Leadership Keys to Success

Restorative Nursing Program
Leadership Keys to Success

Objectives/Standards

Understand RNP scope of service
RNA and RNPC verbalize understanding of their roles and responsibilities to RNP
Verbalize understanding of admission and discharge criteria
Review types of documentation forms.
Leadership Keys to Success
Objectives/Standards (cont’d)

Review OBRA & Title 22 regulations
Verbalize effective leadership strategies for the RNP
Restorative Nursing Program
Definition

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

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

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

- Bathing, dressing, grooming
- Toileting
- Oral Hygiene
- Personal hygiene
- Ambulation
- Wheelchair mobility
- Bed mobility
Scope of service (cont’d)

<table>
<thead>
<tr>
<th>Transfer training</th>
<th>Exercise programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positioning</td>
<td>Splints,</td>
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<tr>
<td>Range of motion</td>
<td>adaptive/assistive</td>
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<tr>
<td>Bowel &amp; Bladder retraining</td>
<td>devices</td>
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<tr>
<td>Communication programs</td>
<td>Dining programs</td>
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<tr>
<td></td>
<td>Eating &amp; Swallowing</td>
</tr>
</tbody>
</table>
RNP organizational chart

- Skilled Therapy
  - Restorative Nursing Program Coordinator
    - Restorative Nursing Assistant
  - Director of Nursing Services
    - Charge Nurse
      - Certified Nursing Assistant
Roles & responsibilities
RNPC

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

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

Skilled therapy
Nursing
IDT
Resident/Family/CNA/RNA/Caregivers
Admission criteria

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

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

Clear & concise
WHO will provide the service
WHAT service will be provided
Frequency
Duration of order
Obtain order for discharge
RNP orders (cont’d)

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

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

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

RNP Summary

RNA Summary routinely (e.g., daily, weekly, monthly)

- Activity provided
- Resident response
- Outcomes/progress/lack of progress
- Unusual occurrences

Document pain when it occurs, stop the activity & notify nursing/therapy

- Plan to continue program
“Resident maintained skills this week. Complained three times of lack of energy, requiring 5 minute rest. Walked 100 feet with FWW 2/5 days. Resident did not complain of pain. Resident follows swallow protocol when supervised at meals in the dining room.”
Documentation
Nurse Weekly Summary

Licensed Nurse’s Weekly Summary of resident progress in RNP
Ongoing chart reviews/audits to assure compliance/quality
Discharge criteria

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

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

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

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

Know the regulations affecting the RNP
Strive to maintain consistent compliance
Know your role in the regulatory process
Regulations influence the quality of care and quality of life of the residents
Quality Assurance Performance Improvement (QAPI)

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

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

Show me!
Post Test
Medical Overview

Restorative Nursing Program
Medical Overview
Objectives/Standards

Understand major muscle groups
Identify characteristics of normal aging
Understand common medical problems/pathologies addressed by the RNP
Basic anatomy & physiology

Muscles
Joints
Nerves
Normal aging

Aging is a normal process that occurs with the passage of time. Aging past maturity implies a slowing down of biological function.
Normal aging (cont’d)

Biological aspects
- Skin
- Skeletal
- Muscle
- Nervous system
- Senses
- Respiratory system
- GI system
Normal aging (cont’d)

Psycho-social aspects
- Sensory changes
- Psychosocial changes
- Coping with stress
Medical problems/pathologies

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

Orthopedic – Mrs. Connelly
Multiple medical – Tessie Tripper
Neurological – Mr. Lowe
Dementia – Mrs. AW
Demonstrating Clinical Competency

Cognition, Hearing & Communication
Cognition
Objectives/Standards

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

Cognitive impairment is the decreased ability to mentally process information.

