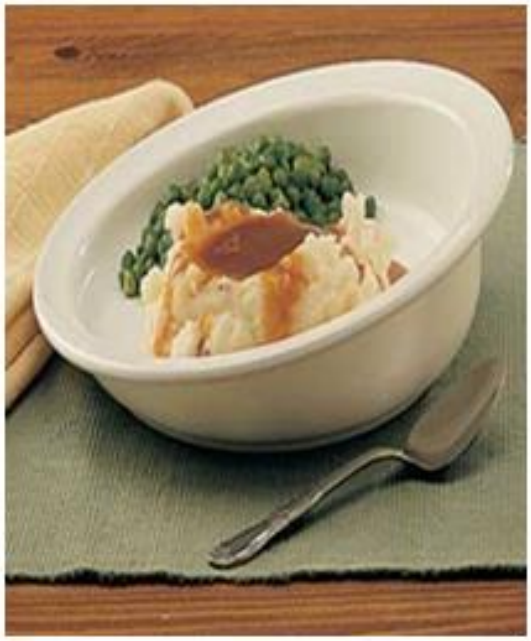
Alternate Nosey Cup

Swivel Utensils

Angled Utensils

Foam for Built Up Handles

Sandwich Clip



High-Rimmed Scoop Dish

Suction Bowl

Dycem

Dycem on Chair

Rocker Knife

Gravity-Eliminated Feeding Apparatus

Post-test
Eating and Swallowing

Name: _____ Title: _____

Social Security: _____ Work: _____

Mailing Address: _____

1. **Aspiration occurs when the resident breathes food or liquid into the lungs.**
   True / False
2. **There are four stages of swallowing, (three traditional and one additional).**
   True / False
3. **Coughing during or after a meal may be a sign of dysphagia.**
   True / False
4. **Pocketing occurs when a resident puts food in their pockets to eat at a later time.**
   True / False
5. **A universal cuff may help a resident with reduced strength hold eating utensils for self-feeding.**
   True / False
6. **Blind residents should never be allowed to self-feed.**
   True / False
7. **When feeding a resident, you should always tilt the resident's head back.**
   True / False
8. **Dycem is non-slip material that prevents eating utensils from sliding.**
   True / False
9. **It is okay to give un-thickened water to a resident on thickened liquids.**
   True / False
10. **It is very important to be sure a resident is wearing his dentures and/or glasses when eating**
    True / False
11. **It is appropriate for a resident to feed himself lying on his side if he is tired**
    True / False
12. **It is better to feed the resident rather than allow him to feed himself**
    True / False
13. **If you don't know how to use adaptive equipment, cover it with a napkin – pretend it's not there**
    True / False

Answer Key
Eating and Swallowing

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Clinical Competency Checklist
Restorative Nursing – Swallowing

Employees Name / Credentials: _____

Swallowing	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Informs resident in a pleasant manner that it is mealtime						
Checks that resident has dentures in place if needed						
Assess oral hygiene prior to intake/performs oral care						
Identifies diet level and precautions prior to meal						
Identifies and describes diet texture levels						
• Regular						
• Mechanical soft						
• Ground/chopped						
• Puree						
Demonstrates thickening of liquids to appropriate consistency						
• Thin						
• Nectar						
• Honey						
• Pudding						
Able to stimulate food acceptance						
• Pressure on jaw						
• Icing						
• TG stim						
• Finger foods						
Verbalizes 5 signs/symptoms of Swallowing disorders						
Observes adam's apple movement to assess swallow						
Verbalizes definition of aspiration and silent aspiration						

Clinical Competency Checklist
Restorative Nursing – Swallowing

Swallowing	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
Completes oral motor exercises prior to eating, as indicated						
• Open and close mouth						
• Pucker lips						
• Smile						
• Stick out tongue						
• Stick out tongue and move right and left						
• Attempt to touch nose with tongue						
• Attempt to touch chin with tongue						
Identifies reasons for and demonstrates swallow strategies						
• Chin tuck						
• Double swallow						
• Throat clear/re-swallow						
• Tongue sweeps						
Positioned resident for feeding in upright position with head in neutral position						
Does not give resident a straw						
Fed resident small amounts at a time						
Gave resident adequate time to swallow						
Alternates liquids and solids, if indicated						
Checked resident's mouth following swallow and at end of meal to ensure no food remaining						
Ensured resident positioned upright throughout intake						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Clinical Competency Checklist
Restorative Nursing – Dining/Eating

Employees Name / Credentials: _____

Dining	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Informed resident in a pleasant manner that it was mealtime						
Assures pleasant eating environment						
Checks that resident has dentures, glasses and necessary adaptive equipment						
Identifies diet level and precautions prior to meal						
Identifies adaptive equipment and use						
• Dycem						
• Nosey cup						
• Sippy cup/spout cup						
• Two handled mug						
• Weighted utensils						
• Built up handles on utensils						
• Long handled utensils						
• Angled utensils						
• Partitioned scoop dish						
• Inner lip plate						
• Plate guard						
Assured proper positioning						
• Lap tray						
• Tabletop at waist height						
• Shoulders back						
• Elbows supported on chair or table						

Clinical Competency Checklist
Restorative Nursing – Dining/Eating

Dining	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
• Food within 12" reach						
• Hips and knees bent to 90 degrees						
• Feet supported flat on floor/foot pedals						
Presented food and describes items on plate						
Asks resident preference of food placement						
Demonstrates basic feeding techniques						
• Hand over hand assist for self-feeding						
• Tactile cues						
• Verbal cues						
• Clock method for food placement						
• Places food appropriately for visual/perceptual deficits						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Section 9

Amputation and Prosthesis

Objectives:

- To identify the key interventions for residents recovering from an amputation
- To describe strategies for assistance with prosthesis and application

Content Outline:

- Amputation care
- Prosthesis care

Course Competency:

Each participant will complete a pre-/post-test to validate retention of course content.

Amputation and Prosthesis

Amputation Care

- Indications for amputations
  - Trauma
  - Thermal injuries
  - Infection
  - Tumors
  - Pain due to impaired circulation
- Sites of amputations
  - Foot
  - Ankle
  - Below the knee (BKA)
  - Above the knee (AKA)
  - Below the elbow (BE)
  - Above the elbow (AE)

- Aspects of care

- Stump healing and shrinking

- Target objectives:
  - Rapid healing
  - Minimal scarring
  - Minimal adhesion of skin to underlying bone

- Dressing types:
  - Rigid total contact dressing
  - Upper extremities
  - Traumatic amputations
  - Avoided with elderly residents
- Removable rigid dressing
- Unna semi rigid dressing
  - Can be changed
  - Associated with minimal skin breakdown
- Elastic bandages for stump shrinking
  - Must be applied evenly
  - Reapplied at least 4 times daily
  - Even, adequate pressure is essential
- Stump shrinkers
  - Even pressure assured
  - May be applied by the resident
- Temporary prosthesis
  - Applied as soon as the wound is healed
  - Gives even pressure for continued shrinkage

Stump shrinkage occurs over 3 months.

- Prevention of contractures
    - Prevent hip flexion and external rotation – *Do not put pillows under the stump for positioning!!*
    - Promote a prone position (as soon as possible)
    - Crutch walking should be initiated by the therapist
    - Avoid prolonged sitting
    - Resistance exercises may be done under therapist direction and supervision

- Mobility training
    - Residents will practice transfers to wheelchair, toilet, commode or care under the therapist's direction and supervision
    - Gait training with prosthesis
    - The higher the amputation, the greater the energy requirement for ambulation with a prosthesis.

Prosthesis Care

- Key Aspects of Prosthetic Care
    - Sock and shoe on sound foot must be clean and well-fitting
    - Both shoes should have heels and soles in excellent condition
    - Monitor the skin integrity of the stump for areas of tenderness, redness and cuts or abrasions
- Cleaning the prosthesis
    - Plastic sockets
    - Washed with cloth dampened with warm water and mild soap
    - Wipe socket with damp soap free cloth
    - Dry stump with fresh towel
    - During warm weather or humid climates, clean the socket daily at night to assure it will be dry by morning
- Donning
    - Correct application of the prosthesis is critical
    - The amputated limb should be inspected daily prior to the prosthesis application
- Doffing
    - Following removal of the prosthesis, the limb should be inspected for possible problems
    - The prosthesis should be cleaned
- Amputation and Prosthesis Care
    - Activities used to improve or maintain the resident's self-performance in:
    - Putting on and removing a prosthesis
    - Caring for the prosthesis
    - Providing appropriate hygiene at the site where the prosthesis attaches to the body

Post-test
Amputation and Prosthesis

Name: _____ Title: _____

Social Security: _____ Work: _____

Mailing Address: _____

1. **One of the key objectives of stump healing is to prevent the stump site from shrinking.**

   True / False

2. **When positioning a resident after a lower extremity amputation, it is essential that a pillow not be placed under the stump for positioning.**

   True / False

3. **It generally requires no more effort to walk with a prosthesis than with two sound legs.**

   True / False

4. **A key aspect of prosthetic care is monitoring the skin integrity of the stump for redness, irritation and cuts or abrasions.**

   True / False

5. **Plastic prosthetic sockets should be cleaned daily prior to use to assure the resident has a clean socket to use.**

   True / False

Answer Key
Amputation and Prosthesis

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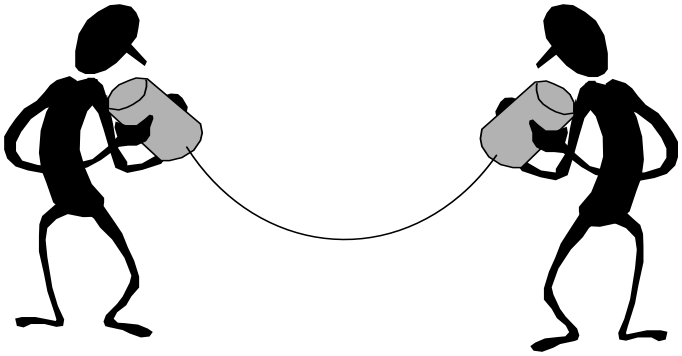
Section 10

Communication Strategies



Objectives:

- To identify the impact of impaired communication.
- To describe alternative strategies for residents with communication disorders.

Content Outline:

- Effective communication
    - Requirements
    - Levels of language production
- Definitions
- Communication Assessment
- Goals of care
- Strategies

Course Competency:

Each participant will complete a pre-/post-test to validate retention of course content.

Communication Strategies

What is communication?
Communication is a two-way process in which people exchange information (e.g., requests, feelings, socialize)

Why do we communicate?
- To request information
- To find information
- To maintain social contact
- To provide information

We receive information (receptive communication) through:
- Listening/hearing
- Reading
- Watching

We exchange information (expressive communication) through:
- Verbal (spoken words)
- Writing
- Gestures (pointing, head nods, etc.)
- Facial expressions (frowns, smiles, etc.)

What happens if we don't communicate?
- Needs are not known or met
- May become isolated, depressed, frustrated, angry, aggressive or belligerent
    - Imagine you are in pain and no one can understand what you are trying to tell them or where you feel the pain
    - Imagine you are looking for an important piece of paper, but no one understands what you need
    - Imagine you want to join a game of bingo, but the group just ignores you because they can't understand what you are saying
- Loss of self esteem
- Decreased social interaction

Goals of Care
- Establishment of functional communication
- Maintenance of client self-esteem/concept
- Prevention of injury
- Promotion of social interaction

Common Communication Problems Experienced by Residents following CVA

Left Hemisphere Brain Damage

- Effects are seen on the right side of the body
- When damage to the left hemisphere of the brain occurs, a resident may:
    - Demonstrate **aphasia**
    - Experience **anomia**
    - Have **apraxia**
    - Have **dysarthria**
    - **Perseverate** – repeating a word, phrase, sentence or action inappropriately
    - **Speak clearly** but not make any sense, using jargon, incoherent speech or gibberish
    - Have **deficits in** writing, reading and arithmetic
    - Use **"yes and no"** inappropriately
    - **Not be able to follow directions** or repeat words or actions when demonstrated

Right Hemisphere Brain Damage

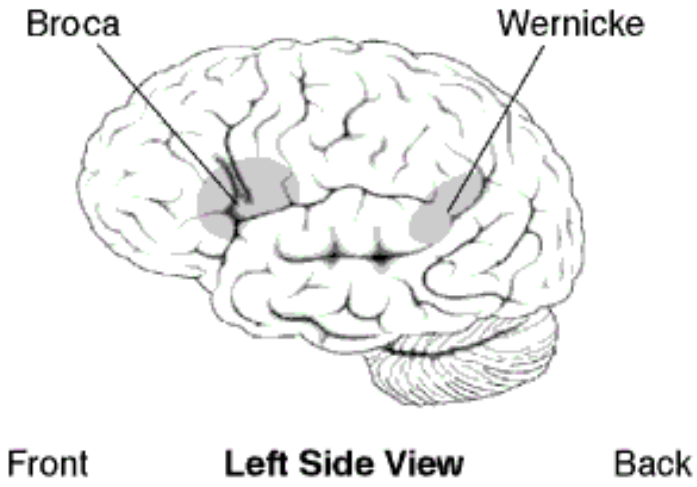
- Effects are seen on the left side of the body
- When damage to the right hemisphere of the brain occurs, cognition is usually affected, for example a resident may:
    - Be highly distractible with an extremely short **attention span**
    - Be **disoriented** and think he is someplace she/he's not
    - Show **poor judgment**
    - **Perseverate**
    - **Misuse objects** e.g., comb, razor, toothbrush or eating utensils used inappropriately
    - **Talk incessantly** repeating the same ideas over and over again
    - **Deny** there is anything wrong with him/her
    - Start to do something then stop as if **confused** about what he/she is doing
    - Confuse **time and place concepts**, i.e., may not know time, day or location
    - Have **behavioral problems** – impulsivity, emotional lability (loss of control of emotional responses, e.g. laughing or crying uncontrollably), decreased inhibition skills
    - Experience difficulty **remembering new information**, history about his/her life and/or situations/procedures
    - **Sequence** tasks incorrectly
    - Demonstrate poor **reasoning, problem solving and safety skills**

Aphasia

Aphasia is a language disorder resulting from damage to the language centers of the brain. Aphasia usually occurs suddenly, often as the result of a stroke or head injury, but it may also develop slowly, as in the case of a brain tumor, series of TIAs or seizures.

- Residents with **Broca's aphasia** have damage to the frontal lobe of the brain. These residents have difficulty expressing themselves and/or speaking.
- Residents with **Wernicke's aphasia** have damage to the temporal lobe of the brain and may have difficulty understanding what is said to them.

- A third type of aphasia, **global aphasia**, occurs when residents have difficulty with speaking and understanding. Residents with global aphasia have severe communication difficulties and may be extremely limited in ability to speak or comprehend language/situations.



Note: From National Institutes of Health. “Aphasia” Bethesda, MD: National Institutes of Health. Copyright October 1997 by National Institutes of Health

Receptive Language Suggestions

- Speak in a normal tone
- Use clear, concise communication
    - Limit adjectives, adverbs and prepositions
    - Use consistent phrases
    - Use gestures and motions to describe actions
- Use communication aids
    - Pictures
    - Spelling boards
- Sample activities:
    - Respond to questions (e.g., yes/no and w/h)
    - Picture matching and/or sequencing
    - Follow one-step directions (with or without physical cues)
    - Crossword puzzles
    - Word unscramble
    - Sentence inconsistencies
    - Complete sentence reading and making a selection
    - Communication board use

Expressive Language Suggestions

- Respond to all communication efforts
- Give adequate time to respond
- Allow completion of statements and thoughts
- Do not anticipate what the resident is trying to say
- Use techniques and triggers when difficulty is experienced
- Watch resident's lips for verbal cues
- Sample Activities:
    - Imitation of words, phrases and/or sentences with over articulation and tone changes
    - Repeat ten functional sentences with over articulation
    - Automatic speech sequences (e.g., days of the week, months of the year, familiar
    - songs/prayers
    - Expressing opinions
    - Similar/differences
    - Comparisons
    - Reminiscing
    - Phrase completion (i.e., opposites, "Up and ____")
    - Sentence completion (i.e., "Open the ____" or "I wish that ___")
    - Provide functional gestures (e.g., eat, sleep, cold, pain, etc.)
    - Pictionary
    - Pantomime
    - Speech device use

General Guidelines for Successful Interaction with Residents with Communication Impairments

- Reduce background noise and visual distractions
- Approach and gain the resident's attention from the front, at eye level
- Use the resident's name, identify yourself by name and what you plan to do
- Put yourself in a face-to-face position, gaining eye-contact with the resident
- State what you plan to do
- Speak clearly and use short simple sentences
- Treat resident as an adult and involve in decision-making
- Limit use of language (use sparingly) when resident is fatigued
- Speak in a normal tone of voice; do not shout
- Begin a conversation with casual topics
- Avoid changing the topic of a conversation too quickly
- Allow extra time for the resident to understand what was said
- Allow extra time for the resident to respond verbally or express himself in some manner to what was said
- Use gestures to help get the message across
- Use a forced choice question technique, e.g., "Would you like …… or ……", so the resident may be able to make personal choices
- Utilize additional communication methods (as defined by the SLP) and the resident to increase communication effectiveness, such as:

    - Pointing to words or pictures
    - Gestures
    - Memory aid
    - Speech generating devices
    - Alphabet board
    - Electrolarynx

Glossary of Terms

Term	Definition
Aphasia	Total or partial loss of the ability to use or understand language; usually caused by stroke, brain disease or injury
Apraxia	Inability to execute a voluntary movement despite being able to demonstrate normal muscle function
Agnosia	Failure to recognize familiar objects perceived by the senses
Agraphia	Writing difficulty
Alexia	Reading difficulty
Augmentative/ Alternative Communicative Device	Augmentative communication devices help residents in producing and/or understanding speech. These can include picture boards, facial expressions, typewriter systems and computers.
Cognition	Thinking skills that include attention, perception, memory, awareness, reasoning, judgment, intellect, problem solving, sequencing, insight, orientation and imagination
Dysarthria	Group of motor speech disorders caused by disturbances in strength or coordination of the muscles of the speech mechanism as a result of damage to the brain or nerves
Language	System for communicating ideas and feelings using sounds, gestures, signs or writing
Language Disorders	Any of a number of problems with verbal communication and the ability to use or understand a system for communication
Motor Speech Disorders	Group of disorders caused by the inability to accurately produce speech sounds because of muscle weakness, incoordination or difficulty performing voluntary muscle movements
Speech	Spoken/verbal communication
Speech Disorder	Any defect or abnormality preventing an individual from communicating by means of spoken words
Speech Language Pathologist (SLP)	Health professional trained to evaluate and treat individuals who have voice, speech, language, cognitive and/or swallowing disorders affecting their ability to communicate.

Dementia

Dementia is defined as “a structurally caused permanent or progressive decline in several dimensions of intellectual function that interferes substantially with the person’s normal social or economic activity”.

Techniques for Communicating Successfully with Residents with Dementia

- Approach resident from the front to avoid startling the resident
- Call resident by name and use gentle touch to get the resident’s attention
- Stand directly in front of the resident. Maintain eye and physical contact to hold attention
- Use a calm, soothing tone of voice and pleasant facial expression
- Use simple adult language and speak slowly
- Use resident’s name frequently
- Give one message at a time
- Allow time for a response
- Repeat statements or questions as often as necessary
- If it is necessary to repeat, use the same words
- Wait until one step is completed before going on to the next step
- Use body language (gestures) to help explain statements
- Make questions into statements; for example; use “Let’s go to the dining room,” instead of “Do you want to go to the dining room?”
- Don’t ask questions to test the resident’s memory, e.g. “What’s my name?” Bombardment may cause the resident to become embarrassed, angry or upset
- Don’t offer choices if there are none or if one of the options is not acceptable
- Use direct statements about what you are preparing to do. Be clear about what is taking place
- Don’t argue, but instead try to change the subject
- Identify feelings rather than arguing facts
- Use non-confronting statements. Agree first then limit your response
- Ask for cooperation and help
- Make negative statements into positive ones, e.g. “Let’s come over here” vs. “Don’t go out”
- Run activities without competing noises, e.g. television in background
- Stimulate resident with language about topic/task, not “gossip”
- Allow for reminiscing. It is ok the resident isn’t oriented to here and now

General Guidelines for Successful Communication with Residents with Hearing Loss

- Be sure resident is wearing hearing aid in correct method and ear, if applicable
- Ensure resident uses assistive listening device if prescribed
- Say the resident's name or tap gently to get the resident's attention before you begin talking
- Eliminate background noise such as TV, radios, noisy carts or others talking nearby
- Position yourself in front of the resident so you can be seen before you start talking
- Have light on your face so your mouth can be seen
- Reduce glare from lights and windows
- Don't talk with anything in your mouth, such as gum, cigarettes or food
- Kneel or bend in order to be at eye level with someone in a wheelchair
- Stay in the same room while talking. Do not move around the room, speak while leaving the room or turn your back while speaking.
- Speak in a normal tone of voice or lower your voice pitch
- Don't shout. Move closer to the resident and speak to the "better" ear or ear with hearing aid.
- Speak clearly, using short sentences
- Don't speak either too fast or too slowly
- Use non-verbal communication such as facial expressions, gestures and pointing
- Rephrase or reword. Some words are easier than others to speech read. Find a different way to say something that is not understood.
- Use written words to help clarify your message
- Verify your communication. Ask the resident to repeat the message to be sure of accuracy.
- Be patient!