Definitions
- Cognitive impairment
- Dementia
- Memory
- Direct and indirect treatment
- Reversible and irreversible
Cognitive disorders
Classifications

Reversible
- Goal is to improve function
- May return to prior level of function

Irreversible
- Goal is to maintain function
- May not return to prior level of function
Cognitive disorders
Treatment techniques

Direct
- Goal is to improve function
- Residents with reversible characteristics benefit form this approach
- Example: “What did you have for breakfast?”
Cognitive disorders
Treatment techniques

Indirect

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

### Etiology

<table>
<thead>
<tr>
<th>Diagnosis &amp; Medical Condition</th>
<th>REVERSIBLE (false dementia)</th>
<th>IRREVERSIBLE (true dementia)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parkinson disease</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Alzheimer disease</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Multi-infarct dementia</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>CVA</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Brain tumor</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Alcohol abuse history</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
# Cognitive Disorders

Specific characteristics

<table>
<thead>
<tr>
<th>Onset of cognitive deficits</th>
<th>Parkinson disease, Huntington’s chorea, etc.</th>
<th>Alzheimer disease, Pick’s disease, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gradual medical deficit first, then cognitive deficits</td>
<td>Initial problem is intellectual functioning</td>
</tr>
<tr>
<td>Language</td>
<td>Normal</td>
<td>Aphasic</td>
</tr>
<tr>
<td>Speech</td>
<td>Dysarthric</td>
<td>Normal</td>
</tr>
<tr>
<td>Memory</td>
<td>Retrieval problems</td>
<td>Unable to learn</td>
</tr>
<tr>
<td>Cognition</td>
<td>Slowed</td>
<td>Poor judgment</td>
</tr>
<tr>
<td>Affect</td>
<td>Depressed</td>
<td>Unconcerned</td>
</tr>
<tr>
<td>Posture</td>
<td>Stooped</td>
<td>Normal</td>
</tr>
<tr>
<td>Tone</td>
<td>Increased</td>
<td>Normal</td>
</tr>
<tr>
<td>Movement</td>
<td>Tremor</td>
<td>Normal</td>
</tr>
<tr>
<td>Gait</td>
<td>Abnormal</td>
<td>Normal</td>
</tr>
</tbody>
</table>
## Cognitive Disorders

### Communication approaches

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

Achieve eye contact
Use touch to gain attention
Be patient!
Keep instructions simple and short
Allow resident time to respond
Alzheimer disease
Creating the best environment

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

Suspicious
- “You stole my money.”

Mommy/daddy pattern
- “Mommy, mommy, mommy.”

Angry/agitated
- “I hate you. You’re stupid. Get out of here.”

Wandering/pacing
- Caregiver: “Where are you going?”
- Resident: “I don’t know.”
Alzheimer disease
Communication tips

Guide a conversation to familiar topics
Be reassuring
Use short, clear sentences
Repeat information often
Allow time for responding
Alzheimer disease
Communication behaviors to avoid

Do not quiz the resident
Do not correct statements the resident has made even if you know that they are wrong
Avoid letting frustration or anger enter into your voice
Cueing/compensatory systems
May include direct and indirect

Daily Schedule
Identification Folder
Memory Wallet
Monthly Calendar
Safety card checklist
Memory Journal
Demonstrating Clinical Competencies

Show me!

Post Test
Hearing in geriatrics

Objectives/Standards

Verbalize/write compensatory techniques for communicating with a hearing impaired resident

Understand the difference between sensori-neural and conductive hearing loss

Identify appropriate wear schedule for a new hearing aid user
Hearing in geriatrics

Hearing loss types

Conductive
  – Outer and middle ear
  – Breakdown in loudness only

Sensorineural
  – Inner ear or auditory nerve
Hearing in geriatrics
Hearing loss types (cont’d)

Mixed
- Combination of any of the following: outer ear, middle ear, peripheral

Central
- Central nervous system or brain
Hearing in geriatrics

Hearing aids

Check/maintain hearing aid
- Stethoscope
- Check batteries
- Clean with alcohol swab
- Never use toothpick, needle to clean wax
Hearing in geriatrics
Suggestions for communication

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

Gestures

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

Show me!

Post Test
Communication
Objectives/Standards

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

Left hemisphere problems

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

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

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

Right CVA

Resident should verbalize how to complete a task

Orient and instruct resident from the right

Break task into small steps
Communication
Motor speech disorders

Dysarthria
- Slurred speech

Apraxia
- Know what they want to say but the message from the brain does not get through to the tongue and mouth
Communication tips
Motor speech disorders

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

Show me!

Post Test
Dysphagia and Eating

Objectives/Standards

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

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

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

- Oral preparatory stage
- Pharyngeal stage and the swallow reflex
- Esophageal stage
Swallow function
Normal swallow stages

1. Bolus in oral cavity
2. Bolus conveyed into oropharynx
3. Bolus extends into laryngopharynx
4. Bolus penetrates opened pharyngoesophageal segment
5. Bolus nearly transversed the pharynx
6. Pharynx returned to referenced position
Swallow function & the normal swallow
Stage 1: Bolus in oral cavity
Stage 2: Bolus conveyed into oropharynx
Stage 3: Bolus extends into the laryngopharynx
Stage 4: Bolus penetrates opened pharyngoesophageal segment
Stage 5: Bolus nearly transversed the pharynx
Stage 6: Pharynx returned to referenced position
Swallowing
Common problems

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

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

Position upright with head tilted slightly forward
Take small bites of food, one bite at a time
Provide frequent verbal instructions while eating
Swallow function
Suggestions and aids (cont’d)

Follow any precaution signs noted in resident’s care plan or room
Alternate sips and bites
Management of impaired swallow requires patience and discipline
Swallow function
Food textures

Food Textures
- Puree
- Ground
- Mechanical Soft
- Liquids
  - Thick – nectar, honey, pudding consistency
  - Thin – water, juice, soda, coffee
Swallow function
Foods that may present difficulty

- Mixed textures
- Stringy textures
- Floppy textures
- Small, hard textures
- Thin liquids
- Foods with tough skins
- Foods that fall apart in the mouth
- Dry sticky foods
Swallow function and self feeding
Proper positioning

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

These devices can facilitate independence in self feeding

- Utensils
  built up, angles, weighted, cuff
- Plates
  lip, scoop, partitioned, guard, dycem
- Beverage cups
  nosey, two handled
Self feeding

Other considerations

Visual changes
- Food contrast of color
- “Clock” position of food on plate
- Verbal cues and directions

Neglect
- Lay out of place setting
- Position of caregiver
- Verbal cues and directions
Dining environment Considerations

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

Show me!

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

Joint Mobility
Joint Mobility
Objectives/Standards

Identify purposes for RNA to perform ROM

Verbalize & demonstrate passive, active/assisted ROM

Identify contraindications for PROM

Identify reasons for the RNA to assist in a routine exercise/maintenance program
Joint Mobility
Objectives/Standards (cont’d)

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

Purpose

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

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

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

PROM
- 100% caregiver

A/A ROM
- Part resident, part caregiver

AROM
- 100% resident
ROM
Types & definitions (cont’d)

Resistive
- Active motion with weights, Theraband, pulleys, exercycle, etc

Functional
- Active use during ADL’s

Self ROM
- Resident uses a strong arm to assist a weaker arm
Assisted exercise

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

Indications

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

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

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

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

Edema reduction
- Elevation
Splint program

Areas to monitor

Check skin for any signs of pressure
  – Marking, redness, discoloration or swelling

Look at all points of contact
  – Bony prominences, web space, areas below straps

Straps should allow 2 fingers to pass between strap and skin (or stockinet)
Demonstrating Clinical Competencies

Show Me!

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

Functional Mobility

Mrs. Connelly - an orthopedic case study
Functional Mobility -- Ortho
Objectives/Standards

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

- Demonstrate safe transfers
- Demonstrate appropriate use of assistive devices
- Demonstrate assisted ambulation with device and weight bearing limits
Basic rules of body mechanics

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

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

Abdominal aortic aneurysm
Severe heart or breathing problems
Gait belt Precautions

PEG tubes
Colostomy bags
Recent abdominal surgery
Recent back surgery or fractures
Recent rib fractures
Heart or breathing problems
Gait belts
Hands on assistance

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

Descriptions of a resident’s ability to perform a task:

- Independent
- Set-up assist
- Supervised
- Contact guard

- Min assist
- Mod assist
- Max assist
- Total assist/dependent
Positioning of residents