Hearing Aid Tips

Be sure resident wears his/her hearing aid every day

- **Morning Care**
  - Place battery in hearing aid (battery should be replaced every 2-3 weeks)
  - Place hearing aid on resident
  - Turn on hearing aid and turn volume to comfortable level for resident
- **Evening Care**
  - Remove hearing aid from resident before bedtime
  - Open battery compartment
  - Check ear mold for wax and assist with ear cleaning. Avoid use of Q-tips.
  - Encourage residents' families to have spare batteries for the resident

Post-test
Communication Strategies

Name: _____ Title: _____

Social Security: _____ Work: _____

Mailing Address: _____

1. **Aphasia is the inability to swallow.**
   True / False
2. **Eye contact is an important part in effective communication.**
   True / False
3. **When communication is impaired, the use of adjectives, and detailed examples may increase comprehension.**
   True / False
4. **Anticipating what a resident is trying to say and saying it for him will decrease frustration.**
   True / False
5. **It is important that all efforts of communication by the resident have a response from the rehabilitation/restorative nurse or assistant.**
   True / False
6. **Shouting is an effective technique for communicating with a resident who has Alzheimer ’s disease**
   True / False
7. **Batteries in hearing aids can be left in overnight**
   True / False
8. **It is important to get the attention of the hearing-impaired resident before you begin to speak to him/her**
   True / False

Answer Key
Communication Strategies

1. **Aphasia is the inability to swallow.**

   True / False

2. **Eye contact is an important part in effective communication.**

   True / False

3. **When communication is impaired, the use of adjectives, and detailed examples may increase comprehension.**

   True / False

4. **Anticipating what a resident is trying to say and saying it for him will decrease frustration.**

   True / False

5. **It is important that all efforts of communication by the resident have a response from the rehabilitation/restorative nurse or assistant.**

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6. **Shouting is an effective technique for communicating with a resident who has Alzheimer ’s disease**

   True / False

7. **Batteries in hearing aids can be left in overnight**

   True / False

8. **It is important to get the attention of the hearing-impaired resident before you begin to speak to him/her**

   True / False

Clinical Competency Checklist
Restorative Nursing – Communication

Employees Name / Credentials: _____

Communication	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Identifies and demonstrates methods of communication						
• Gestures						
• Facial expressions						
• Verbal/words						
• Writing						
• Reading						
Follows general guidelines for communication						
• Uses resident's name						
• Approaches resident from the front on eye level						
• Speaks clearly, facing resident						
• Allows enough time for response						
• Uses short sentences						
• Positively reinforces resident when attempting to respond						
• Uses choice questions						
• Does not shout						
• Uses gestures to get message across as needed						
• Uses communication board when appropriate						

Clinical Competency Checklist
Restorative Nursing – Communication

Communication	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
Demonstrates expressive language exercises						
• Automatic speech						
• Singing						
• Fill-ins						
• Sentence completion						
• Word finding						
• Naming/identification						
• Description						
• Discrimination						
• Pacing techniques						
Demonstrates receptive language exercises						
• Understands yes/no questions						
• Follows directions						
• Choice presentation						
• Object discrimination						
Demonstrates pragmatic language exercises						
• Turn taking						
• Eye contact when speaking						
• Appropriate language when speaking						
• Regulates social exchange						
Appropriately modifies task following communication breakdown						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Clinical Competency Checklist
Restorative Nursing – Cognition

Employees Name / Credentials: _____

Cognition	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Follows general guidelines for interaction with residents with cognitive disorders						
• Approaches resident from front at eye level						
• Aware of cognitive limitations with regard to safety						
• Paces information delivery						
• Watches for signs of frustration						
• Reduces distractions						
• Redirects negative behavior						
• Demonstrates patience						
• Provides structure/cueing for task performance						
Follows general guidelines for interaction with residents with memory disorders						
• Adapts environment to enhance performance						
• Repeats information as needed						
• Provides choices						
• Uses respectful tone of voice						
• Structure tasks for compensation						
• Avoid emotional confrontation						

Clinical Competency Checklist
Restorative Nursing – Cognition

Cognition	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
Demonstrates ability to perform cognitive activities						
• Memory						
• Reality orientation when Appropriate						
• Decision making						
• Attention						
• Thought organization						
• Judgment/problem solving						
Follows through with compensatory strategies as per SLP						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Section 11

Ambulation Training

Objectives:

- To describe components of an ambulation program
- To describe common techniques used with assistive devices
- To demonstrate techniques for guarding residents during ambulation training

Content Outline:

- Ambulation training program
- Common techniques used with assistive devices
- Techniques for guarding the resident during gait training
- Return demonstrations

Course Competency:

Each participant will complete a pre-/post-test to validate retention of course content.

Ambulation Training

Ambulation

- A primary functional goal for many residents
- Often requires therapist intervention and oversight
- Gait belts should be used as directed
- Safe body mechanics should be practiced by all involved in ambulation training

Gait Training

The purpose of a gait-training program is to provide the resident with a method of ambulation that allows maximum functional independence and safety at a reasonable energy cost.

Assistive Devices

- Types of Assistive Devices:
- Walkers:
- Pick up (standard-SW)
- Front wheeled (FWW)
- 3 wheeled walker (3WW)
- Four wheeled (4WW)
- Platform walker
- One-handed walker (stroke walker)

Canes:

- Straight cane/single point cane (SC/SPC)
- Walk cane/hemiwalker
- Quad cane (QC)

Crutches:

- Underarm (Axillary) crutches
- Forearm crutches
- Platform crutches

Adjustment of Assistive Devices

Adjustable Walkers

- Ask the resident his/her height or estimate the resident's height. As a rule of thumb, residents who are 5'2" and below should use a youth walker. Residents who are 5'3" and above should use an adult size walker.
- Choose a walker appropriate for the resident's height
- Examine the walker for obvious defects. Check the tips, wheels and/or brakes on each of the legs.
- To determine the correct height of a walker, have the resident stand and place his/her hands on the walker. Move the walker slightly forward of the resident's feet and have the resident relax his/her arms. In this relaxed position, the elbows will form a 30-degree angle when the walker is at the correct height, or have resident let go of walker and relax arm straight down. Resident's wrist should be at the level of the handgrip. When hand is placed on the walker, the wrist will be at 30 degrees.
- Determine if the walker needs to be raised or lowered in order for the elbows to form a 30-degree angle
- The walker can be adjusted in 1" increments
- Return the resident to the sitting position and adjust the walker
- To adjust the walker, turn the walker upside down and push the button on the adjustable legs. Pull the legs out to make the walker taller or push the legs in to make the walker shorter.

- Be sure when you have finished the adjustment of the walker, the buttons are fully exposed and protruding outward. If the buttons do not "pop out," attempt to re-adjust. If the buttons continue to fail to "pop out," do not use the walker. It is unsafe.
- Be sure all four legs of the walker are adjusted to the same height
- Stand the resident with the walker and re-check the height adjustment. With the arms relaxed, the elbows should form a 30-degree angle. Re-adjust the walker if necessary.

Adjustable Canes

- Examine the cane for obvious defects, as well as a good tip
- To determine the correct height of a cane, have the resident stand up and place his/her hand on the cane
- The cane should be placed slightly forward and to the side of the resident's foot
- When the resident is standing erect with his/her arm relaxed, the elbow will form a 30-degreee angle when the cane is adjusted correctly
- If the angle is greater than 30 degrees, the cane will need to be shortened
- If the angle is less than 30 degrees, the cane will need to be lengthened
- Sit the resident down and adjust the cane
- To adjust the cane, push the button in on the lower half of the cane and pull the cane apart to make it longer, or push the cane together to make it shorter
- The cane can be adjusted in 1" increments
- Once the cane is adjusted, make sure the button has "popped out. If the button has not "popped out," re-adjust the cane until it does. If for any reason the button will not pop back out, do not use the cane. It is unsafe.
- Stand the resident with the newly adjusted cane and re-check the angle of the elbow. The elbow should be in approximately 30 degrees of flexion; if not, re-adjust the cane.

Wooden Cane:

The same procedure should be used as for the adjustable cane; however, the wooden cane should be cut off in 1" increments until the correct height is obtained. Again, examine the cane and check the tip for defects.

Ambulation Guidelines

Know the resident's weight bearing status prior to ambulation. DO NOT ambulate with the resident until this is confirmed by the Charge Nurse or the Physical Therapist.

- Weight Bearing Status
- Non-Weight Bearing (NWB): The resident should not touch the foot to the floor while ambulating
- Toe Touch Weight Bearing (TTWB): 10% or less weight bearing. The resident can touch his/her toe down for balance.
- Partial Weight Bearing (PWB): 50% or less weight bearing. The resident can weight bear on the ball of the foot.
- Full Weight Bearing (FWB)/Weight Bearing as Tolerated (WBAT): The resident can weight bear 100%, or as much as is comfortable

The resident should be wearing a robe or dressed in street clothes and non-skid slippers or shoes with good rubber soles. Check the policy of your facility regarding dress requirements for out of room.

- Explain to the resident what you are going to do and what you expect him/her to do
- If the resident is lying in bed when approached, have him/her sit up on the edge of the bed
- Make sure the resident is not lightheaded, dizzy or nauseous before standing

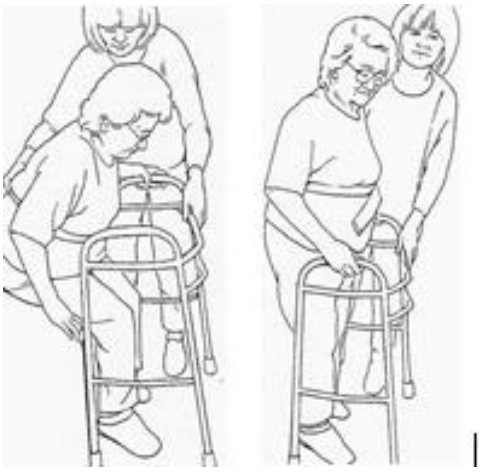
Place a safety/gait belt around the resident's waist. Make it snug, as the belt will loosen up when he/she stands up. Prior to practicing gait training techniques outdoors, consult the therapist on resident capability and limitations.

Gait Patterns

Depending on the resident's diagnosis, the resident may use a variety of gait patterns, which will be specified by the Physical Therapist. If a gait pattern is not specified, general gait patterns should be utilized.

Walker: Resident should move the walker ahead first, followed by the weaker leg, then the stronger one. Don't allow the resident to carry the walker or take too big of steps. If the resident has to bend forward or reach outside of his/her base of support, instruct the resident not to place walker so far out. This could cause the resident to lose his/her balance and fall.
Check the height of the walker. The elbow should be flexed at approximately 30-degrees; if not, have the resident sit down while adjusting the walker.
Do not allow the resident to hold onto the walker while sitting down or standing up.

- **To stand**
  - Resident moves forward in chair
  - Walker is positioned in front of the resident
  - Resident leans forward and pushes down with both hands-on armrests and stands
  - Resident reaches for walker, one hand at a time
- **To sit**
  - As resident approaches chair, he turns toward the stronger side
  - Resident backs up until he can feel the chair touch the back of his legs
  - Resident reaches for the armrests, one at a time
  - Resident lowers to chair



Canes: Generally, a resident should utilize a cane on the opposite side of the involvement. The resident should first place the cane in front and slightly to the side of the strong leg a comfortable distance. The resident then should advance his/her weaker or involved leg, followed by his/her strong leg.

- **To stand**
  - Resident moves forward in chair
  - Cane is positioned on uninvolved side (or leaned against armrest)
  - Resident leans forward and pushes down with both hands-on armrests, stands and grasps cane
- **To sit**
  - As resident approaches chair, he makes a turn toward the uninvolved side
  - The resident backs up until the chair touches the back of his legs
  - The resident reaches for the armrest with the free hand, and releases the cane, and reaches for opposite armrest

Crutches

- **To stand**
  - Resident moves forward in chair
  - Crutches are placed together in vertical position on affected side
  - One hand is placed on hand pieces of the crutches, one on the armrest of the chair
  - Resident leans forward and pushes down with both hands-on arm rests and stands
  - Resident gains balance, places crutch under axilla on unaffected side – The resident should not lean on the crutches
  - Second crutch is placed on the affected side
  - A tripod stance is assumed
- **To sit**
  - As resident approaches chair, resident turns toward the uninvolved side
  - Resident backs up until he feels the chair touch the back of his legs
  - Both crutches are placed in a vertical position (out from the axilla)
  - One hand is placed on the hand pieces of the crutches, one on the armrest of the chair
  - Resident lowers to the chair

Techniques for Guarding the Resident during Ambulation Training

- For level surfaces
- With your hand securely on the safety/gait belt (palm up), walk beside or slightly behind the resident on the involved side. Keep your feet apart (broad base of support) so you can easily maintain your balance, as well as the resident's.
- Use your leading lower extremity following the assistive device
- Your opposite lower extremity should be externally rotated and follow the resident's weaker lower extremity
- Place one hand posterior on the gait belt and the other anterior to, but not touching the resident's shoulder on the involved side
- Walk at the resident's pace. **Do not try to rush him/her**. The distance walked will depend on the resident's functional activity tolerance.
- If balance is lost or threatened during gait training
    - The hand guarding the shoulder should make contact
- If balance loss is severe
    - Move in toward the resident so that the body and guarding hands can be used for stabilization
    - Allow resident to regain balance while "leaning" on you
    - If balance is not recovered and it is apparent the resident will fall --- ***Do not attempt to break the resident's fall since this will result in injury to the resident and you.***
    - Brace the resident against your body and move with the resident to a sitting position to break the fall and to protect the head.
    - Talk to the resident and explain that you are lowering him to the floor to prevent him from panicking and trying to correct his balance.
    - Call for assistance and report the incident.

Assistive Devices

Standard Walker

Rolling Walker

Platform Walker

Hemi-Walker

3-Wheeled Walker

4-Wheeled (Rollator) Walker

Quad Walker

One-Handed Walker

Assistive Devices

Stairs and Curbs

The purpose of this section it to instruct regarding proper techniques, assistive devices and safety precautions to follow when negotiating stairs or inclines. Before assisting an individual up or down stairs or curbs, you must know resident's:

- Diagnosis
- Involved or weak side
- Weight bearing status, if appropriate
- Ability to follow instructions
- Medical precautions (e.g., no excessive hip flexion or internal rotation)

Assistive Devices

Very few walkers are designed for stair climbing. If the resident has an assistive device, the following should be noted:

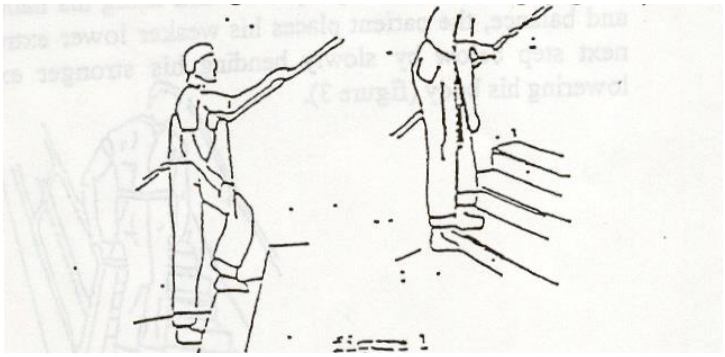
- With a walker, the physical therapist will give the assistant specific instructions in its use
- Canes should be carried in the strong hand or in the resident's shirt pocket while ascending or descending stairs. Quad canes are turned sideways.

Ascending Stairs

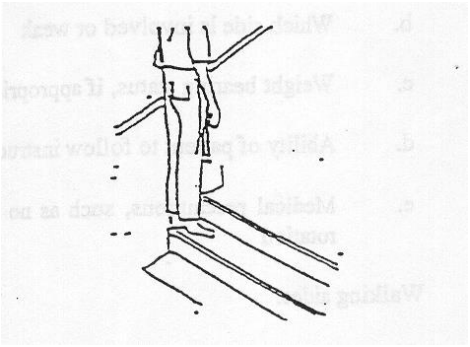
For ascending and descending stairs or curbs, the memory cue is "Up with the good and down with the bad." In other words, the resident should always start going up the stairs or curb by leading with the stronger or uninvolved leg and should always start going down the stairs or curb by leading with the weaker or involved leg.

When climbing stairs, the resident should lead with the stronger extremity and use a handrail whenever possible.

- When assisting the resident, always use a safety/gait belt
- Position yourself posterior and lateral to the affected side, behind the resident
- Keep each foot on a different stair.
- Take a step ***only*** when the resident is not moving.
- Keep one hand on the gait belt and the second adjacent to, but not touching the shoulder on the involved side.
- Have the resident place his/her hand on the handrail nearest the stronger side
- Have the resident place the stronger foot up on the first step



- By leaning slightly forward and using his/her arm to push down on the handrail and by straightening his/her stronger leg, the resident can raise his/her body and place his/her weaker extremity on the same step. If resident is using a cane (in the right hand in this example), the cane will always be with the involved leg.



AVOID allowing the resident to bend excessively forward and
Attempting to pull him/herself up the stairs.
This places the resident in a potentially unsafe position.

Descending Stairs

As a rule of thumb, always lead with the weaker extremity down the stairs. Use the handrail whenever possible.

- When assisting the resident, always use a safety/gait belt
- Position yourself anterior and lateral to the affected side, in front of the resident.
- Keep each foot on a different stair.
- Take a step *only* when the resident is not moving.
- Keep one hand on the gait belt and the second adjacent to, but not touching the shoulder on the involved side.
- Have the resident place his/her hand on the handrail nearest his/her stronger side
- While maintaining an erect posture and using his/her hand for support and balance, the resident places his/her weaker lower extremity on the next step below by slowly bending his/her stronger extremity and lowering his/her body
- If using a cane (in right hand in this example), the cane would be placed down on the next step prior to the weaker leg to give resident additional support

Once the weaker extremity is firmly on the step below and the knee is straightened, allow the resident to step down to the same step with his/her stronger extremity

AVOID allowing the resident to bend excessively forward or backward.
This will result in an unsafe position.

If balance is threatened:

- Make contact with the guarding hand at the shoulder.
- Move toward the resident to help brace the resident.
- ***Do not pull the resident toward you on the stairs.***
- If necessary, move with the resident to sit the resident down on the stairs.
- Inform the resident that you will assist him in sitting on the stairs.
- Call for assistance and report the incident.

Ascending a Curb

As a rule of thumb, always lead with the stronger extremity up the curb.

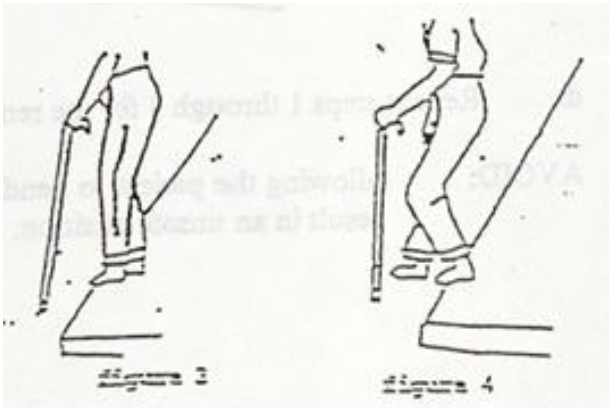
- When assisting the resident, always use a safety/gait belt
- Have the resident place the stronger extremity on the curb
- Position yourself anterior and lateral to the affected side, in front of the resident.
- Keep each foot on a different stair.
- Take a step ***only*** when the resident is not moving.
- Keep one hand on the gait belt and the second adjacent to, but not touching the shoulder on the involved side.

- The resident shifts the body weight onto the stronger extremity
- The resident then leans slightly forward and straightens the stronger extremity pushing on a cane to assist, if applicable
- As the body elevates, have the resident place the weaker extremity and the cane, if applicable, on the curb.

Descending a Curb

As a rule of thumb, always lead with the weaker extremity down the curb

- Have the resident step up to the curb, so his/her toes are at the edge of the curb
- While standing erect and bending the stronger extremity to lower the body, the resident places the weaker extremity and cane, if applicable, on the street.



AVOID allowing the resident to lean "heavily" on the cane or to lean excessively forward. This will put the resident in an unbalanced position and will make him/her use extra effort to ascend or to descend the curb.

Ascending/Descending using a walker.

Return Demonstrations

- Form groups of two or three persons in each
- One individual will act as the resident
- The second individual will complete gait training practice in the following sequence:

Assist from sitting to standing using

- Cane
- Crutches
- Walker
- Standing to sitting
- Cane
- Crutches
- Walker

Walking on level surface

- Ascending stairs
- Descending stairs
- Correction of balance loss while on:
- Level surface
- Stairs

Gait belts should be used throughout the practice sequence
If a third person is involved, this individual will oversee the process for possible issues
Change roles and repeat the process until all have participated

Post-test
Ambulation Training

Name: _____ Title: _____

Social Security: _____ Work: _____

Mailing Address: _____

1. **Ambulation is a key component of resident care. Cornerstones of the gait-training program are functional independence, safety and energy consideration**.

   True / False

2. **When using a cane, the cane should be positioned on the involved side.**

   True / False

3. **When returning to a sitting position, the resident should walk up to the chair until the chair is touching the front of the knees and then turn to sit.**

   True / False

4. **When guarding a resident during ambulation, a gait belt should be used.**

   True / False

5. **If the resident starts to lose balance and you are not able to correct the balance by contact with the shoulder and by moving closer to the resident, you should try to break the fall.**

   True / False

6. **When assisting the resident to the floor to prevent a "fall", you should explain to the resident that you are lowering him to the floor since he may begin to panic and make the situation worse by struggling.**

   True / False

7. **When ascending stairs, you should position yourself in front of the resident to guide him up the stairs.**

   True / False

8. **If a resident has no problems ambulating inside, you should feel comfortable that he will be able to ambulate outside without any issues.**

   True / False

9. **The walker is at the correct height when the hands are placed on the hand grips and the elbow forms a 30-degree angle**

   True / False

10. **The resident should always lead with the weak extremity when going down the curb/stairs**

    True / False

11. **You should always walk beside the resident on the involved side**

    True / False

Answer Key
Ambulation Training

1. **Ambulation is a key component of resident care. Cornerstones of the gait-training program are functional independence, safety and energy consideration**.

   True / False

2. **When using a cane, the cane should be positioned on the involved side.**

   True / False

3. **When returning to a sitting position, the resident should walk up to the chair until the chair is touching the front of the knees and then turn to sit.**

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   True / False

10. **The resident should always lead with the weak extremity when going down the curb/stairs**

    True / False

11. **You should always walk beside the resident on the involved side**

    True / False

Clinical Competency Checklist
Restorative Nursing – Ambulation

Employees Name / Credentials: _____

Ambulation	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Identifies weak/involved side						
Identifies precautions, weight bearing status or strength						
Informs resident in a pleasant manner what is going to happen						
Uses a safety/gait belt correctly						
Adjusts walker/cane correctly						
Locks wheelchair brakes						
Helps resident scoot forward so feet are flat on floor						
Has resident lean forward and push down with hands on surface to stand up						
Instructs resident to stand straight						
Weight bearing status emphasized						
Walks at resident's pace						
Walks on resident's involved side						
When returning to chair, instructs resident to move backward until he feels chair touching backs of legs						
Instructs resident to reach for wheelchair armrest prior to sitting down						
Resident instructed to bend knees while lowering to the chair						

Clinical Competency Checklist
Restorative Nursing – Ambulation

Ambulation	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
Good use of body mechanics at all-times						
Identifies cases where 2 people are needed						
Identifies and demonstrates use of assistive devices						
• Walker						
• Rolling walker						
• Cane						
• Quad cane						
• Hemi walker						
When assisting, supports resident around the trunk or with gait belt, not holding under the arms						
Identifies and demonstrates weight bearing terms						
• Full weight bearing						
• Partial weight bearing						
• Toe touch weight bearing						
• Non weight bearing						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Clinical Competency Checklist
Restorative Nursing – Stairs and Curbs

Employees Name / Credentials: _____

Stairs and Curbs	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely/accurate documentation of resident performance during task						
Identifies weak or involved side						
Identifies precautions, weight bearing status or strength						
Informs resident in a pleasant manner what is going to happen						
Uses a safety/gait belt correctly						
Instructs resident to lead with the strong extremity up stairs/curb						
Instructs resident to lead with the weak extremity down stairs/curb						
Did not allow resident to lean forward excessively						
Positioned to assist resident in case of balance loss						
Climbed stairs at resident's pace						
Good body mechanics used at all times						
Identifies cases where 2 people are needed						
When assisting, supports resident around the trunk or with gait/safety belt, not holding under the arms						

Clinical Competency Checklist
Restorative Nursing – Stairs and Curbs

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Section 12

Bladder and Bowel Continence

Objectives:
To describe methods of assessing bladder and bowel function
To identify appropriate management programs for bladder and bowel dysfunctions
To discuss strategies to prevent bladder and bowel complications that may occur with disability and chronic illness

Content Outline:

- Bladder management
    - General treatment principles
    - Evaluation
    - Goals of a bladder management program
    - Continence self-control programs
- Bowel management
    - General treatment principles
    - Evaluation
    - Goals of a bowel management program
    - Continence self-control programs

Course Competency:
Each participant will complete a pre-/post-test to validate retention of course content.

Bladder and Bowel Continence

General Treatment Principles

- Good intake is a way of life
    - 3000 cc per day
    - Caution with congestive heart failure
- Acidic urine desired
    - Alkaline urine should be avoided
    - Leads to increased bacteria (UTIs)
    - Leads to increased calculi

Goals of a Bladder Management Program

- Preserve urinary function
- Prevent complications
- Develop resident's ability to:
    - Manager bladder program
    - Correctly use equipment
    - Recognize and prevent bladder complications

Evaluation

- Physical and mental status
    - Hand function
    - Potential for cooperation
    - Ability to transfer on and off toilet/commode
    - History of comorbidity (diabetes, hypertension)
    - Medications
- History
    - Usual Pattern
    - Previous Urinary tract problems
    - Infections
    - Calculi
    - Irregularities
- Present urinary status
    - Condition of urinary structures
    - Circumcision
    - Strictures
    - Sensation
    - Control of external sphincter
- Voiding Pattern
    - Equipment use (catheter, appliances)
    - Nocturia
    - Force, stream
    - Amount and frequency
    - Residual

- Urinary infections
    - Odor of urine
    - Color of urine
    - Precipitates in the urine
    - Cloudiness or blood in the urine
    - Vital signs and generalized malaise
- Incontinence estimates
- Evaluate frequency
- Evaluate amount
    - 9" (50 – 75ml)
    - 12" (100 – 125 ml)
    - 18" (150 – 175 ml)
    - 24" (200 – 300 ml)

Types of Incontinence and Treatments

Urge Incontinence is the inability to hold urine long enough to reach and void in a toilet. Urge urinary incontinence is often found in people who have conditions such as diabetes, stroke, dementia, Parkinson's disease and/or multiple sclerosis. Bladder disease and enlarged prostates are two other conditions that may cause urge incontinence. Statistics show that 11-15% of the adult population has urge incontinence. The cause is an "overly sensitive bladder" which feels full even when it contains a little amount of urine. The bladder contracts unexpectedly, the bladder neck opens, and if the external sphincter is weak, the urine in the bladder is released. Urge or urgency is an uncomfortable feeling that makes the resident want to empty his/her bladder. Improved control occurs when a resident can retrain the bladder to wait.

Questions to ask about urge incontinence:

- Does the resident have strong urges to urinate but is unable to make it to the restroom?
- Does the resident have to strain to urinate?
- Does the resident have large accidents?
- Is the resident urinating frequently?

Treatment ideas for urge incontinence:

- Assess the resident's voiding pattern and maintain careful bladder records
- Assess resident's use of bladder-irritating substances such as caffeine, aspartame and alcohol
- Assess the resident for chronic constipation and institute a bowel regimen, if necessary
- Encourage the resident to drink six to eight 8 oz glasses of fluid/water during the day
- Limit fluid intake after 6 pm
- Instruct the resident on voiding habitually if they do not void regularly (every 2-4 hours)
- Implement a bladder-retraining program once the resident has successfully adapted to a 2-hour voiding schedule, gradually increasing the voiding intervals by 30 minutes until normal 3-4-hour voiding pattern is achieved.
- Teach the resident relaxation techniques such as deep breathing exercises and imagery to alleviate anxiety and inhibit the urge to void
- Teach the resident Kegel exercises, pelvic floor exercises and abdominal exercises
- Use a beside commode or urinal

Stress Urinary Incontinence is the involuntary loss of urine during coughing, sneezing, laughing or other physical activities that increase abdominal pressure. This condition can be caused by childbirth or hormonal changes in women. The bladder neck is not able to stay closed and the external sphincter cannot compensate, so leakage occurs. There are two types of stress incontinence that occur. The first is the loss of supporting tissue around the base of the bladder and the urethra, and the second results in loss of function of the urethra. Many people also report that bladder problems worsen after weight gain. Through behavioral techniques and pelvic muscle strengthening, the symptoms of stress incontinence may disappear or be significantly reduced. Stress incontinence is the most common type of incontinence and can almost always be cured.

Questions to ask about stress incontinence:

- Does the resident leak while laughing, coughing, sneezing or physical activity?
- Has the resident had a prostatectomy or hysterectomy?
- Did the resident have vaginal birth deliveries?
- Does the resident leak when lifting?

Treatment ideas for stress incontinence:

- Teach the resident to perform pelvic floor exercises
- Instruct resident to contract pelvic muscles before coughing, walking or otherwise increasing intra-abdominal or thoracic pressure
- Refer the resident for biofeedback if indicated
- Abdominal strengthening exercises

Mixed Incontinence is very common and occurs when residents present with both urge and stress incontinence symptoms. Treatment will depend on which set of symptoms are more prevalent or bothersome to the resident.

Functional Incontinence occurs when continent individuals are unable to get to the toilet in time due to environmental obstacles. Arthritis may be a factor of functional incontinence due to pain that may not allow someone to reach the toilet or undress in time to urinate. Muscle weakness, fatigue, problems with balance, broken bones or joint problems can also create problems when trying to reach the bathroom. Some people may not know how to get to the restroom or become confused as to whether they are wet or dry. Some of the most common causes of functional incontinence include:

- Height of toilet
- Fear of falling
- Poor lighting
- Inability to get out of a chair or bed fast enough
- Difficulty getting undressed in time
- Lack of privacy while using the restroom
- Problems keeping balance when transferring to toilet

Questions to ask about functional incontinence:

- Does the resident urinate before making it to the restroom due to slowness?
- Has the resident fallen during attempts to get to the restroom?
- Does the resident have arthritis?
- Does the resident have muscle weakness or fatigue problems?
- Does the resident demonstrate signs and symptoms of dementia?
- Does the resident have trouble removing clothing?
- Does the resident have trouble walking?
- Does the resident have accidents early in the morning?

Treatment ideas for functional incontinence:

- Habit training for a bladder schedule
- Eliminating functional inhibitors to the bathroom
- Schedule assistance to the toilet
- Behavior modification for those who are unwilling to go to the toilet
- Use of a bedside commode or urinal

Overflow Incontinence is the leakage of small amount of urine without the feeling that you may urinate. The bladder never empties completely and is overly full. When this happens bladder weakness or blockage prevents normal emptying. An enlarged prostate may result in such a blockage. This is the reason overflow incontinence is more common in men than women. Other obstructions include medications, tumors, benign structures and scar tissue.

- Questions to ask about overflow incontinence:
  - Does the resident have a spinal cord injury?
  - Does the resident have diabetes?
  - Could this resident have an enlarged prostate?
  - Has this resident had a surgery that could traumatize the urethra?
  - Could this resident be constipated?
  - Does the resident have tenderness over the pubic bone?

- Treatment ideas for overflow incontinence:
  - Medication
  - Adaptive equipment
  - Habit training
  - Environmental modifications

Iatrogenic incontinence is a condition caused directly or indirectly as a side effect of medications. While some medications cause urinary incontinence, others exacerbate symptoms, create abnormal voiding patterns or promote unwanted urinary retention. The following table identifies medication groups impacting urinary continence:

Medication/Drug Class	**Effect on Continence**
Sedatives	Causes incontinence and increased urgency
Antipsychotics	Mixed incontinence
Anti-Parkinson's drugs	Overflow incontinence
Antidepressants	Overflow incontinence
High blood pressure medications	Increased retention
Pain medications/narcotics	Increased retention
Antihistamines/decongestants	Increased retention
Cold remedies	Increased retention
Anti-spasm medications (CVA, TBI)	Increased retention
Diuretics	Causes incontinence and increased urgency

Treatment Strategies

- There are several things the interdisciplinary team can do to assist with treatment of urinary incontinence:
    - Reduce or eliminate factors contributing to incontinence
    - UTI
    - Medications that can irritate or exacerbate incontinence
    - Immobility
    - Environmental barriers
    - Fecal impaction
- Maintain adequate hydration
- Promote respect, personal integrity and self-esteem through daily compassionate physical and verbal interactions
- Give respectful private responses during any potential communication or actions regarding urinary incontinence
- Maintain skin integrity
    - Monitor skin for redness or sore areas
    - Perform perineal hygiene at least twice a day and after every episode of urinary incontinence
    - Use moisture barrier creams or films adequately
- Establish a bladder voiding schedule
    - Timed voiding
    - Prompted voiding
    - Habit training
- Bladder training
    - Pelvic muscle exercises
- Consider bladder capacity, mobility and clothing
- Intermittent catheterization
    - Every two or three hours initially, until residual is less than 100cc
    - Goal of every four to six hours
- Pharmacological management
    - Antispasmodic: Ditropan to decrease the excitability of the detrusor muscle
    - Cholinergic: Urecholine to increase bladder tone
    - Skeletal muscle relaxant: Baclofen to decrease spasticity of the external sphincter
    - Acidifiers: Vitamin C to increase the acidity of the urine
    - Antiseptics: Septra for long term prevention (controversial)
- Bladder retraining program
    - Intentional delay of voiding
    - Urge to void is delayed by the resident in an effort to manage urinary incontinence
    - The rationale for this type of program is to “Increase” the capacity of the detrusor muscle

- Prompted voiding
  - Begin with a 2-hour daytime voiding schedule
  - Approach the resident at the scheduled time
  - Wait 5 seconds to allow an opportunity to self-initiate toileting
  - Prompt the resident with verbal cuing if needed
  - In the bathroom, check the undergarments and protective garments for wetness
  - Assist the resident with the toileting needs
  - For a higher-level resident, inform him/her when you will return and provide a reminder to call for assistance if needed. Lower level residents should not be left completely unattended while toileting but should be given intermittent cues and assistance.
  - Praise all instances of self-initiated or independent toileting
  - Adjust the schedule up or down as needed, do not exceed 4-hour intervals
  - Consult with therapy and nursing regarding changes/concerns
- External catheter
  - Does not control voiding pattern
  - Prevents soiling, but does not prevent incontinence
- Indwelling catheter
  - Includes Foley catheters and suprapubic catheters
  - Linked with a high, almost universal incidence of urinary tract infection
  - Research demonstrates that within 72 hours of catheter insertion, over 90% of individuals will develop a urinary tract infection
- Intermittent catheterization
  - Method to prevent urinary retention
  - May be used as part of a continuing bladder program

Exercises

These include Kegel, gluteal setting, adductor setting, pelvic tilts and bridging. These can be done supine, sitting or standing. Care needs to be taken not to over fatigue the muscles in this region. Exercises to this region for the purpose of improving pelvic floor muscular control should be performed daily in order to achieve success.

Nutrition

Some foods and beverages are thought to contribute to bladder leakage. Their effect on the bladder is not always understood, but the resident may want to eliminate some of these items to improve urine control. These include:

- Alcoholic beverages
- Milk
- Coffee
- Medicines with caffeine
- Tomatoes
- Spicy foods
- Honey
- Corn syrup
- Colas
- Tea
- Citrus juice and fruits
- Sugar
- Chocolate
- Artificial sweetener

Grape, cranberry, cherry and apple juices are thirst quenchers that are not irritating to the bladder, and, in the case of cranberry and cherry juices, may help to control odor. The best beverage is water.

Socialization
Social isolation is a problem often related to embarrassment about urinary incontinence. It is the team's goal to prevent the resident's withdrawal from family, friends and social events because of embarrassment about urinary incontinence. Signs and symptoms of social isolation may include:

- Verbalized fear of leaving the room or apartment
- Lack of interest in socialization
- Self-imposed isolation
- Depression

Appropriate treatments for social isolation include getting the resident to discuss usual social activities. The resident should then get involved in the Continence Program in order to get set up with appropriate methods for dealing with incontinence. Encourage the resident to express concerns about incontinence and its social effects. Encourage discussion during group session to encourage support and decrease risk of isolation.

Improving personal hygiene
Maintaining and improving personal hygiene for the incontinent resident will help to prevent skin breakdown caused by exposure to urine leakage. Signs and symptoms include:

- Itching and burning in the groin or on the upper thighs and buttocks
- Excoriated epidermis
- Pain over the entire affected area
- Ammonia body odor

Follow this sequence when providing skin care:

- Assess the resident's perineum for signs of skin breakdown, rash or infection
- Wash the affected area with mild soap and warm water whenever the resident's clothing or pad is changed
- Apply a moisture barrier cream to the affected area
- Change the resident's saturated pads or protective garments promptly
- Dry the resident's skin thoroughly
- Inspect the resident's skin frequently
- Avoid tight fitting undergarments
- Report any abnormal drainage or bleeding immediately to nursing

Cognition
Some residents may display decreased cognitive capabilities, however, there are many interventions that may assist these residents in achieving the highest level of function in relation to urinary continence.

- Encourage the resident to drink six to eight 8 oz glasses of water a day
- Respond promptly to the resident's calls for assistance
- Assist the resident with a regular voiding pattern
- Talk to the OTR or the COTA about putting a commode near the resident's bed
- Advise the resident to wear less restrictive clothing
- Consult with the SLP regarding options for residents with decreased communication and/or cognition so that they might be able to express their needs regarding toileting, and/or improve sequencing, problem solving, or attention related to toileting

Environmental strategies
One effective treatment for urinary incontinence is to set up an environment that will promote functional independence.

- Make sure there are adequate toilet facilities and they are readily accessible to the resident
- Make sure that clothing can be managed quickly and easily
- Remove obstacles in the path to the bathroom
- Ensure proper lighting
- Ensure accessibility of hygiene items in the bathroom
- Consult with the OTR or COTA to assist with setting up a safe and functional environment and recommending adaptive equipment

Other considerations
When caring for someone who is disabled, it is important to keep the person comfortable and safe from harm. Residents who are bedridden or have difficulty moving cannot use the toilet without help or special attention. Without such attention, residents may develop skin problems or ulcers.