**Do’s**

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

Don’ts

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

Pressure
Friction
Sheer
Moisture
Incontinence
Immobility
Nutrition
Major Pressure Areas

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

Lap tray
Cushions
Upper extremity supports – slings, troughs, lap buddy
Bed positioning
Hip fractures

Total Hip Precautions must be followed at all times – everyone is responsible for these precautions:
- No hip flexion beyond 60-90 degrees
- No hip adduction
- No hip internal rotation
Positioning
Total Hip Replacement (THR)

THR Precautions -- Primarily a posterior approach:
- No hip flexion beyond 60-90 degrees
- No hip adduction
- No hip internal rotation

THR Precautions -- Anterior approach
- Restrictions are the opposite of the posterior approach
Supine positioning
THR

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

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

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

Safety
Proper set up of wheelchair
Proper alignment of resident
Footrest legrest position
Repositioning
OSHA recommends, “Manual lifting of residents be minimized in all cases and eliminated when feasible.”
Transfers
With Rehab residents

Purpose:
– Increase strength and endurance skills through practice

Candidates:
– Rehab residents who have NOT reached a plateau in their skills and are expected to improve
– Rehab residents with limited assist, CGA and/or supervised assist levels
Transfers With Non-Rehab residents

Purpose:
- Maintain and/or improve functional level of transfer

Candidates:
- Non-Rehab residents who are not expected to significantly improve in their skill level
- Non-Rehab residents with total dependent assist typically use a sling mechanical lift
- Non-Rehab residents with extensive assist level typically use a weight-bearing mechanical lift or a sling mechanical lift
Transfers
Hip fractures

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

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

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

Maximum (Max)
- Resident needs 75% or more assistance

Moderate (Mod)
- Resident needs 25-75% assistance

Minimum (Min)
- Resident needs 25% or less assistance
Ambulation Assist levels (cont’d)

Contact Guard Assist (CGA)
- Resident needs hand contact/cues/no weight bearing assistance

Stand-by/Supervised Assist (SBA/S)
- Resident needs supervision/cues/no hands on

Independent (I)
- Resident is independent with or without devices
Ambulation

Weight bearing definitions

FWB
- Full weight bearing

WBAT
- Weight bear as tolerated

PWB
- Partial weight (25-75%)

TDWB
- Touch down weight (10%)

NWB
- Non weight bearing (0%)
Ambulation
Gait sequence

With all gait patterns, sequence is:
1. Assistive device
2. Weaker leg
3. Stronger leg
Dressing techniques
Post hip surgery (THA or fracture)

Remember total hip precautions
All positions that force the head of the femur against surrounding muscles should be AVOIDED
Dress the operated leg first
Use appropriate adaptive devices
Undress the operated leg last
Adaptive devices
Ortho
- Long-handled shoe horn
- Reacher
- Dressing stick
- Sock aid
- Long-handled sponge
- Raised toilet seat
Pacing for low endurance

Identify early signs of fatigue

- Breathing – SOB, rate
- Cooperation
- Judgment
- Pace
- Balance
Demonstrating Clinical Competencies

Show Me!

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

Functional Mobility

Mr. Lowe - a neurological case study
Functional Mobility -- Neuro Objectives/Standards

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

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

Conditions that can increase tone
– Pain
– Emotion
– Noise
– Poor Positioning

Proper Positioning can reduce tone
– Increase comfort
– Increased function
Positioning and protecting Hemiplegic shoulder

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

Overhead
Lateral Chop
Pronation / Supination
Positioning
Hemiplegic resident

Bed positioning
Wheelchair positioning
Transfers
Hemiplegic or weak resident

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

One-person partial transfer
Sliding board transfer
Ambulation
Hemiplegic resident

Gait belt
Assistive device
Prescribed technique
Precautions/safety
RNP ambulation
Admission criteria

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

Decline in functional progress due to
- Pain or marked fatigue
- Change of medical condition
- Decline or change in cognition
- Decline in gait skills

Falls & need for Therapy intervention

Plateau of skills – CNA can follow
Dressing techniques
Adult hemiplegia

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

Neuro

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

Show Me!

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

Show Me!

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

“Activity strengthens. Inactivity weakens.”