- Examine the resident's skin each day
- Reposition an immobile resident every hour
- Lift, do not drag the resident
- Keep skin clean and dry
- Encourage fluids and food

Bowel Management

- Goals of a Bowel Management Program
  - Establish program that will be compatible with resident's lifestyle
  - Maintain regularity and continence
  - Prevent complications

Evaluation

- Physical and mental status
  - Hand function
  - Potential for cooperation
  - Ability to transfer on and off toilet/commode
  - History of comorbidity: Cardiac, depression
  - Medications
- History
  - Resident perceptions of "normal" bowel function
  - Stool characteristics
  - Problems with constipation, impaction, diarrhea
  - History of colon malfunction: colitis, diverticulitis, hemorrhoids
  - Methods used in the past to correct irregularity
  - Nutritional history
  - Functional ability and support systems

General Treatment Principles

- Fluid intake
  - 3000 cc per day
  - Caution with congestive heart failure
  - Hot fluids stimulate peristalis
- High fiber foods
  - Avoid bran with digitalis, oral anticoagulants, salicylates, nitrofurantoin (bran binds with these drugs)
- Avoid high fat foods (slows peristalsis)
- Activity
  - Promotes muscle tone
  - Passive ROM
- Positioning
  - Upright, sitting position
  - Feet on floor or footstool
  - Avoid bedpans
- Privacy
  - Visual
  - Olfactory
  - Auditory
- Abdominal massage (follow direction of the colon)
- Consistent timing
  - Pre-disability habits
  - Current lifestyle
  - Gastrocolic reflux
  - Therapy schedule
  - Goal: Bowel program should be complete within 30 minutes or less
- Medications
  - Suppositories
  - Bulk formers (Metamucil)
  - Hyperosmotics (Glycerin)
  - Lubricants (Mineral oil)
  - Saline laxatives (MOM, Lactulose, Fleets)
  - Stimulant laxatives (Cascara, prune juice, Ducolax)
  - Stool softeners (Surfax, Colace)

Continence Self Control Strategies

- Begin with a “clean colon”
- Only change one aspect of the bowel program at a time
  - Suppository frequency “or”
  - Diet “or”
  - Fluid volume “or”
  - Activity “or”
  - Medication

Post-test
Bladder and Bowel Continence

Name: _____ Title: _____

Social Security: _____ Work: _____

Mailing Address: _____

1. **Good intake of fluids is necessary for effective bladder management. An effective fluid intake includes at least 3,000 cc of fluid daily.**

   True / False

2. **Alkaline urine is a serious issue with residents with bladder issues, since it leads to renal calculi and a predisposition to urinary tract infections. Alkaline urine is linked with a high intake of citrus fluids, carbonated beverages and milk.**

   True / False

3. **The primary complication of an indwelling catheter is dysuria.**

   True / False

4. **It is not possible to achieve bladder continence if a resident has had a stroke.**

   True / False

5. **Using a bedpan at night is a common practice in many acute care hospitals. Continuing this practice in the nursing facility will allow the resident to sleep better at night and will not reduce the efficacy of the bladder management program.**

   True / False

6. **In estimating the amount of incontinence, a 9-inch spot is equivalent to 300 ml or urine.**

   True / False

7. **According to the MDS definition of incontinence, a score of 2 is equated to frequent incontinence with daily incidents.**

   True / False

8. **The goals of a bladder management program include: Preservation of urinary function and prevention of complications.**

   True / False

9. **In a bowel management program, high fat foods slow peristalsis, which will lead to incontinence.**

   True / False

10. **The secret to success with a bowel management program is timing, timing, timing.**

    True / False

11. **Changes in the bowel program should be focused on only one element of the program at a time.**

    True / False

12. **Foods and fluids that contain sugar and caffeine can often contribute to urinary incontinence**

    True / False

13. **Kegel exercises are done by contracting and relaxing the pelvic floor muscle**

    True / False

14. **Proper hygiene includes washing the perineal area after every incident of urinary incontinence and using a moisture barrier cream**

    True / False

Answer Key
Bladder and Bowel Continence

1. **Good intake of fluids is necessary for effective bladder management. An effective fluid intake includes at least 3,000 cc of fluid daily.**

   True / False

2. **Alkaline urine is a serious issue with residents with bladder issues, since it leads to renal calculi and a predisposition to urinary tract infections. Alkaline urine is linked with a high intake of citrus fluids, carbonated beverages and milk.**

   True / False

3. **The primary complication of an indwelling catheter is dysuria.**

   True / False

4. **It is not possible to achieve bladder continence if a resident has had a stroke.**

   True / False

5. **Using a bedpan at night is a common practice in many acute care hospitals. Continuing this practice in the nursing facility will allow the resident to sleep better at night and will not reduce the efficacy of the bladder management program.**

   True / False

6. **In estimating the amount of incontinence, a 9-inch spot is equivalent to 300 ml or urine.**

   True / False

7. **According to the MDS definition of incontinence, a score of 2 is equated to frequent incontinence with daily incidents.**

   True / False

8. **The goals of a bladder management program include: Preservation of urinary function and prevention of complications.**

   True / False

9. **In a bowel management program, high fat foods slow peristalsis, which will lead to incontinence.**

   True / False

10. **The secret to success with a bowel management program is timing, timing, timing.**

    True / False

11. **Changes in the bowel program should be focused on only one element of the program at a time.**

    True / False

12. **Foods and fluids that contain sugar and caffeine can often contribute to urinary incontinence**

    True / False

13. **Kegel exercises are done by contracting and relaxing the pelvic floor muscle**

    True / False

14. **Proper hygiene includes washing the perineal area after every incident of urinary incontinence and using a moisture barrier cream**

    True / False

Clinical Competency Checklist
Restorative Nursing – Continence

Employees Name / Credentials: _____

Continence	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
ID's roles of IDT in continence program						
Defines types of incontinence and 2 treatment strategies for each						
• Urge incontinence						
• Stress incontinence						
• Functional incontinence						
• Overflow incontinence						
Verbalizes procedures to establish bladder schedule						
• Timed voiding						
• Prompted voiding						
• Habit training						
• Bladder training						
• Pelvic muscle (Kegel) exercises						
Identifies importance of other treatment interventions						
• Nutrition						
• Socialization						
• Coping skills						
• Personal hygiene/skin integrity						
• Cognitive retraining						
• Environmental modification						

Clinical Competency Checklist
Restorative Nursing – Continence

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Section 13

Documentation

Documentation

Documentation Skills
The purpose of documentation is to provide a record of treatment. It establishes standards of care, acts as a daily communication tool between treating RNAs and their supervisors and provides a basis for evaluating the quality of care.

Intake Data
Notes should include the resident's name, room number, attending physician, diagnosis and date of admission to the RNA program. Specific treatment instructions should be written by the Nurse or Therapist and include:

- Program/area(s) treated
- Procedures to be performed
- Duration of each procedure or number of repetitions
- Frequency and duration of Restorative Program
- Resident-specific strategies
- Goals for each program

Much of this information can be gathered from the initial referral form

Weekly Notes
Any weekly documentation should be specific and describe the resident's ability to perform activities in measurable terms (e.g., distance ambulated, assistance needed, amount eaten). Weekly notes should be compared to goals to determine whether the resident is progressing. If a resident is not moving toward the written goals, intervention by Nursing or Therapy may be warranted.

The weekly summary should include:

- Number of times the resident was seen
- Whether or not the resident made any gains
- Any unusual occurrence that happened during the week (should be written in a daily note on the day of occurrence)
- Resident's response to treatment
- Strategies addressed in treatment and functional performance
    - Extremities ranged (active and/or passive), percentages and/or splint tolerance (if applicable)
    - Distance ambulated, assistive devices, functional activity tolerance and assistance required
    - Self-care tasks performed and assistance required
    - Texture of food eaten, compensatory swallow strategies and percentage of meal consumed

Guidelines for RNA Documentation

- Daily notes documented as per facility protocol
- Time spent per program must be documented
- All entries should be neat and legible
- Weekly summaries should have complete sentences
- Do not use confusing abbreviations. Use only Nursing approved symbols and abbreviations.
- Compare progress to last week/last month
- If resident refuses or treatment is withheld, please note reason for refusal or withholding of treatment

Codes:

- **R**=Refused
- **W**=Withheld
- **OOF**=Out of Facility
- **H**=Hospital
- **S**=Sick

Document communication with Nursing and/or Therapists regarding resident's status and include what was discussed

Program Specific Documentation

The following is a list of items that should be included in the documentation of the following RNA programs:

- Ambulation
  - Length/distance walked
  - Assistance needed
  - Weight bearing precautions
  - Any assistive devises used, such as FWW (front wheel walker), PUW (pick up walker), or cane
- Range of Motion
  - Joint(s) ranged
  - Type of range (PROM, AROM, AAROM)
  - Number of repetitions able to perform or tolerate
  - Amount (in percentage) of movement
  - If appropriate:
    - Application of splint
    - Positioning the resident
- Restorative Dining Program
  - Amount (in percentage) eaten/consumed
  - Assistance needed
  - Any assistive device used such as a plate guard, built up utensil, rocker knife and/or nosey cup
  - Precautions for safety in swallowing
    - Thickened liquids
    - Positioning
    - Compensatory techniques (as suggested and trained by the Speech-Language Pathologist)
- Activities of Daily Living Program
  - Goal
  - Assistance needed
  - Any assistive device(s) used such as a Reacher, wash mitt, built up handle, button-aid, zipper pull, dressing stick and/or sock aid
- Continence
  - Goal
  - Assistance needed
  - Adaptive equipment used
  - Voiding schedule/bladder training schedule
  - Number/frequency of incontinent episodes
  - Medications impacting continence

Levels of Independence (as typically documented by therapy)

Level	Abbreviation	Definition
Independent	I	No help or oversight
Modified Independent	MI	Independent with extra time or assistive device
Supervision	S	Oversight, encouragement or cueing provided
Stand by Assistance	SBA	Direct stand by oversight required for safety
Contact Guard Assistance	CGA	Highly involved in task, requires limited guidance of limbs, <25% physical assist
Minimum Assistance	Min A	Requires 25% physical assist
Moderate Assistance	Mod A	Requires 50% physical assist
Maximum Assistance	Max A	Requires 75% physical assist
Total Assistance/Dependent	D	Requires 100% physical assist

Sample Problem List for Communication

- Difficulty expressing wants and needs
- Difficulty following simple instructions
- Difficulty understanding Y/N questions
- Slurred speech
- Difficulty naming or using common ADL objects
- Difficulty following conversation

Sample Problem list for Swallowing

- Doesn't swallow all food
- Coughs during meals
- Recent weight loss
- Poor intake
- Requires altered diet
- Requires compensatory swallow strategy for safe swallow
- Difficulty accepting oral intake, drooling
- Difficulty or prolonged chewing
- Pockets food in cheeks

Sample Problem List for Ambulation

- Can ambulate only short distances
- Failure to progress with ambulation
- Needs daily ambulation to maintain mobility status
- Difficulty transferring from bed to wheelchair
- Needs assistance in coming to sitting
- Poor balance
- Limited function – both upper extremities
- Leans to the left when ambulating
- Weak, with decreasing ability to walk
- Impaired ambulation due to recent ankle facture (ankle sprain, foot injury, etc.)
- Need to use walker for ambulation

Sample Problem List for Range of Motion

- Unable to use right arm due to CVA
- Developing hand contractures
- Foot drop
- Edema in arms or legs
- Needs to be taught self-repositioning

Sample Problem List for Self-feeding

- Tires easily at mealtime
- Needs to be encouraged to use non-dominant hand
- Recent removal of N/G or G-tube
- Requires supplemental tube feeding
- Eats slowly
- Recent weight loss
- Needs socialization at mealtime
- Needs reminder to eat
- Does not finish meals
- Decreased attention to eating task
- Difficulty recognizing food and/or utensils

Sample Problem List for ADL

- Tires easily during morning routine
- Needs encouragement and/or verbal cues to perform grooming/hygiene in standing
- Poor balance
- Limited use of upper extremity for grooming
- Easily distracted during ADLs
- Needs assistance with dressing
- Need to use adaptive equipment for dressing

Sample Problem List for Continence

- Urge to urinate but cannot make it to the restroom
- Frequent urination
- Leaks while laughing, coughing, sneezing
- Frequent episodes of urinary incontinence (document frequency/number)
- Urinates before making it to the restroom due to slowness

Discharge Summaries

- A resident may be discharged from Restorative Nursing when:
- Resident can perform the activity at independent level
- Resident can perform the activity under nursing supervision
- Further improvement is not anticipated, and nursing can follow through with the activity, or
- Regression has occurred and the resident can no longer perform the activity. If regression occurs, Nursing and/or Therapy should be consulted.

The discharge summary should be written by the Restorative Nursing Coordinator and should include:

- Start of care
- Type of services received
- Goal(s)
- Resident's level of performance at the start of care
- Length of treatment
- Resident's performance at discharge
- Reason for discharge
- Follow up to be provided

Prioritizing

- If caseload is too large and additional staffing is not possible:
  - If caseloads are consistently large, consider adding additional dedicated RNA staff
  - Review caseload with therapy to see which residents can be seen by nursing via integrated nursing program
  - Form group programs as clinically appropriate
    - Upper extremity ROM group
    - Exercise group
    - Dining group
    - ADL group
    - Swallowing group
    - Communication group
- Discharge residents who can be ambulated with stand by assistance to nursing
- Discharge services for residents who are regressing
- Prioritize residents requiring services based on severity, diagnosis, onset of deficits, perceived burden of care on nursing unit, motivation and potential for improvement
- If feasible, have nursing complete non-restorative tasks such as:
  - Weekly weights
  - Bed making/linen distribution
  - Counting dining aprons
  - Water distribution
  - 2-hour turning
  - Hand roll or other positioning device placement
- Initiate a facility walking or "happy feet" program
- Decrease number of residents in the dining program and have only 1 RNA monitoring the program for each meal

Caseload too small

- Consult with nursing and therapy staff for residents who may benefit from treatment
- Add a new program, such as Activities of Daily Living or Cognitive Program

One RNA pulled to work on the floor

- Treat those residents who would regress if they did not receive treatment
- Reduce length of session (i.e., walk a resident 50 feet instead of 200)
- Rotate residents missed so as not to miss the same residents on a daily basis during a staffing shortage
- Ask CNAs to do ROM treatments during self-care and/or ambulate residents to the bathroom or activities

Time Management

- Schedule your day so you are not waiting for residents
  - See ROM and splinting/contracture management residents first, since they do not need to be out of bed
  - See ADL residents in the AM during normal dressing/grooming time
  - Rotate ambulation of residents around their shower day or mealtimes
  - Ambulate residents to and from activity programs or meals
- Gather your materials together to prevent needless walking back and forth to get supplies
- Carry a small pad of paper to jot down notes on resident performance during treatment. It is easier than remembering later in the day.
- If you have several residents in the same room, only make one trip to the room and complete all the residents in one period
- Group similar residents together to promote socialization

Documentation

- Don't save it all until the end of the day. Charting for extended periods of time is fatiguing. Alternate treatment with charting, or document while resident is resting between exercises/activities. Documenting during or as soon after the treatment as possible will promote faster, more accurate charting since the information is fresh in your mind.
- Do not complete all weekly summaries on one day
  - Calculate the total number of weekly summaries you will be writing per week
  - Divide by the number of days worked
  - Write that number of weeklies each day

Nursing Documentation to Support Rehab Services

Documentation to support medical necessity and the delivery of skilled care is critical. Both nursing and therapy must support the services provided to the resident in their documentation to ensure appropriate delivery of care and appropriate reimbursement for these services. A chart with missing or inconsistent documentation from nursing and therapy is a denial waiting to happen. Unfortunately, just telling therapy there is an issue with a resident doesn't cut the mustard if the claim is reviewed. It must be written down.

CMS delineates many guidelines and requirements for documentation. Understanding these regulations and being able to document accurately across disciplines is key to ensuring decreased risk during medical review.

Nursing documentation to support therapy services is essential to justify services and ensure Medicare and third-party payment.

- Supportive daily nursing documentation must reflect a coordination of efforts between nursing and rehab
- The vocabulary utilized prior to a resident's referral to therapy and during therapy treatment can impact a billing claim if reviewed
- Nursing documentation can support what effect or impact therapy is having on the resident and may make a difference in whether the therapy claim is covered or not
- Good nursing documentation is necessary for reimbursement and minimizes loss risk for a facility
- Good nursing documentation should avoid subjective terms that may conflict with rehab documentation
- When in doubt, check the therapy progress notes or ask the therapist prior to writing a note for the day
- Supportive nursing documentation is essential for anyone
    - Skilled by Medicare
    - Treated in therapy
    - Referred to therapy for a decline in function
    - Receiving Part B therapy service

To support the need for rehabilitation services, the nurse must document functional deficits observed while the resident is under nursing care. The inability to perform one or more of the following activities would constitute a functional deficit and should be brought to the attention of the rehabilitation team. The following questions should be asked:

Grooming

- Does the resident express desire to participate but cannot?
- Does it take more effort from nursing staff than in recent past to assist resident during grooming activities?
- Are assistive devices being used?
- Are gestures, verbal or visual cues needed?
- Can the resident:
    - Obtain or use supplies to shave?
    - Apply and/or remove cosmetics?
    - Wash, comb, style or brush hair?
    - Complete nail care? Skin care?
    - Apply deodorant?

Dressing

- Does the resident express desire to participate but cannot?
- Does it take more effort from nursing staff than in recent past to assist resident during dressing activities?
- Are assistive devices being used?
- Are gestures, verbal or visual cues needed?
- Can the resident:
  - Select appropriate clothing?
  - Obtain clothing from storage area?
  - Dress and undress in a sequential fashion?
  - Fasten and adjust clothing and shoes?
  - Don and doff assistive or adaptive equipment, prosthesis or orthoses?

Oral Hygiene

- Is the resident performing these activities in bed when they were previously performed at the sink?
- Are noticeable odors present even though resident performs hygiene?
- Are cues or gestures needed to complete the task?
- Can the resident:
  - Obtain or use supplies?
  - Clean mouth and teeth?
  - Remove, clean and reinsert dentures?

Bathing

- Does it take more nursing staff to perform bath than in recent past?
- Does the resident take longer yet still is not cleaning self adequately?
- Does resident exhibit frustration with this task more than usual?
- Are assistive devices being used?
- Are gestures or cues needed to perform the task?
- Are there safety concerns?
- Can the resident:
  - Obtain and use supplies?
  - Soap, rinse and dry all body parts?
  - Maintain bathing position?
  - Transfer to and from bathing position?

Toilet Hygiene

- Does the resident require extra assistance due to loss of balance or impaired ability to sequence steps necessary to complete task?
- Is the resident as clean as he/she used to be upon completing task independently?
- Is good judgment used or is the resident unsafe?
- Can the resident:
  - Obtain and use supplies?
  - Clean self?
  - Maintain toileting position?
  - Transfer to and from bedpan, toilet and/or commode?

Feeding and Eating

- Are cues or gestures needed?
- How much food gets into the mouth?
- Does the resident cough during or after meals?
- Is the vocal quality wet and gurgly?
- Can the resident sit up straight to eat?
- Is an altered diet consumed?
- Is any food left in the mouth after swallowing (pocketing)?
- Can the resident:
    - Set up food?
    - Use appropriate utensils and tableware?
    - Bring food or drink to mouth?
    - Suck, masticate (chew) and swallow?

Functional Communication

- Can a listener understand the resident's words? Gestures?
- Is there a change from normal communication patterns?
- Are any devices or equipment (e.g., writing equipment, hearing aid, telephone, communication board, call light, emergency systems, augmentative communication system, computer) used to successfully communicate with others?
- Can the resident make wants and needs known?
- Can the resident follow directions?
- Is the resident oriented?

Bed Mobility/Transfers

- How much assistance is needed to sit up in bed? Roll? Scoot?
- How many people does it take to transfer the resident from bed to the wheelchair?
- Is the amount of assistance needed more or less than usual?
- Does the resident lose his/her balance?
- Are there safety concerns?
- Any assistive devices used?

Functional Mobility

- How many people does it take to walk with the resident to the bathroom?
- If you left the resident's side, would he/she fall?
- Any assistive devices needed?
- How far can the resident walk? Is this distance more or less than usual?
- Is the amount of assistance needed for mobility more or less than usual?
- Are there safety concerns?

Positioning

- Is the resident less comfortable than before?
- Is the resident leaning? Sliding? Falling?
- Safety concerns?

Range of Motion

- Are the joints tighter than usual?
- Is the range of motion less than normal?
- Do the resident's splints fit?

Socialization

- Can the resident interact in appropriate contextual and cultural ways?

Communication between nursing and therapy, both verbal and written through appropriate documentation in the medical record, is an essential part of identifying appropriate candidates for therapy. This can be done via a communication form, rounds or mini clinics, for example.

Nursing documentation must reflect a pattern of a change in function. For example, if the resident normally requires minimum assist to complete grooming, a referral would be made to therapy not after one incident of more assist but after a pattern has been established (perhaps a few days or a week). If the issue is of serious consequence (e.g., a fall or choking) an immediate referral to therapy should be made.

Notice some referral areas overlap between therapy types (e.g., OT and PT both might address transfer issues). Though the treatments appear to be the same, the goals or functional outcomes will be different. It is important the specific deficits are documented in the nursing documentation so therapists know which discipline should get involved. A referral form like the one on the next page might be used to communicate with therapy.

NURSING TO THERAPY COMMUNICATION FORM

Resident: **Room #:**

Physician: **Date:**

NURSING REQUEST

Physical Therapy	Occupational Therapy	Speech Therapy
Decreased coordination	Cannot lift utensils	Cannot or will not chew
Decreased functional act tol	Unable to open containers/pour	Food falls out of mouth
Decreased lower body ROM	Unable to cut food	Food and/or liquid coming out nose
Decreased lower body strength	Difficulty feeding self	Pockets food in cheeks
Falls or slips forward/side	Visual problems	Poor lip closure/drooling
Frequent falls	Does not look left/right	Wet, gurgly voice
Gait, shuffled	Decreased upper body strength	Coughing during/after meals
Gait, unsteady	Limited upper body ROM	Vomiting during or after meals
Balance loss walking	Poor trunk/neck control	Heartburn
Balance loss sitting/standing	Hand/wrist splint with redness	History of hiatal hernia
Shortness of breath	Upper body contractures	Increased mucous or phlegm
Lower body contractures	Difficulty grooming/hygiene	Recurrent pneumonia
Needs assistance with transfers	Difficulty dressing	Non-oral feedings
Needs assistance with walking	Difficulty bathing	Recurrent temperature spikes
Pain in lower extremities	Unable to get in/out of bed	Significant weight loss
Poor neck/trunk control	Unable to get in/out of w/c	Dehydration
Poor safety awareness	Unable to get on/off toilet	Difficulty speaking
Poor sitting balance	Disoriented	Unable to indicate wants/needs
Restraints	Poor problem-solving skills	Frequently asks speaker to repeat
Shakes or has tremors	Poor safety awareness/judgment	
Skin breakdown	Unable to follow directions	
Swelling	Decreased attention	
Unable to get in/out of bed	Decreased memory	
Unable to get in/out of w/c	Difficulty propelling w/c	
Leg splint causing redness	Unable to sit upright in w/c	
	Has shortness of breath	
	Decreased functional act tol	

Date(s) of Nursing documentation showing a decline or improvement in function _____

Nursing Signature: **Date:**

THERAPIST RECOMMENDATIONS					
	Therapy Screen completed				
	Reason Therapy screen not completed:				
	PT Orders requested		**OT Orders requested**		**ST Orders requested**
	Nursing to request Therapy Orders				
THERAPY PROGRAM INDICATED					
	Rehab Dining		ADL		Communication
	Balance/Falls Management		Dementia Management		Wound Management
	Restraint Reduction		Cognitive Training		Low Vision
	Positioning/Contracture Mgmt.		Gait/Transfer Training		Continence Improvement
	Activities Programming		Dysphagia		Pain Management
Therapy Signature:				**Date:**	

Nursing services are skilled if the complexity is such that it can only safely be performed by a nurse. This guidance is taken from CMS. It is very important nursing documentation support the deficits or issues experienced by the resident can only be addressed by a nurse. Nursing notes should be comprehensive and detailed, not incomplete or vague. Some examples of non-skilled nursing services include: routine administration of oral meds, eye drops and ointments; general maintenance care of a colostomy or ileostomy; routine care/function of an indwelling catheter; dressing changes for uninfected postoperative or chronic conditions; routine care of the incontinent resident; assistance in dressing, eating and toileting; periodic turning and positioning in bed; prophylactic/palliative skin care and/or including treatment of minor skin problems.

It is essential all nurses know why a resident is skilled and documentation should include detailed descriptions of pertinent assessments or interventions. "Check off" flow sheets are not sufficient. Documentation should include communication from different areas of the team (MD, nursing and therapy) to support the team approach to care and coordination of services.

For residents receiving therapy services under Part B, nursing documentation must support the change in status that triggered the therapy evaluation and treatment. There must be good communication between therapy and nursing to accurately and efficiently identify residents who would benefit from therapy, but this communication is not enough. The documentation must support the change in status. Additionally, the functional gains made in therapy must be carried over by nursing and documented in the medical record and on the resident's MDS. OBRA mandates that residents should not decline in function simply because they reside in a SNF. As a team, we have to do everything we can to maximize their independence and prevent further decline.

If a resident is receiving skilled therapy, nursing documentation should mirror therapy documentation with regard to functional status and should support the need for therapy intervention. The following list details factors that might skill a resident for Medicare and what should be included in nursing documentation to support skill:

1. CATEGORY: EXTENSIVE SERVICES

O0100E2	Tracheostomy care while a resident
O0100F2	Ventilator or respirator while a resident
O0100M2	Isolation or quarantine for active infectious disease while a resident

<u>Tracheostomy:</u>

- V/S q _____ - note any change from previous
- Condition of trach site
    - Signs of infection
    - Fistulas
    - Signs of necrosis
    - Tissue surrounding stoma
    - Secretions (color, odor, amt, etc.)
- Specific care provided
- Supplies used during care
- Frequency of suctioning
- Effectiveness of suctioning (response or tolerance)
- Description of sputum/mucus suctioned
- Oxygen Therapy
    - Flow rate
    - Continuous
    - How delivered – nasal cannula, trach adaptor mask, etc.
    - Pulse oximetry

- Aspiration precautions
- Nutritional status – if below IBW, what interventions are in place
- Speaking valve?
- Weaning from the tracheotomy
    - Resident/Family teaching
    - O_2 SATs as ordered
    - Plugging the trachea
    - Resident response
- Document in Interdisciplinary Care Plan
- Resident's response to intervention
- Document observation for potential risks; chosen interventions and rationale to support

Vent Care/Suctioning:

- V/S q _____
- Description of lung sounds, respirations (eliminate or pharyngeal rales)
- Type of suctioning – oral suctioning, nasopharyngeal suctioning, tracheotomy suctioning, nasotracheal suctioning
- Type of suction instrument used
- Amount suctioned
- Frequency of suctioning
- Description of suctioned matter --- color, odor, consistency, etc.
- Resident's response to suctioning
- Description of lung sounds and respirations following suctioning
- Pulse Oximetry
- Resident response to intervention
- Document in Interdisciplinary Care Plan
- Document observation for potential risks; chosen interventions and rationale to support

Active Infection/Isolation:

- V/S q _____
- Presence or absence of fever
- Isolation precautions including type (e.g., airborne, contact, droplet)
- Lab values and relative care planning
- Description of lung sounds, respirations
- Fluid and food intake – I & O
- Positioning
- Administration of O2, IV fluids, antibiotics as ordered
- Respiratory status – rate, depth, effort, pattern
- Productive cough (color, amt, etc.)
- Energy level
- Medication side effects
- Resident response to interventions/treatment
- Document in Interdisciplinary Care Plan
- Document observation for potential risks; chosen interventions and rationale to support

2. CATEGORY: SPECIAL CARE HIGH

B0100, Section GG items	Comatose and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all equal 01, 09, or 88)
I2100	Septicemia
I2900, N0350A, B	Diabetes with both of the following: • Insulin injections (N0350A) for all 7 days • Insulin order changes on 2 or more days (N0350B)
I5100, Nursing Function Score	Quadriplegia with Nursing Function Score <= 11
I6200, J1100C	Chronic obstructive pulmonary disease and shortness of breath when lying flat
J1550A, others	Fever and one of the following: I2000 Pneumonia J1550B Vomiting K0300 Weight loss (1 or 2) K0510B1 or K0510B2 Feeding tube*
K0510A1 or K0510A2	Parenteral/IV feedings
O0400D2	Respiratory therapy for all 7 days

*Tube feeding classification requirements:
(1) K0710A3 is 51% or more of total calories OR
(2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.

Documentation for Depression

D0200A or D0500A	Little interest or pleasure in doing things
D0200B or D0500B	Feeling down, depressed, or hopeless
D0200C or D0500C	Trouble falling or staying asleep, sleeping too much
D0200D or D0500D	Feeling tired or having little energy
D0200E or D0500E	Poor appetite or overeating
D0200F or D0500F	Feeling bad about yourself - or that you are a failure or have let yourself down or your family down
D0200G or D0500G	Trouble concentrating on things, such as reading the newspaper or watching television
D0200H or D0500H	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
D0200I or D0500I	Thoughts that you would be better off dead, or of hurting yourself in some way
D0500J	Being short-tempered, easily annoyed

Comatose:

- Skin Assessment
    - Complete vital signs
    - Findings -- location, size, color, drainage
    - Mobility status/Activity level
    - Body weight and alterations
    - Continence
    - Nutritional and hydration intake status
    - Preventative measures
    - Mental status
    - Inflammation/Edema
    - Impairment of circulation, neurological, musculoskeletal, immune system, etc.
    - Any treatment of medical/nursing measures taken such as medications or external conditions
    - Physician notification/family or POA notification
    - Other
- Neurological Assessment
    - Complete vital signs including pupillary responses
    - Pain (type, location, pain score – interventions for pain and response)
    - LOC
    - Seizures
    - Movement and strength of extremities
    - Sleep patterns
    - Vomiting
    - Parenthesis or paralysis
    - Speech patterns
    - All physician, family, other notification
    - Any treatment or medical/nursing measures taken
- Nursing rehabilitation/Restorative services
- Activities of daily living provided
- Resident response to intervention
- Documents in Interdisciplinary Care Plan
- Document observation for potential risks; chosen interventions and rationale to support

Septicemia:

- V/S q _____
- Presence or absence of fever
- Isolation precautions (e.g., type, specifications)
- Lab values and relative care planning
- Description of lung sounds, respirations
- Fluid and food intake – I & O
- Administration of O2, IV fluids, antibiotics as ordered
- Energy level
- Medication side effects
- Resident response to interventions/treatment
- Document in Interdisciplinary Care Plan
- Document observation for potential risks; chosen interventions and rationale to support

Diabetes:

- V/S q _____
- Assess for hyperglycemia/hypoglycemia and associated signs/symptoms
- Monitor blood glucose as ordered
- Assess body systems for complications related to condition
- Dietary modification
- Purpose, dosage, route of insulin
- Order changes and rationale
- Side effects of hypoglycemic agents
- Skin/foot care
- Resident response to interventions/treatment
- Diabetic teaching
- Document in Interdisciplinary Care Plan
- Document observation for potential risks; chosen interventions and rationale to support

Quadriplegia & ADL Sum <=11:

- V/S q _____
- Current diagnosis of one of the above in medical record/routine physician orders
- Current treatment for above condition
- Resident response to treatment for above condition
- Amount of assistance required for bed mobility, transferring, toileting and eating
- Document in Interdisciplinary Care Plan
- Document observation for potential risks; chosen interventions and rationale to support

Chronic Obstructive Pulmonary Disease:

- V/S q _____include lung sounds, pulse ox
- O2 use? Type?
- Positioning techniques to manage symptoms
- Pursed lip breathing to decrease air trapping
- Respiratory status – rate, depth, effort, pattern
- Dyspnea symptom management
- Energy conservation/work simplification
- Caloric intake
- Instruction in metered-dose inhaler
- Side effects of medications
- Resident response to interventions/treatment
- Document in Interdisciplinary Care Plan
- Use of O2 and pulse oximetry measurement
- Monitoring of labs
- Monitoring level of anxiety or presence of depression/coping mechanisms
- Document observation for potential risks; chosen interventions and rationale to support

Fever with Pneumonia:

- V/S q _____including pulse ox
- Presence or absence of fever
- Lung sounds – presence of rales, ronchi, wheezes
- Tracheobronchial secretions? Description?
- Sternal/Intercoastal muscles used in breathing?
- Chest expansion symmetrical?
- Ability to cough and deep breath
- Cough present? Productive? Description?
- Meds/Other interventions
- Cyanosis or Pallor noted?
- Nutritional status – if below IBW range – what interventions are in place?
- Hydration status – what interventions in place if needed?
- Endurance level – note difference from previous abilities
- O2 usage – flow rate, continuous/PRN, delivery via cannula, mask, etc., resident response to treatment
- Documentation in Interdisciplinary Care Plan
- Resident response to interventions
- Monitoring of labs/chest x-ray/urinary output
- Document observation for potential risks; chosen interventions and rationale to support

Fever with Vomiting:

- V/S q _____
- Presence or absence of fever
- Amount of emesis
- Color, odor, consistency of emesis
- Interventions
- Resident response to interventions
- Nutritional status and interventions if indicated
- Hydration status and interventions if indicted
- Documented in Interdisciplinary Care Plan
- Resident response to interventions
- Medications administered and effectiveness
- Monitoring of labs/urinary output
- Document observation for potential risks; chosen interventions and rationale to support

Fever with Weight Loss:

- V/S q _____
- Presence or absence of fever
- Amount of weight loss in what amount of time
- Daily weight
- Nutritional status and interventions if indicated and response to interventions
- Hydration status and interventions if indicated and response to interventions
- Notification of physician and responsible party of weight loss
- Documentation in Interdisciplinary Care Plan
- Resident response to interventions
- Monitoring of labs/urinary output
- Record bowel movements & characteristics
- Document observation for potential risks; chosen interventions and rationale to support

Fever with Tube Feeding:

- V/S q _____
- Presence or absence of fever
- Type of feeding tube
- Tube sutured in place – if so, condition of sutures and surrounding tissue
- Frequent assurance of correct placement of tube
- Head of bed elevated at all times when formula running in (and post-feed)
- Feeding formula used
- Amount and frequency of feedings
- Feeding administered via pump or gravity
- Response to tube feeding
- Complaints or signs and symptoms of nausea or vomiting
- Hydration status and interventions, response to interventions
- Nutritional status and response to tube feeding
- Weekly weight
- Any food taken po – percentage of daily intake – response to po intake
- Document in Interdisciplinary Care Plan
- Resident response to intervention
- Monitor labs/urinary output/bowel movements
- Document observation for potential risks; chosen interventions and rationale to support

Parenteral/IV Therapy:

- V/S q _____ - note change in temperature and/or blood pressure
- IV solution and rate
- Solution administered via pump or gravity?
- Intake and output accurately maintained
- IV site – condition of skin at insertion site, condition of surrounding tissue, at risk for infiltration? If so, what interventions are in place to prevent?
- IV site inspected … how often? (e.g., q shift, pre-, post-infusion)
- Reaction to IV therapy
- History of reaction
- Complications to IV and any interventions taken and response to these interventions
- Any complaints of pain
- Physician/other intervention
- Monitor pertinent labs
- Resident response to intervention
- Document in Interdisciplinary Care Plan

Respiratory Therapy in the last 7 Days:

- V/S q _____include pulse ox
- Documentation of receiving daily Respiratory Therapy
- Specific treatment provided and response to treatment
- Dyspnea/respiratory distress
- Pain (type, location, pain score – interventions for pain and response)
- Bilateral breath sounds
- Color of skin, nail beds, mucosa
- Tracheobronchial secretions – color, amount, consistency
- Use of accessory muscles for breathing
- Abnormal breath pattern – apnea, tachypnea, Cheyne-Stokes, shallow breathing pattern
- Document in Interdisciplinary Care Plan
- Resident response to interventions
- Document observation for potential risks; chosen interventions and rationale to support

3. CATEGORY: SPECIAL CARE LOW

I4400	Nursing Function Score Cerebral palsy, with Nursing Function Score <=11
I5200	Nursing Function Score Multiple sclerosis, with Nursing Function Score <=11
I5300	Nursing Function Score Parkinson's disease, with Nursing Function Score <=11
I6300, O0100C2	Respiratory failure and oxygen therapy while a resident
K0510B1 or K0510B2	Feeding tube*
M0300B1	Two or more stage 2 pressure ulcers with two or more selected skin treatments**
M0300C1, D1, F1	Any stage 3 or 4 pressure ulcer with two or more selected skin treatments**
M1030	Two or more venous/arterial ulcers with two or more selected skin treatments**
M0300B1, M1030	1 stage 2 pressure ulcer and 1 venous/arterial ulcer with 2 or more selected skin treatments**
M1040A, B, C; M1200I	Foot infection, diabetic foot ulcer or other open lesion of foot with application of dressings to the feet
O0100B2	Radiation treatment while a resident
O0100J2	Dialysis treatment while a resident

*Tube feeding classification requirements:
(1) K0710A3 is 51% or more of total calories OR
(2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.

**Selected skin treatments:
M1200A, B Pressure relieving chair and/or bed
M1200C Turning/repositioning
M1200D Nutrition or hydration intervention
M1200E Pressure ulcer care
M1200G Application of dressings (not to feet)
M1200H Application of ointments (not to feet)
#Count as one treatment even if both provided

Multiple Sclerosis, Cerebral Palsy, Parkinson's Disease <=11:

- V/S q _____
- Current diagnosis of one of the above in medical record/routine physician orders
- Current treatment for above condition
- Resident response to treatment for above condition
- Amount of assistance required for bed mobility, transferring, toileting and eating
- Document in Interdisciplinary Care Plan
- Document observation for potential risks; chosen interventions and rationale to support

Respiratory Failure:

- V/S q _____
- Signs of distress (nasal flaring, sternal retraction)
- Symmetry of chest wall movement
- Lower extremity edema
- Nail bed cyanosis/clubbing indicating chronic hypoxia
- O2 saturation
- O2 use, type equipment, etc.
- Respiratory status – rate, depth, effort, pattern
- Cough (productive, non-productive, sputum with description)
- Dyspnea symptom management
- Energy level, sleep patterns
- Medication review including side effects
- Lung sounds
- Resident response to interventions/treatment
- Document in Interdisciplinary Care Plan
- Document observation for potential risks; chosen interventions and rationale to support

Tube Feeding:

- V/S q _____
- Type of feeding tube
- Tube sutured in place – if so, condition of sutures and surrounding tissue
- Head of bed elevated at all times when formula running in
- Feeding formula used
- Amount and frequency of feedings
- Feeding administered via pump or gravity
- Hydration status and interventions, response to interventions
- Nutritional status and response to tube feeding
- Weekly weight
- Any food taken po – percentage of daily intake – response to po intake
- Assessment bowel sounds
- Palpation: rigidity, distention, tenderness
- Route, formula, caloric intake
- Assess tube placement including skin for risk of infection at tube site
- Aspiration assessment
- I & O
- Monitor for gastric distention, nausea, bloating, vomiting
- Monitor pertinent labs
- Resident response to interventions/treatment
- Document in Interdisciplinary Care Plan
- Document observation for potential risks; chosen interventions and rationale to support

Pressure Ulcers with Treatment:

- V/S q _____
- Location, size, color, type, stage (if stageable)
- Drainage from wound – amount, color, odor
- Inflammation or edema of surrounding tissue
- Impairment of circulatory, neurological, musculoskeletal or immune systems
- Assistance required by staff with bed mobility, transferring, toileting and eating
- Nutritional status, interventions and response to interventions
- Weekly weight
- Hydration status, interventions and response to interventions
- Continence
- Mental status
- Medical and nursing treatment being provided
- Preventative measures in place
- Document in Interdisciplinary Care Plan
- Resident response to interventions
- Document if wounds were present on admission
- Baseline & periodic Braden Scale or similar Pressure Ulcer Risk Assessment
- Document observation for potential risks; chosen interventions and rationale to support

Radiation:

- V/S before and after each treatment
- Type of treatment
- Frequency of treatment
- Adverse reactions to therapy
- Where is resident in course of treatment
- Any complaints of nausea or vomiting
- Edema – location, severity
- Complains of pain – location, type, severity
- Skin integrity, nutritional and hydration status, interventions and response
- Document in Interdisciplinary Care Plan
- Resident response to interventions
- Document observation for potential risks; chosen interventions and rationale to support

Dialysis:

- V/S q _____
- Type of dialysis
- Type of access (shunt, AV, fistula) – assessment
- Skin care
- Lab values and relative care plan
- I & O
- Turning and positioning
- ROM to prevent skin breakdown
- Care of dialysis shunt
- Monitor pertinent labs
- Resident response to interventions/treatment
- Document in Interdisciplinary Care Plan
- Document observation for potential risks; chosen interventions and rationale to support

4. CATEGORY: CLINICALLY COMPLEX

I2000	Pneumonia
I4900, Nursing Function Score	Hemiplegia/hemiparesis with Nursing Function Score <= 11
M1040D, E	Open lesions (other than ulcers, rashes, and cuts) with any selected skin treatment* or surgical wounds
M1040F	Burns
O0100A2	Chemotherapy while a resident
O0100C2	Oxygen Therapy while a resident
O0100H2	IV Medications while a resident
O0100I2	Transfusions while a resident

*Selected Skin Treatments: M1200F Surgical wound care, M1200G Application of nonsurgical dressing (other than to feet), M1200H Application of ointments/medications (other than to feet)

Pneumonia:

- V/S q _____
- Presence or absence of fever
- Lung sounds – presence of rales, ronchi, wheezes
- O2 saturation
- Tracheobronchial secretions?
- Sternal/Intercoastal muscles used in breathing?
- Chest expansion symmetrical?
- Ability to cough and deep breath
- Cyanosis or Pallor noted?
- Respiratory status – rate, depth, effort, pattern
- Cough (productive, non-productive, sputum with description)
- Dyspnea symptom management
- O2 usage – flow rate, continuous/PRN, delivery via cannula, mask, etc., resident response to treatment
- Antibiotics
- Isolation precautions
- Early mobility and level of assist
- Respiratory/pulmonary hygiene
- Nutritional status – if below IBW range – what interventions are in place?
- Hydration status – what interventions in place if needed?
- Endurance level – note difference from previous abilities
- Drug reactions and management
- Resident response to interventions/treatment
- Document in Interdisciplinary Care Plan
- Document observation for potential risks; chosen interventions and rationale to support

Hemiplegia:

- V/S q _____
- Airway support, breathing, circulation
- Neurologic assessment
- Treatment for hyperthermia
- Treatment for hyperglycemia
- Blood pressure management
- Dysphagia/aspiration management
- DVT/antithrombotic treatment
- Management of edema
- Skin assessment
- Positioning of the hemi-body
- Stroke education
- Nutrition/hydration
- Resident response to interventions/treatment
- Document in Interdisciplinary Care Plan
- Document observation for potential risks; chosen interventions and rationale to support

Surgical Wounds or Open Lesions with Treatment:

- V/S q _____
- Presence or absence of fever
- Location, size, color, type, stage (if stageable)
- Drainage from wound – amount, color, odor
- Inflammation or edema of surrounding tissue
- Impairment of circulatory, neurological, musculoskeletal or immune systems
- Assistance required by staff with bed mobility, transferring, toileting and eating
- Nutritional status, interventions and response to interventions
- Weekly weight
- Hydration status, interventions and response to interventions
- Continence
- Mental status
- Medical and nursing treatment being provided
- Response to any above treatments
- Preventative measures in place
- Document in Interdisciplinary Care Plan
- Resident response to interventions

Burns:

- Skin Assessment
    - Complete vital signs
    - Location, size, color
    - Mobility status/Activity level
    - Body weight and alterations
    - Continence
    - Drainage (type, color, amount, etc.)
    - Nutritional and hydration intake status
    - Preventative measures
    - Mental status
    - Inflammation/Edema
    - Impairment of circulation, neurological, musculoskeletal, immune system, etc.
    - Any treatment of medical/nursing measures taken such as medications or external conditions
    - Physician notification
- Presence or absence of fever
- Hydration status, how hydrated, interventions and response to interventions
- Pain (type, location, pain score – interventions for pain and response)
- Nursing rehabilitation/Restorative services
- Activities of daily living provided
- Resident response to intervention
- Document in Interdisciplinary Care Plan
- Document observation for potential risks; chosen interventions and rationale to support

Chemotherapy:

- V/S before and after each treatment
- Type of treatment
- Frequency of treatment
- Adverse reactions to therapy
- Where is resident in course of treatment
- Any complaints of nausea or vomiting
- Edema – location, severity
- Complains of pain – location, type, severity/ treatment and response
- Skin integrity, nutritional and hydration status, interventions and response
- Document in Interdisciplinary Care Plan
- Resident response to interventions

Oxygen Therapy:

- Respiratory assessment
    - Complete vital signs including pulse ox
    - SOB/respiratory distress
    - Pain (location and type
    - Bilateral breath sounds
    - Color of skin
    - Use of accessory muscles for breathing
    - Oxygen supplies, liters of oxygen required
    - All physician, family, other notifications
- Hydration status, how hydrated, interventions and response to interventions

IV Medications:

- V/S q _____
- Evaluate for effectiveness of new medications
- Drug, dose, route, rate, time given
- I & O
- Drug reactions
- DC time, reason (if applicable)
- IV site – condition of skin at insertion site, condition of surrounding tissue, at risk for infiltration? If so, what interventions are in place to prevent?
- IV site inspected … how often? (e.g., q shift, pre-, post-infusion)
- Reaction to IV therapy
- History of reaction
- Complications to IV and any interventions taken and response to these interventions
- Any complaints of pain
- Physician/other intervention
- Monitor pertinent labs
- Resident response to interventions/treatment
- Document in Interdisciplinary Care Plan

Transfusions:

- VS per infusion policy
- Assess for the following signs and symptoms:
    - Chills and fever
    - Hematuria and oliguria
    - Jaundice
    - Headache
    - Backache
    - Dyspnea
    - Cyanosis
    - Chest Pain
    - Malaise
    - Bloody vomitus
    - Diarrhea
    - Mild edema
    - Hives
    - Bronchial wheezing
    - Anaphylaxis
    - Cough
    - Tachycardia
    - Frothy pink sputum
- Nursing rehabilitation/Restorative services
- Activities of daily living provided
- Document resident condition pre/post transfusion
- Document observation for potential risks; chosen interventions and rationale to support
- Resident response to intervention
- Document in Interdisciplinary Care Plan

5. CATEGORY: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

E0100A	Hallucinations
E0100B	Delusions
E0200A	Physical behavioral symptoms directed toward others (2 or 3)
E0200B	Verbal behavioral symptoms directed toward others (2 or 3)
E0200C	Other behavioral symptoms not directed toward others (2 or 3)
E0800	Rejection of care (2 or 3)
E0900	Wandering (2 or 3)

Behavior:

- Psychological assessment
    - Vital signs if abnormal
    - Affect/Interactions with others
    - Behavioral Changes – use quoted and describe actual behavior exhibited
    - Hallucinations/Delusions – describe actual behavior exhibited
    - Need to restrain for safety
    - All physician, family, mental health, other notifications
    - Any treatment or medical/nursing measure that is taken such as behavioral management, medication, etc.
    - Psychotropic medications used are monitored for effect and tolerance
- Nursing rehabilitation/Restorative services required
- Activities of daily living provided
- Resident response to intervention
- Documentation in Interdisciplinary Care Plan
- Document risk for wandering/elopement
- Document observation for potential risks; chosen interventions and rationale to support

Short-term memory/Daily decision making/Making self-understood:

- Neurological assessment
    - Complete vital signs
    - Pain (type, location)
    - LOC, seizures
    - Movement and strength of extremities
    - Sleep patterns
    - Pupillary responses
    - Vomiting
    - Parenthesis or paralysis
    - Speech patterns
    - All physician, family, other notification
    - Any treatment or medical/nursing measures taken
- Ability to perform activities of daily living effectively
- Hydration status, how hydrated, other interventions, response to interventions
- Skin integrity, preventive measures in place
- Nursing rehabilitation/Restorative services
- Resident response to intervention
- Document in Interdisciplinary Care Plan

6. CATEGORY: REDUCED PHYSICAL FUNCTION

Determine Restorative Nursing Count

H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A, B**	Passive and/or active range of motion
O0500C	Splint or brace assistance
O0500D, F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training

**Count as one service even if both provided

Reduced Physical Function:

- Nursing rehabilitation/Restorative services required – functional status of resident
- Activities of daily living provided
- Skin assessment
- Hydration assessment
- Resident's response to interventions
- Document in Interdisciplinary Care Plan

Nursing Rehabilitation/Restorative Services:

- V/S q_____
- Documentation in Nurses Notes resident receives Restorative Services; what these services are
- Documentation by the CNA via the ADL Flow Sheet that corresponds to the appropriate Rehabilitation/Restorative services delivered
- Nursing Restorative Services should be documented in Interdisciplinary Care Plan with specific service(s) provided, goal(s) for resident and approach(es) to attain goal(s)
- Nursing documentation to specific functional status on a daily basis
- Resident response to interventions
- Document observation for potential risks; chosen interventions and rationale to support
- Document in the Interdisciplinary Care Plan

Documentation to Support Section GG:

- Amount of nursing staff assistance required with bed mobility, transfers, toileting, eating, mobility, etc.
- Any change in function from baseline
- Specific activities of daily living provided
- Assistive devices and/or adaptive equipment utilized
- Resident safety during task
- Ability to follow sequence/instructions (i.e., cognition)
- Resident's response to interventions
- Daily documentation to demonstrate coordination of services between nursing and therapies

The form on the following page may help to streamline nursing documentation to support skill.

Nursing Note Guideline for Skilled Services

Resident:	**Room #**

Directions: Include the following in your narrative documentation (underlined phrases should be used in the narrative). Your documentation must indicate why the resident requires your skilled services.

Resident requires skilled nursing assessment and evaluation of:

Diagnoses: _____

Treatments:

_____

_____

Resident requires skilled therapy services related to:

Discipline/why: _____

_____

Resident requires skilled observation and monitoring for:

(Write the individualized needs of the resident in the appropriate box(es).

□ VS for irregularities	□ Evaluation of resident's overall condition	□ S/S infection
□ Pain	□ Oxygen use/record O_2 sat on/off	□ Antibiotic therapy/other Medication
□ Respiratory status	□ Circulatory status	□ Neurological status
□ Level of consciousness	□ Fluid status/edema	□ Nutrition status/ feeding tube
□ Skin condition/actual and potential risk	□ Initiate treatment	□ D/C treatment
□ Motivation/ability to participate	□ Mood	□ Behaviors
□ Tolerance to PT	□ Tolerance to OT	□ Tolerance to ST

To support the need for rehabilitation services, the nurse must document functional deficits observed while the resident is under nursing care. Daily documentation must show skill, change in resident's functional level, support therapy involvement in resident's care and show carryover of gains made through FMP or RNP.

Nursing MUST document change in status to support therapy involvement—both for therapy to get involved initially and to justify the positive effect of their involvement. Nurses and nursing staff care for the residents almost all of the time. It is YOU who are best able to see if the resident is not doing as well as usual or if he or she is doing better since being seen by therapy. The following 3 pages contain tools useful for guiding nursing documentation that will support therapy involvement.

Resident Name: _____ Date:_____ Therapist: _____

Nursing Documentation for Occupational Therapy

(Please document for the following checked areas)

Functional Skills: Example:

____Feeding	Amount of assistance required Use of adaptive equipment Cognitive issues that interfere with self-feeding	Feeds 50% of meal with built up spoon. Resident easily distracted by noise in dining room.
____Grooming / Hygiene	Amount of assistance / set-up required	Brushes teeth and combs hair if prompted by staff
____Bathing	Amount of assistance / set-up required	Needs assist with tub and shower. Attempts to wash face and upper body.
____Dressing	Amount of assistance / set-up required	Resident puts on own shirt. Staff assist required for lower body as they are unable to use a reacher well yet.
____Sitting Balance	Amount of assistance Able to maintain for how long?	Sits to eat meals but becomes fatigued by end of meal.
____Transfers (toilet, too)	Amount of assistance Resident's safety awareness	Transfers to raised toilet seat with assist of one nurse aide.
____Mobility, W/C Skills	Amount of assistance required Resident's safety awareness	Resident propels self from bed to hall. Endurance poop, forgets to lock brakes.
____Activity Tolerance	Level of fatigue with activity	Resident complains of fatigue after 1 to 1.5 hours in W/C
____Splinting	Need for splinting secondary to contractures Resident's ability to tolerate splint wear schedule Skin irritation / breakdown from splint wear	Resident complains of pain in thumb web space

Resident Name: _____ Date:_____ Therapist: _____

Nursing Documentation for Physical Therapy

(Please document for the following checked areas)

Functional Skills: Example:

____Bed Mobility	Amount of assistance required	Resident holds onto bed rail to pull self onto side. Pillow is placed between knees to maintain correct alignment of hip.
____Supine to Sit	Amount of assistance required	Resident sits up with assist but is unable to remain up at edge of bed without losing balance.
____Transfers	Amount of assistance required	Transfer to chair with assist of one nurse aid. Needs reminders not to wear weight on left leg.
____Ambulation	Amount of assistance required Resident's safety awareness	Attempts to take several steps when transferring from bed to chair. Poor safety observed.
____Stairs	Amount of assistance required Patient's safety awareness	Resident observed to ascend 2 steps with SBA from family member when returning to facility from community outing. Preparation for d/c to home in place.
____Positioning to W/C	Poor positioning and how it's affecting functional activities Tolerating trial W/C or trial equipment # of min./hrs. able to tolerate up in chair c/o pain/discomfort with equipment	Resident observed to be appropriately seated in W/C during activities.

Resident Name: _____ Date:_____ Therapist: _____

Nursing Documentation for Speech Therapy

(Please document for the following checked areas)

Functional Skills: Example:

____Response to Name/Voice		Smiles and turns head when greeted
____Follows Verbal Directions	What level of complexity? (1 step, 2 steps etc.) Need for repetition clarification	Resident follows simple commands only with visual cues. Resident follows simple commands but cannot express needs.
____Response to yes/no questions	Accuracy of response Timeline of response	Nods yes/no, but not always correct
____Gestures	How effective is general communication	Resident is unable to explain what they want. Attempts to point but is unsuccessful.
____Speech	Clarity of speech Content of speech (i/e/, confused vs. appropriate) Word retrieval ability	Speech is difficult to understand, occasional single words understood.
____Conversation	Content of speech Word retrieval ability Initiation of conversation	Resident is confusing to listen to. Resident is inconsistently able to get a message across.
____Non-oral Communication	Initiation of use of communication board Accuracy of use of communication board Ability to convey needs with communication board	Resident is using communication board to request items. Resident uses it to request items in ADL. Staff uses board to get residents to express needs.
____Dysphasia	S/S of aspiration Pocketing Use of compensatory swallow strategies	Eats 50% of pureed meal with no drooling noted. Coughs with liquids, instructed to tuck chin.

Sample nursing documentation to support skilled interventions

Incorrect Documentation	Correct Documentation
Resident ate in dining room at lunch	Resident consumed 50% of food at lunch in dining room. Noted difficulty with feeding self, (+) tremors.
Dressed and bathed resident at bedside, no c/o	Resident requires limited assist w/upper body dressing & bathing at bedside; requires extensive assist with lower body.
Resident walked into BINGO this afternoon; holds onto railings	Resident ambulated holding onto railing to BINGO; more unsteadiness noted.
Resident falling forward out of w/c, complains of back pain	Noted leaning forward in w/c, unable to maintain upright posture w/o assist. Rated back pain 6/10 sitting.
Resident wearing hand splint today	Wearing hand splint per schedule' skin integrity maintained with no areas of redness; no c/o discomfort.
Resident answers "no" to every question	Inconsistent responses with yes/no questions - answers "no" to every question. Difficulty making needs known.
Amb ad lib	Walks in corridors with RW, able to go to/from activities and dining room with cues only.
A & O x1, combative	Noted to have increased confusion and combativeness; difficulty following commands.
Refused to get up to chair; ate breakfast in bed	Required max encouragement and assist of 2 to transfer to chair for breakfast, expresses fear if falling during transfer. Ate 100% of meal while seated at bedside chair.
Yelling at roommate and nursing staff	Increased loud outbursts noted in social situations, resists attempt to redirect.
AM care completed in bathroom	Amb to BR with RW and limited assist; able to brush teeth & wash face with set -up but requires extensive assist with sponge bath at sink.
Increased agitation this morning, better in PM	Resident agitated in AM, BP 150/95, grimacing. PRN pain med given at 0830. Agitation ↓ at 0910.
Red area on buttock noted; turned onto R side	2x2 cm Stage I decubitus on sacrum; resident repositioned on R side and turning scheduling initiated q 2°

Nursing Documentation
Key Words/Phrases to Avoid

The following list of words/phrases should be avoided in documentation to support therapy intervention as they:

- Do not reflect
  - Progress
  - The need for skilled rehabilitative services
  - The potential for improvement
- Demonstrate a potential conflict in documentation between rehabilitation and nursing services

Words/phrases to avoid:

- Custodial care
- Maintaining
- Intermittent care/service
- Out of facility on pass
- Poor or fair rehab potential
- Inability to follow directions
- Refused to participate in treatment
- Chronic condition
- Not motivated
- Extreme depression
- Little change
- Status quo
- Plateau
- Ambulating “ad lib” when resident is receiving physical therapy

Section
14

Program Quality Assurance Review, Improvement Plan, Annual Review/Position Description, Program Referral Form, Competency Assessments, References

Quality Assurance Review

- Caseload Summary
- Care Plan and Referral
- Physician Orders
- Documentation
- Equipment
- Program Summary

Improvement Plan

Objectives for the Next Period

Rehabilitation and Restorative Nursing Program

Caseload Summary

List the current residents being seen by the designated Restorative Nursing Assistants and mark each of the services each one is receiving. (Some patients may be counted in more than one category):

Patient	Unit	Ambulation	Range of Motion	Bed Mobility	Use of Prosthetics	Transfers	Bowel & Bladder	Communication	ADLs	Eating	Swallowing	Use of Splints	Hygiene	Other_____	Other _____

Rehabilitation and Restorative Nursing Program

Care Plan and Referral

Survey at least 25% of the Restorative residents' charts:

_____ # of charts surveyed
_____ # with MDS forms that accurately reflect current functional problems
_____ # with Care Plans that accurately reflect restorative interventions being provided

Survey at least 5 charts from each Unit (with disregard for whether or not the residents are receiving restorative services). Answer the following questions for each:

A. According to the last MDS that was completed on the patient, have functional changes occurred? (Answer Y=yes, N=no, or N/A not applicable).
B. If a change has occurred, could the functional change possibly have been prevented, and/or could future changes possibly be prevented, or could improvements occur, if a rehabilitation or restorative program was provided? (Answer Y=yes, N=no, or N/A=not applicable).
C. If a rehabilitation or restorative nursing program was appropriate, was one actually provided? (Answer Y=yes, N=no, or N/A = not applicable)

Unit				Unit				Unit				Unit			
Patient	A	B	C	Patient	A	B	C	Patient	A	B	C	Patient	A	B	C

Yes No Does the Restorative Nursing Supervisor routinely participate in Care Plan Meetings?

If the Facility Policy Requires Physician's Orders

Yes No A Policy has been written regarding the Facility's policy requiring physician's orders for the Restorative Nursing Program.

Survey at least 25% of the current Restorative Patients' charts.

_____ # of charts surveyed
_____ # with appropriate physician's orders

Summarize errors found:

_____
_____
_____

Rehabilitation and Restorative Nursing Program

Documentation

Yes No A policy has been written regarding the facility's policy regarding charting by the Restorative Nursing Assistants.

Survey at least 25% of the current Restorative Patient's charts:

_____ # of charts surveyed.
_____ # of charts with a written restorative nursing patient plan
_____ # of charts with adequate documentation that daily services were performed.
_____ # of charts with timely documentation according to facility policy.

Summarize errors found:

_____
_____
_____

Equipment

Yes No Equipment maintenance/cleaning schedules have been established and are posted.

Yes No Maintenance and cleaning logs are routinely documented.

Describe instances in which documentation on the maintenance and cleaning of equipment has not been completed in accordance with facility policy:

_____
_____
_____

Sample Job Description / Performance Evaluation (circle one)
Restorative Nurse Assistant (RNA)

Name: _____ Review Date:_____

Department: _____ Nursing: _____ Annual:_____ 90 day: _____

Hire Date: _____

Position Summary:
Works as a cooperative geriatric nursing care team member in meeting the needs and goals of each resident as written on the nursing care plan. Provides care and services for residents referred to the Restorative Nursing Program. Functions under the direction, instruction and supervision of a qualified professional.

Qualifications:
Minimum of high school diploma or GED. At least one year of successful work experience in the healthcare field. Must have completed formal course of training in basic nursing assisting skills and an advanced program of training in special rehabilitation competencies needed to care for the aging person. Must have a reliable source of transportation. Must have good communication skills in order to work effectively with employees, facility staff, residents and resident families.

Physical Demands:
Has a thorough knowledge of the aging process, the special needs of the aging person and the application of nursing responses to meet those needs. Mobility, reaching, bending, talking, typing, sitting, carrying, standing, grasping, fine hand coordination, ability to hear, ability to read and write and the ability to remain calm under stress. Ability to reach with hands and arms, climb stairs, balance, stoop, kneel, crouch or crawl. Specific vision abilities include close, distance, color, peripheral, depth perception and the ability to adjust focus. Requires moderately heavy physical exertion on a regular and recurring basis such as assisting residents in transfer activities (wheelchair to bed, to tub, to commodes) and providing substantial support to individuals in ambulation therapy. Ability to lift residents using appropriate body mechanics frequently during the course of a workday. Must be capable of communicating information concerning a resident's condition. Must be capable of lifting 50 pounds of dead weight alone. Occasionally lift, push, pull and/or move over 100 pounds. May be required to complete standing presentations involving speaking and listening to audience. May be required to assist with facility disaster plan and evacuation of residents.

Work Environment:
Health care setting – exposure to infectious disease. Noise level is usually moderate.

Reports To:
Nursing/RN Restorative Program Coordinator with consultation from OT, PT or SLP.

Scale:

1 = Did not meet performance expectations
2 = Met minimum performance expectations
3 = Met all performance expectations
4 = Exceeded most performance expectations
5 = Exceeded all performance expectations
N/A= Not Applicable

ESSENTIAL FUNCTIONS	1	2	3	4	5	N/A	COMMENTS
Implements restorative nursing Interventions as prepared, approved and supervised by a qualified professional							
Prepares, maintains and cleans treatment areas and supportive areas							
Transports records, equipment and supplies							
Assists residents in preparation for treatment, dressing and positioning							
Reports observations, changes or other pertinent information related to resident care immediately to appropriate staff							
Participates in staff development activities.							
Participates in in-service education programs							
Adheres to all applicable federal, state, local and company-maintained standards of care and ethics/ policies concerned with the practice of therapy and, among other things, personnel qualifications							
Meets productivity and utilization expectations as established by the facility							
Documents objective information related to resident care on daily flow sheets and weekly summaries							
Provides services that support the care delivered to the resident							
Has regular and prompt attendance							
Able to meet physical demands of the position							
Provides input in the formulation of the Resident Plan of Care							
Participates in quality assessment and improvement process activities							
Conducts self in a professional manner in compliance with facility rules, policies and procedures							
Communicates effectively with team members and residents							
Recognizes the uniqueness of each resident and applies principles of restorative and rehabilitative nursing in caring for each resident							
Other duties as assigned							

Job Description Review and Acknowledgement:
I have read this job description and fully understand the requirements set forth therein, and that I am expected to complete all duties as assigned. I understand the job functions may be altered from time to time. I understand this job description is not all-inclusive and that I will be responsible for performing other duties as assigned.

I have noted below any accommodations that are required to enable me to perform these duties. I have also noted below any job responsibilities or functions, which I am unable to perform, with or without accommodation.

_____
_____
_____

_____
Employee Signature Date

OVERALL PERFORMANCE REVIEW RATING: (check one)

- ❑ Did not meet performance expectations
- ❑ Met minimum performance expectations
- ❑ Met all performance expectations
- ❑ Exceeded most performance expectations
- ❑ Exceeded all performance expectations

GOALS FOR NEXT PERFORMANCE ASSESSMENT PERIOD: (Attached separate sheets as needed)
_____
_____
_____

EMPLOYEE COMMENTS: (Optional – attach separate sheets as needed)
_____
_____
_____

PERFORMANCE REVIEW AND ACKNOWLEDGEMENT:
This performance assessment was discussed with me

_____
Employee Signature Date

_____
Supervisor Signature Date

Rehabilitation and Restorative Nursing Program

Discharge Summary from Restorative Program
To Floor Maintenance Program

Name: _____ Room #_____

Date of Discharge to Nursing: _____

Current Ability:

Program:

ADL _____ ROM _____ B&B _____ Dining _____ Transfers _____ Splints_____

Follow up required: _____ Yes _____ No

Explanation:

Program to follow:

Precautions:

Signature of Restorative Aide: _____

Signature of Restorative Nurse: _____

Signature of Floor Aides: 1 _____ 2 _____
3_____ 4 _____
5 _____ 6 _____

Rehabilitation and Restorative Nursing Program

Restorative Program Follow-up

Name of Resident:_____ Room: _____ Date of Discharge: _____

Restorative Follow-up:

Functional Ability at the time of discharge:

Thirty Day Review

Sixty Day Review

Ninety Day Review

Rehabilitation and Restorative Nursing Program

Restorative Referral

Patient Name:	Physician: Diagnosis:	Room # Referral Date:

History:	Precautions:

Referred for:

	Communication		Bed Mobility
	ADL's		Ambulation
	Transfer Training		Range of Motion
	Toileting		Eating/Swallowing
	Splints/Orthotics		Other

Problem/Assessment	Goal:
1.	
2.	
3.	
4.	
5.	
Restorative Nursing Assistant Signature:	Date Reviewed with Restorative Nursing Assistant:
Restorative Nurse Signature:	Date:
Therapist Signature:	Date:

Levels of Assistance

Independent (I) -- No help or oversight	Modified Independent (MI) – Extra time/assistive device
Supervision (S) – Oversight encouragement/cues	Standby Assist (SBA) – Direct standby oversight
Contact Guard Assist (CGA) – Requires <25% assist	Minimum (Min) Assist – Requires 25% assist
Moderate (Mod) Assist – Requires 50% assist	Maximum (Max) Assist – Requires 75% assist
Total Assist – Requires 100% assist	

Cognition ☐☐Oriented to self ☐☐Locates room, activities area, dining room ☐☐Recognizes staff names/faces	**Bathing** ☐☐Upper body Assist _____ ☐☐Lower body Assist _____ ☐☐Assistive device _____
Communication/Hearing Patterns ☐☐Hearing aid ☐ Left ☐ Right ☐☐Speaks ☐☐Reads/writes messages☐ ☐☐Sign language ☐☐Gestures, points or sounds ☐☐Communication board Assist _____	**Hygiene/Grooming** ☐☐Combing hair Assist _____ ☐☐Brushing teethAssist _____ ☐☐Shaving Assist _____ ☐☐Make up Assist _____ ☐☐Wash/Dry face ☐☐Wash/Dry hands
Vision Patterns ☐☐Adequate ☐☐Impaired_____ ☐☐Wears glasses	**Locomotion** ☐☐Wheelchair Assist _____ ☐☐Geri-chair Assist _____ Positioning devices _____
Bed Mobility ☐☐Turn q 2 hours ☐☐Assistive device_____ Assist _____	**Continence** ☐☐Continent ☐ Bowel ☐ Bladder ☐☐Incontinent ☐ Bowel ☐ Bladder Schedule _____ _____
Transfers☐ ☐☐Assistive device _____ Assist _____ ☐☐Weightbearing status_____	**Toilet Use**☐ Assist _____ ☐☐Assistive device _____
Walking ☐☐Assistive device _____ Assist_____ ☐☐Weightbearing status_____ Distance_____	**Dressing** ☐☐Gather clothing ☐☐Upper body Assist _____ ☐☐Lower body Assist _____ ☐☐Socks/shoes Assist _____ Adaptive equipment _____
Range of motion ☐☐Active ☐☐Passive ☐☐Upper extremity ☐ Left ☐ Right ☐ ☐☐Lower extremity ☐ Left ☐ Right ☐ ☐☐Neck	**Swallowing/Eating** ☐☐Eating Assist _____ ☐☐Diet _____ ☐☐Swallow strategies _____ Adaptive equipment _____☐
Goals: 1. 2. 3.	
Specific approaches/precautions:	

Referring therapist signature: _____Date: _____
Resident : _____Date: _____

Rehabilitation and Restorative Nursing Program

Program Summary

Area	Satisfactory	Not Satisfactory	Problems Summary
Caseload			
Program Supervisor			
Program Documentation			
Staffing			
Training			
Therapist Participation			
Care Plan and Referral			
Physician's Orders			
Daily Charting			
Equipment			
Restorative by the Unit			

Comments:

Rehabilitation and Restorative Nursing Program

Improvement Plan

Objectives for the Next Period

Objective	Intervention strategy	Implementation Date

Clinical Competency Checklist
Restorative Nursing – Active Range of Motion

Employees Name / Credentials: _____

AROM	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Identifies weak or involved side						
Identifies precautions, contractures or pain						
Informs resident in a pleasant manner what is going to happen						
Facilitates all motions correctly						
Ranged each extremity through its end range						
Placed hands correctly						
• Hip						
• Flexion						
• Extension						
• Abduction						
• Adduction						
• Internal rotation						
• External rotation						
• Knee						
• Flexion						
• Extension						
• Ankle						
• Dorsiflexion						
• Plantar flexion						
• Inversion						
• Eversion						
• Toes						
• Flexion						
• Extension						

Clinical Competency Checklist
Restorative Nursing – Active Range of Motion

AROM	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
• Shoulder						
• Flexion						
• Extension						
• Abduction						
• Adduction						
• Internal rotation						
• External rotation						
• Elbow						
• Flexion						
• Extension						
• Forearm						
• Pronation						
• Supination						
• Wrist						
• Flexion						
• Extension						
• Ulnar deviation						
• Radial deviation						
• Fingers						
• Flexion						
• Extension						
• Abduction						
• Adduction						
• Neck						
• Flexion						
• Extension						
• Lateral flexion						
• Lateral rotation						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:**_____

Clinical Competency Checklist
Restorative Nursing – Passive Range of Motion

Employees Name / Credentials: _____

PROM (Passive Range of Motion)	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Identifies weak or involved side						
Identifies precautions, contractures or pain						
Informs resident in a pleasant manner what is going to happen						
Performs all motions correctly						
Ranged each extremity through its end range						
Placed hands placed correctly						
• Hip						
• Flexion						
• Extension						
• Abduction						
• Adduction						
• Internal rotation						
• External rotation						
• Knee						
• Flexion						
• Extension						
• Ankle						
• Dorsiflexion						
• Plantar flexion						
• Inversion						
• Eversion						
• Toes						
• Flexion						
• Extension						

Clinical Competency Checklist
Restorative Nursing – Passive Range of Motion

PROM (Passive Range of Motion)	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
• Shoulder						
• Flexion						
• Extension						
• Abduction						
• Adduction						
• Internal rotation						
• External rotation						
• Elbow						
• Flexion						
• Extension						
• Forearm						
• Pronation						
• Supination						
• Wrist						
• Flexion						
• Extension						
• Ulnar deviation						
• Radial deviation						
• Fingers						
• Flexion						
• Extension						
• Abduction						
• Adduction						
• Neck						
• Flexion						
• Extension						
• Lateral flexion						
• Lateral rotation						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:**_____

Clinical Competency Checklist
Restorative Nursing – Splinting

Employees Name / Credentials: _____

Splinting	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Informed resident in a pleasant manner that it is time to don/doff splint						
Checks precautions prior to application						
Checks wearing schedule prior to application						
Identifies reasons why splint is used						
Completes ROM to affected site prior to splinting						
Identifies purpose and demonstrates donning for each splint						
• Resting hand splint						
• Palm guard						
• Palm guard w/ finger separators						
• Elbow splint						
• Abductor wedge						
• Knee splint						
• AFO						
• Multi-podus boot						
• Isotoner glove						
Doffs splints						
Identifies symptoms of intolerance						
• Skin check						
• Looks for redness						
• Looks for blisters						
• Looks for edema						

Clinical Competency Checklist
Restorative Nursing – Splinting

Splinting	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
Identifies how to store splints						
Identifies how to clean splints						
Replaces worn/soiled						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:**_____

Clinical Competency Checklist
Restorative Nursing – Body Mechanics

Employee's Name/Credentials: _____

Body Mechanics	N/A	Able To Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Uses safety equipment (lift sheet, gait/safety belt)						
• Keeps back straight						
• Keeps head up						
• Maintains wide base of support						
• Bends knees before lifting						
• Holds object/resident close to the body						
• Does not hurry through task						
• Lifts with legs not back						
• Pulls objects instead of pushing						
• Does not twist back when lifting						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas:

_____

_____

_____

_____

Employee Signature:_____ **Date:**_____

Clinical Competency Checklist
Restorative Nursing – Bed Mobility

Employees Name / Credentials: _____

Bed Mobility	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Identifies weak or involved side						
Identifies precautions, weight bearing status or strength prior to transfer						
Informs resident in a pleasant manner what will happen						
Starts with bed flat, in low position, with siderails down						
Resident instructed to bend hips and knees so that feet are flat on the bed						
Resident instructed to drop knees to one side						
Resident instructed to roll onto side						
Assistance is given with one hand on shoulder blade and one on pelvis						
Resident instructed to push up to sitting using arms						
Assistance is given with one hand under upper back and one around knees						
Resident is supported in sitting position until position maintained independently						
Good body mechanics used at all times						
Follows same procedures for scooting in bed, rolling to opposite side						

Clinical Competency Checklist
Restorative Nursing – Bed Mobility

Bed Mobility	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
Identifies cases where 2 people are needed						
Identifies and demonstrates use of trapeze for bed mobility						
When assisting, supports resident at shoulders and pelvis, does not allow resident to hold onto the neck						
Identifies and demonstrates use of bed rails for mobility						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:**_____

Clinical Competency Checklist
Restorative Nursing – Transfers

Employees Name / Credentials: _____

Transfers	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Identifies weak or involved side						
Identifies precautions, weight bearing status or strength prior to transfer						
Informs resident in a pleasant manner what is going to happen						
Uses a safety/gait belt correctly						
Wheelchair placed correctly so resident can lead with strong leg						
Wheelchair brakes are locked						
Helps resident scoot forward so feet touch floor						
Has resident lean forward and push down with hands on surface to stand up						
Resident instructed to stand straight						
Resident instructed to pivot to wheelchair and all precautions are carried out						
Resident instructed to move backward until he feels chair touching backs of legs						
Resident instructed to reach for wheelchair armrest prior to sitting down						
Resident instructed to bend knees while lowering to the chair						
Good body mechanics used at all times						

Clinical Competency Checklist
Restorative Nursing – Transfers

Transfers	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
Follows same procedures for bed, chair, toilet transfers						
Identifies cases where 2 people are needed						
Identifies and demonstrates use of sliding board for transfers						
When assisting, supports resident around the trunk or with gait/safety belt, not holding under the arms						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:**_____

Clinical Competency Checklist
Restorative Nursing – ADL/Grooming

Employees Name / Credentials: _____

ADL/Grooming	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Informed resident in a pleasant manner that it is time to get dressed/undressed						
Checks precautions prior to dressing						
Checks that resident has necessary toiletries and adaptive equipment						
Identifies safest place for dressing (lying in bed, edge of bed, wheelchair)						
Identifies adaptive equipment and demonstrates use						
• Button hook						
• Dressing stick						
• Elastic shoelaces						
• Long handled shoehorn						
• Reacher						
• Sock aid						
• Long handled sponge						
• One handed wash mit						
• Suction brush						
• Built up handles						
Basic dressing techniques						
• One handed pullover shirt						
• One handed button-down shirt						
• Pants from sitting position						
• Pants from lying position						
• Socks/shoes						

Clinical Competency Checklist
Restorative Nursing – ADL/Grooming

Instructions/techniques						
• Cues for energy conservation						
• Follows hip precautions						
• Verbal cues						
• Hand over hand assist						
• Tactile cues						
• Visual demonstration						
• Allows extra time for independence before lending physical assist						
• Ensures safety						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:**_____

Clinical Competency Checklist
Restorative Nursing – Swallowing

Employees Name / Credentials: _____

Swallowing	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Informs resident in a pleasant manner that it is mealtime						
Checks that resident has dentures in place if needed						
Assess oral hygiene prior to intake/performs oral care						
Identifies diet level and precautions prior to meal						
Identifies and describes diet texture levels						
• Regular						
• Mechanical soft						
• Ground/chopped						
• Puree						
Demonstrates thickening of liquids to appropriate consistency						
• Thin						
• Nectar						
• Honey						
• Pudding						
Able to stimulate food acceptance						
• Pressure on jaw						
• Icing						
• TG stim						
• Finger foods						
Verbalizes 5 signs/symptoms of Swallowing disorders						
Observes adam's apple movement to assess swallow						
Verbalizes definition of aspiration and silent aspiration						

Clinical Competency Checklist
Restorative Nursing – Swallowing

Swallowing	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
Completes oral motor exercises prior to eating, as indicated						
• Open and close mouth						
• Pucker lips						
• Smile						
• Stick out tongue						
• Stick out tongue and move right and left						
• Attempt to touch nose with tongue						
• Attempt to touch chin with tongue						
Identifies reasons for and demonstrates swallow strategies						
• Chin tuck						
• Double swallow						
• Throat clear/re-swallow						
• Tongue sweeps						
Positioned resident for feeding in upright position with head in neutral position						
Does not give resident a straw						
Fed resident small amounts at a time						
Gave resident adequate time to swallow						
Alternates liquids and solids, if indicated						
Checked resident's mouth following swallow and at end of meal to ensure no food remaining						
Ensured resident positioned upright throughout intake						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:**_____

Clinical Competency Checklist
Restorative Nursing – Dining/Eating

Employees Name / Credentials: _____

Dining	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Informed resident in a pleasant manner that it was mealtime						
Assures pleasant eating environment						
Checks that resident has dentures, glasses and necessary adaptive equipment						
Identifies diet level and precautions prior to meal						
Identifies adaptive equipment and use						
• Dycem						
• Nosey cup						
• Sippy cup/spout cup						
• Two handled mug						
• Weighted utensils						
• Built up handles on utensils						
• Long handled utensils						
• Angled utensils						
• Partitioned scoop dish						
• Inner lip plate						
• Plate guard						
Assured proper positioning						
• Lap tray						
• Tabletop at waist height						
• Shoulders back						
• Elbows supported on chair or table						

Clinical Competency Checklist
Restorative Nursing – Dining/Eating

Dining	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
• Food within 12" reach						
• Hips and knees bent to 90 degrees						
• Feet supported flat on floor/foot pedals						
Presented food and describes items on plate						
Asks resident preference of food placement						
Demonstrates basic feeding techniques						
• Hand over hand assist for self-feeding						
• Tactile cues						
• Verbal cues						
• Clock method for food placement						
• Places food appropriately for visual/perceptual deficits						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:**_____

Clinical Competency Checklist
Restorative Nursing – Communication

Employees Name / Credentials: _____

Communication	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Identifies and demonstrates methods of communication						
• Gestures						
• Facial expressions						
• Verbal/words						
• Writing						
• Reading						
Follows general guidelines for communication						
• Uses resident's name						
• Approaches resident from the front on eye level						
• Speaks clearly, facing resident						
• Allows enough time for response						
• Uses short sentences						
• Positively reinforces resident when attempting to respond						
• Uses choice questions						
• Does not shout						
• Uses gestures to get message across as needed						
• Uses communication board when appropriate						

Clinical Competency Checklist
Restorative Nursing – Communication

Communication	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
Demonstrates expressive language exercises						
• Automatic speech						
• Singing						
• Fill-ins						
• Sentence completion						
• Word finding						
• Naming/identification						
• Description						
• Discrimination						
• Pacing techniques						
Demonstrates receptive language exercises						
• Understands yes/no questions						
• Follows directions						
• Choice presentation						
• Object discrimination						
Demonstrates pragmatic language exercises						
• Turn taking						
• Eye contact when speaking						
• Appropriate language when speaking						
• Regulates social exchange						
Appropriately modifies task following communication breakdown						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:**_____

Clinical Competency Checklist
Restorative Nursing – Cognition

Employees Name / Credentials: _____

Cognition	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Follows general guidelines for interaction with residents with cognitive disorders						
• Approaches resident from front at eye level						
• Aware of cognitive limitations with regard to safety						
• Paces information delivery						
• Watches for signs of frustration						
• Reduces distractions						
• Redirects negative behavior						
• Demonstrates patience						
• Provides structure/cueing for task performance						
Follows general guidelines for interaction with residents with memory disorders						
• Adapts environment to enhance performance						
• Repeats information as needed						
• Provides choices						
• Uses respectful tone of voice						
• Structure tasks for compensation						
• Avoid emotional confrontation						

Clinical Competency Checklist
Restorative Nursing – Cognition

Cognition	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
Demonstrates ability to perform cognitive activities						
• Memory						
• Reality orientation when Appropriate						
• Decision making						
• Attention						
• Thought organization						
• Judgment/problem solving						
Follows through with compensatory strategies as per SLP						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:**_____

Clinical Competency Checklist
Restorative Nursing – Ambulation

Employees Name / Credentials: _____

Ambulation	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
Identifies weak/involved side						
Identifies precautions, weight bearing status or strength						
Informs resident in a pleasant manner what is going to happen						
Uses a safety/gait belt correctly						
Adjusts walker/cane correctly						
Locks wheelchair brakes						
Helps resident scoot forward so feet are flat on floor						
Has resident lean forward and push down with hands on surface to stand up						
Instructs resident to stand straight						
Weight bearing status emphasized						
Walks at resident's pace						
Walks on resident's involved side						
When returning to chair, instructs resident to move backward until he feels chair touching backs of legs						
Instructs resident to reach for wheelchair armrest prior to sitting down						
Resident instructed to bend knees while lowering to the chair						

Clinical Competency Checklist
Restorative Nursing – Ambulation

Ambulation	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
Good use of body mechanics at all-times						
Identifies cases where 2 people are needed						
Identifies and demonstrates use of assistive devices						
• Walker						
• Rolling walker						
• Cane						
• Quad cane						
• Hemi walker						
When assisting, supports resident around the trunk or with gait belt, not holding under the arms						
Identifies and demonstrates weight bearing terms						
• Full weight bearing						
• Partial weight bearing						
• Toe touch weight bearing						
• Non weight bearing						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:**_____

Clinical Competency Checklist
Restorative Nursing – Stairs and Curbs

Employees Name / Credentials: _____

Stairs and Curbs	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely/accurate documentation of resident performance during task						
Identifies weak or involved side						
Identifies precautions, weight bearing status or strength						
Informs resident in a pleasant manner what is going to happen						
Uses a safety/gait belt correctly						
Instructs resident to lead with the strong extremity up stairs/curb						
Instructs resident to lead with the weak extremity down stairs/curb						
Did not allow resident to lean forward excessively						
Positioned to assist resident in case of balance loss						
Climbed stairs at resident's pace						
Good body mechanics used at all times						
Identifies cases where 2 people are needed						
When assisting, supports resident around the trunk or with gait/safety belt, not holding under the arms						

Clinical Competency Checklist
Restorative Nursing – Stairs and Curbs

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:**_____

Clinical Competency Checklist
Restorative Nursing – Continence

Employees Name / Credentials: _____

Continence	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards as applicable						
• Completes timely and accurate documentation of resident performance during task						
ID's roles of IDT in continence program						
Defines types of incontinence and 2 treatment strategies for each						
• Urge incontinence						
• Stress incontinence						
• Functional incontinence						
• Overflow incontinence						
Verbalizes procedures to establish bladder schedule						
• Timed voiding						
• Prompted voiding						
• Habit training						
• Bladder training						
• Pelvic muscle (Kegel) exercises						
Identifies importance of other treatment interventions						
• Nutrition						
• Socialization						
• Coping skills						
• Personal hygiene/skin integrity						
• Cognitive retraining						
• Environmental modification						

Clinical Competency Checklist
Restorative Nursing – Continence

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Clinical Competency Checklist
Restorative Nursing – Moist Heat

Employee's Name/Credentials: _____

Moist Heat	N/A	Able To Perform	Need to Improve	Comments	F/U Needed	F/U Date
General						
• Washes hands before and after task						
• Identifies appropriate resident before initiating task						
• Identifies self to resident before initiating task						
• Adheres to privacy standards						
• Completes timely and accurate documentation of resident performance during task						
Prepares resident for modality						
• Reviews care plan and orders prior to treatment						
• Explains procedure to resident and duration of heat treatment						
• Explains how heat will feel and to alert nurse of any discomfort						
• Ensures resident has call bell to notify nurse of any problems						
• Assists resident to a position that allows for comfort						
• Drapes resident with area to be treated exposed						
• Performs thorough skin check prior to application						
Prepares Equipment						
• Using tongs, removes appropriate sized hot pack from hydroculator						
• Places hot pack in appropriately sized hot pack cover						
• Wraps with 3-4 layers of towels or more as indicated by resident tolerance						

Moist Heat	N/A	Able to Perform	Need to Improve	Comments	F/U Needed	F/U Date
Sensation of treated area is checked, and any metal objects or jewelry are removed						
Resident reminded to notify nurse if pack becomes too hot						
Hot pack placed appropriately on area to be treated						
Area checked every 5 minutes for tolerance						
Are treated for no more than 15-25 minutes						
Are inspected for unusual signs after hot pack is removed						
Wet linen discarded appropriately						
Identifies precautions and contraindications to hot pack use						
Equipment maintenance						
• Identifies appropriate water level for hydroculator						
• Identifies appropriate temperature for hydroculator (150-170 degrees F)						
• Identifies conditions when water should be changed or cleaned						
• Identifies hot packs that should be discarded						

Manager Signature:_____ **Date:**_____

Additional Certifications/Specialty Areas: _____

_____

_____

_____

Employee Signature: _____ **Date:** _____

Annual Competency Testing

Introduction to Rehabilitation/Restorative Nursing

1. **Rehabilitation/restorative nursing is a key aspect of nursing care. The overall philosophy of rehabilitation/restorative nursing is rest and recovery.**

   True / False

2. **Immobility may be an issue with any chronic illness or injury. Immobility affects the skin and muscle strength but does not have a major impact on other body systems.**

   True / False

3. **Rehabilitation goals are always determined through mutual goal setting involving the resident and the team members.**

   True / False

4. **Rehabilitation/Restorative nursing care is best completed by focusing on rehabilitation program needs 24 hours a day, seven days a week.**

   True / False

5. **The rehabilitation team includes nurses, therapists, rehabilitation/restorative nursing assistants, the patient and family members.**

   True / False

The Rehabilitation Team

1. **The three cornerstones of rehabilitation include: Focus on abilities, resident centered plan, and rehabilitation/restorative nursing delivered care.**

   True / False

2. **A team is nice but not necessary for effective rehabilitation.**

   True / False

3. **Rehabilitation teams achieve successful outcomes through effective communication, which includes the resident and family members.**

   True / False

4. **Effective teams never disagree.**

   True / False

5. **The rehabilitation team includes rehabilitation/restorative nurses, therapists, rehabilitation/restorative nursing assistants, the patient and family members.**

   True / False

Range of Motion

1. **Range of motion is important only if the resident is unable to move independently.**
   True / False
2. **Active range of motion is done for the resident but is lively in pace.**
   True / False
3. **The sequence of range of motion must not be interrupted but should flow from head to toe.**
   True / False
4. **Range of motion is contraindicated if a resident has spasticity or pain.**
   True / False
5. **Range of motion can be combined with bathing and dressing routines.**
   True / False
6. **Contractures can be prevented**
   True / False
7. **Hand splints, rolls and cones can help to prevent hand contractures**
   True / False
8. **If you feel a spasm during ROM, you should push harder**
   True / False

Splint and Brace Care

1. **Each time a splint is applied, the skin should be checked for red areas.**
   True / False
2. **Splint straps should be applied tightly so the splint does not move.**
   True / False
3. **Splints can cause excess pressure over bony areas if not monitored.**
   True / False
4. **Dynamic splints do not allow the joints to move.**
   True / False
5. **Range of motion should be completed each time a splint is applied.**
   True / False

Bed Mobility and Transfers

1. **You should use your back muscles to lift heavy objects.**

   True / False

2. **Using a gait belt may help to prevent injury to a resident or to you.**

   True / False

3. **Partial weight bearing means that the resident can place as much body weight as is tolerated on the affected leg.**

   True / False

4. **You should remind the resident with recent hip surgery not to cross their legs while sitting or lying down.**

   True / False

5. **When rolling a dependent resident in bed, the resident's head should be positioned toward the opposite direction of the roll.**

   True / False

6. **You should always transfer to the resident's stronger side.**

   True / False

7. **It is not necessary to be concerned with the weight bearing status of a resident with a fracture while doing a transfer**

   True / False

8. **The resident should scoot forward in the wheelchair before attempting to stand up**

   True / False

9. **To assist the resident in doing a transfer, it is acceptable for the resident to hold around your neck**

   True / False

10. **To transfer from the bed to the wheelchair, the resident should reach for the armrest of the wheelchair before standing up**

    True / False

11. **When lifting, it is important to hold the object as close to your body as possible**

    True / False

12. **When lifting, it is important to keep your feet close together so you can maintain your balance**

    True / False

Activities of Daily Living

1. **A resident that had recent hip surgery may need to use a Reacher to assist with dressing.**

   True / False

2. **Residents with limited range of motion should wear garments that you pull over the head.**

   True / False

3. **You should instruct the resident with problems of coordination to stand up when dressing.**

   True / False

4. **Use front opening garments for residents with problems with coordination or limited range of motion.**

   True / False

5. **Residents are not able to dress themselves using one-handed techniques.**

   True / False

6. **Weighted wrist cuffs may help hold a resident's hand steady while shaving.**

   True / False

7. **If set-up properly and oriented to the surroundings, it is possible for a resident with dementia to independently complete ADL tasks.**

   True / False

8. **Water temperature should be checked before completing hygiene/grooming tasks to ensure a resident is not burned.**

   True / False

9. **The RNA should allow a resident only 2 attempts to complete ADLs independently. After 2 attempts, the RNA should step in and complete tasks for the resident.**

   True / False

Eating and Swallowing

1. **Aspiration occurs when the resident breathes food or liquid into the lungs.**

   True / False

2. **There are four stages of swallowing, (three traditional and one additional).**

   True / False

3. **Coughing during or after a meal may be a sign of dysphagia.**

   True / False

4. **Pocketing occurs when a resident puts food in their pockets to eat at a later time.**

   True / False

5. **A universal cuff may help a resident with reduced strength hold eating utensils for self-feeding.**

   True / False

6. **Blind residents should never be allowed to self-feed.**

   True / False

7. **When feeding a resident, you should always tilt the resident's head back.**

   True / False

8. **Dycem is non-slip material that prevents eating utensils from sliding.**

   True / False

9. **It is okay to give un-thickened water to a resident on thickened liquids.**

   True / False

10. **It is very important to be sure a resident is wearing his dentures and/or glasses when eating**

    True / False

11. **It is appropriate for a resident to feed himself lying on his side if he is tired**

    True / False

12. **It is better to feed the resident rather than allow him to feed himself**

    True / False

13. **If you don't know how to use adaptive equipment, cover it with a napkin – pretend it's not there**

    True / False

Amputation and Prosthesis

1. **One of the key objectives of stump healing is to prevent the stump site from shrinking.**

   True / False

2. **When positioning a resident after a lower extremity amputation, it is essential that a pillow not be placed under the stump for positioning.**

   True / False

3. **It generally requires no more effort to walk with a prosthesis than with two sound legs.**

   True / False

4. **A key aspect of prosthetic care is monitoring the skin integrity of the stump for redness, irritation and cuts or abrasions.**

   True / False

5. **Plastic prosthetic sockets should be cleaned daily prior to use to assure the resident has a clean socket to use.**

   True / False

Communication Strategies

1. **Aphasia is the inability to swallow.**

   True / False

2. **Eye contact is an important part in effective communication.**

   True / False

3. **When communication is impaired, the use of adjectives, and detailed examples may increase comprehension.**

   True / False

4. **Anticipating what a resident is trying to say and saying it for him will decrease frustration.**

   True / False

5. **It is important that all efforts of communication by the resident have a response from the rehabilitation/restorative nurse or assistant.**

   True / False

6. **Shouting is an effective technique for communicating with a resident who has Alzheimer ’s disease**

   True / False

7. **Batteries in hearing aids can be left in overnight**

   True / False

8. **It is important to get the attention of the hearing-impaired resident before you begin to speak to him/her**

   True / False

Ambulation Training

1. **Ambulation is a key component of resident care. Cornerstones of the gait-training program are functional independence, safety and energy consideration.**

   True / False

2. **When using a cane, the cane should be positioned on the involved side.**

   True / False

3. **When returning to a sitting position, the resident should walk up to the chair until the chair is touching the front of the knees and then turn to sit.**

   True / False

4. **When guarding a resident during ambulation, a gait belt should be used.**

   True / False

5. **If the resident starts to lose balance and you are not able to correct the balance by contact with the shoulder and by moving closer to the resident, you should try to break the fall.**

   True / False

6. **When assisting the resident to the floor to prevent a "fall", you should explain to the resident that you are lowering him to the floor since he may begin to panic and make the situation worse by struggling.**

   True / False

7. **When ascending stairs, you should position yourself in front of the resident to guide him up the stairs.**

   True / False

8. **If a resident has no problems ambulating inside, you should feel comfortable that he will be able to ambulate outside without any issues.**

   True / False

9. **The walker is at the correct height when the hands are placed on the hand grips and the elbow forms a 30-degree angle**

   True / False

10. **The resident should always lead with the weak extremity when going down the curb/stairs**

    True / False

11. **You should always walk beside the resident on the involved side**

    True / False

Bladder and Bowel Continence

1. **Good intake of fluids is necessary for effective bladder management. An effective fluid intake includes at least 3,000 cc of fluid daily.**

   True / False

2. **Alkaline urine is a serious issue with residents with bladder issues, since it leads to renal calculi and a predisposition to urinary tract infections. Alkaline urine is linked with a high intake of citrus fluids, carbonated beverages and milk.**

   True / False

3. **The primary complication of an indwelling catheter is dysuria.**

   True / False

4. **It is not possible to achieve bladder continence if a resident has had a stroke.**

   True / False

5. **Using a bedpan at night is a common practice in many acute care hospitals. Continuing this practice in the nursing facility will allow the resident to sleep better at night and will not reduce the efficacy of the bladder management program.**

   True / False

6. **In estimating the amount of incontinence, a 9-inch spot is equivalent to 300 ml or urine.**

   True / False

7. **According to the MDS definition of incontinence, a score of 2 is equated to frequent incontinence with daily incidents.**

   True / False

8. **The goals of a bladder management program include: Preservation of urinary function and prevention of complications.**

   True / False

9. **In a bowel management program, high fat foods slow peristalsis, which will lead to incontinence.**

   True / False

10. **The secret to success with a bowel management program is timing, timing, timing.**

    True / False

11. **Changes in the bowel program should be focused on only one element of the program at a time.**

    True / False

12. **Foods and fluids that contain sugar and caffeine can often contribute to urinary incontinence**

    True / False

13. **Kegel exercises are done by contracting and relaxing the pelvic floor muscle**

    True / False

14. **Proper hygiene includes washing the perineal area after every incident of urinary incontinence and using a moisture barrier cream**

    True / False

Annual Competency Testing – Answer Key

Introduction to Rehabilitation/Restorative Nursing

1. **Rehabilitation/restorative nursing is a key aspect of nursing care. The overall philosophy of rehabilitation/restorative nursing is rest and recovery.**

   True / False

2. **Immobility may be an issue with any chronic illness or injury. Immobility affects the skin and muscle strength but does not have a major impact on other body systems.**

   True / False

3. **Rehabilitation goals are always determined through mutual goal setting involving the resident and the team members.**

   True / False

4. **Rehabilitation/Restorative nursing care is best completed by focusing on rehabilitation program needs 24 hours a day, seven days a week.**

   True / False

5. **The rehabilitation team includes nurses, therapists, rehabilitation/restorative nursing assistants, the patient and family members.**

   True / False

The Rehabilitation Team

1. **The three cornerstones of rehabilitation include: Focus on abilities, resident centered plan, and rehabilitation/restorative nursing delivered care.**

   True / False

2. **A team is nice but not necessary for effective rehabilitation.**

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3. **Rehabilitation teams achieve successful outcomes through effective communication, which includes the resident and family members.**

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   True / False

2. **Active range of motion is done for the resident but is lively in pace.**

   True / False

3. **The sequence of range of motion must not be interrupted but should flow from head to toe.**

   True / False

4. **Range of motion is contraindicated if a resident has spasticity or pain.**

   True / False

5. **Range of motion can be combined with bathing and dressing routines.**

   True / False

6. **Contractures can be prevented**

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7. **Hand splints, rolls and cones can help to prevent hand contractures**

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8. **If you feel a spasm during ROM, you should push harder**

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1. **Each time a splint is applied, the skin should be checked for red areas.**

   True / False

2. **Splint straps should be applied tightly so the splint does not move.**

   True / False

3. **Splints can cause excess pressure over bony areas if not monitored.**

   True / False

4. **Dynamic splints do not allow the joints to move.**

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5. **Range of motion should be completed each time a splint is applied.**

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Bed Mobility and Transfers

1. **You should use your back muscles to lift heavy objects.**

   True / False

2. **Using a gait belt may help to prevent injury to a resident or to you.**

   True / False

3. **Partial weight bearing means that the resident can place as much body weight as is tolerated on the affected leg.**

   True / False

4. **You should remind the resident with recent hip surgery not to cross their legs while sitting or lying down.**

   True / False

5. **When rolling a dependent resident in bed, the resident's head should be positioned toward the opposite direction of the roll.**

   True / False

6. **You should always transfer to the resident's stronger side.**

   True / False

7. **It is not necessary to be concerned with the weight bearing status of a resident with a fracture while doing a transfer**

   True / False

8. **The resident should scoot forward in the wheelchair before attempting to stand up**

   True / False

9. **To assist the resident in doing a transfer, it is acceptable for the resident to hold around your neck**

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10. **To transfer from the bed to the wheelchair, the resident should reach for the armrest of the wheelchair before standing up**

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11. **When lifting, it is important to hold the object as close to your body as possible**

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1. **A resident that had recent hip surgery may need to use a Reacher to assist with dressing.**

   True / False

2. **Residents with limited range of motion should wear garments that you pull over the head.**

   True / False

3. **You should instruct the resident with problems of coordination to stand up when dressing.**

   True / False

4. **Use front opening garments for residents with problems with coordination or limited range of motion.**

   True / False

5. **Residents are not able to dress themselves using one-handed techniques.**

   True / False

6. **Weighted wrist cuffs may help hold a resident's hand steady while shaving.**

   True / False

7. **If set-up properly and oriented to the surroundings, it is possible for a resident with dementia to independently complete ADL tasks.**

   True / False

8. **Water temperature should be checked before completing hygiene/grooming tasks to ensure a resident is not burned.**

   True / False

9. **The RNA should allow a resident only 2 attempts to complete ADLs independently. After 2 attempts, the RNA should step in and complete tasks for the resident.**

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Eating and Swallowing

1. **Aspiration occurs when the resident breathes food or liquid into the lungs.**
   True / False
2. **There are four stages of swallowing, (three traditional and one additional).**
   True / False
3. **Coughing during or after a meal may be a sign of dysphagia.**
   True / False
4. **Pocketing occurs when a resident puts food in their pockets to eat at a later time.**
   True / False
5. **A universal cuff may help a resident with reduced strength hold eating utensils for self-feeding.**
   True / False
6. **Blind residents should never be allowed to self-feed.**
   True / False
7. **When feeding a resident, you should always tilt the resident's head back.**
   True / False
8. **Dycem is non-slip material that prevents eating utensils from sliding.**
   True / False
9. **It is okay to give un-thickened water to a resident on thickened liquids.**
   True / False
10. **It is very important to be sure a resident is wearing his dentures and/or glasses when eating**
    True / False
11. **It is appropriate for a resident to feed himself lying on his side if he is tired**
    True / False
12. **It is better to feed the resident rather than allow him to feed himself**
    True / False
13. **If you don't know how to use adaptive equipment, cover it with a napkin – pretend it's not there**
    True / False

Amputation and Prosthesis

1. **One of the key objectives of stump healing is to prevent the stump site from shrinking.**

   True / False

2. **When positioning a resident after a lower extremity amputation, it is essential that a pillow not be placed under the stump for positioning.**

   True / False

3. **It generally requires no more effort to walk with a prosthesis than with two sound legs.**

   True / False

4. **A key aspect of prosthetic care is monitoring the skin integrity of the stump for redness, irritation and cuts or abrasions.**

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5. **Plastic prosthetic sockets should be cleaned daily prior to use to assure the resident has a clean socket to use.**

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5. **It is important that all efforts of communication by the resident have a response from the rehabilitation/restorative nurse or assistant.**

   True / False

6. **Shouting is an effective technique for communicating with a resident who has Alzheimer ’s disease**

   True / False

7. **Batteries in hearing aids can be left in overnight**

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8. **It is important to get the attention of the hearing-impaired resident before you begin to speak to him/her**

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Ambulation Training

1. **Ambulation is a key component of resident care. Cornerstones of the gait-training program are functional independence, safety and energy consideration.**

   True / False

2. **When using a cane, the cane should be positioned on the involved side.**

   True / False

3. **When returning to a sitting position, the resident should walk up to the chair until the chair is touching the front of the knees and then turn to sit.**

   True / False

4. **When guarding a resident during ambulation, a gait belt should be used.**

   True / False

5. **If the resident starts to lose balance and you are not able to correct the balance by contact with the shoulder and by moving closer to the resident, you should try to break the fall.**

   True / False

6. **When assisting the resident to the floor to prevent a "fall", you should explain to the resident that you are lowering him to the floor since he may begin to panic and make the situation worse by struggling.**

   True / False

7. **When ascending stairs, you should position yourself in front of the resident to guide him up the stairs.**

   True / False

8. **If a resident has no problems ambulating inside, you should feel comfortable that he will be able to ambulate outside without any issues.**

   True / False

9. **The walker is at the correct height when the hands are placed on the hand grips and the elbow forms a 30-degree angle**

   True / False

10. **The resident should always lead with the weak extremity when going down the curb/stairs**

    True / False

11. **You should always walk beside the resident on the involved side**

    True / False

Bladder and Bowel Continence

1. **Good intake of fluids is necessary for effective bladder management. An effective fluid intake includes at least 3,000 cc of fluid daily.**

   True / False

2. **Alkaline urine is a serious issue with residents with bladder issues, since it leads to renal calculi and a predisposition to urinary tract infections. Alkaline urine is linked with a high intake of citrus fluids, carbonated beverages and milk.**

   True / False

3. **The primary complication of an indwelling catheter is dysuria.**

   True / False

4. **It is not possible to achieve bladder continence if a resident has had a stroke.**

   True / False

5. **Using a bedpan at night is a common practice in many acute care hospitals. Continuing this practice in the nursing facility will allow the resident to sleep better at night and will not reduce the efficacy of the bladder management program.**

   True / False

6. **In estimating the amount of incontinence, a 9-inch spot is equivalent to 300 ml or urine.**

   True / False

7. **According to the MDS definition of incontinence, a score of 2 is equated to frequent incontinence with daily incidents.**

   True / False

8. **The goals of a bladder management program include: Preservation of urinary function and prevention of complications.**

   True / False

9. **In a bowel management program, high fat foods slow peristalsis, which will lead to incontinence.**

   True / False

10. **The secret to success with a bowel management program is timing, timing, timing.**

    True / False

11. **Changes in the bowel program should be focused on only one element of the program at a time.**

    True / False

12. **Foods and fluids that contain sugar and caffeine can often contribute to urinary incontinence**

    True / False

13. **Kegel exercises are done by contracting and relaxing the pelvic floor muscle**

    True / False

14. **Proper hygiene includes washing the perineal area after every incident of urinary incontinence and using a moisture barrier cream**

    True / False