

Restorative CNA Program



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Welcome!

Congratulate participants on their presence today as an example of their dedication to improving their knowledge and care of their residents

Background on certification course grant and process for design and development

Acknowledge all the people who have assisted in the process

Acknowledge all of the participant's employers/organizations who are supporting their presence here today

Introductions

- Instructors introduce self -- name, discipline (PT, OT, SLP, RN), experience in geriatrics and RNP
- Participants introduce self -- name, years as RNA/CNA/LVN/RN, place of work, what they want to learn/reason for being here today

Course overview

- Two-day format and outline
- Sign in each day
- Course evaluation (each day if possible)
- Passing criteria -- 80% passing on written post test and 100% passing on competency demonstrations
- Your responsibility to assure the instructors sign-off on your post test and competencies
- Assurance that our goal is to help you pass, but we do have the right to deny graduation
- Goal is to earn an RNA or RNPC pin (cool pins!)
- Goal is to earn the pay differential when they work in their facility as an RNA

Ground rules for participation

- Everyone participates, ask questions, get to know others
- Sing or tell a joke/story is return late from a break
- Phone off/vibrate
- It's your course, have fun!

Team breakout

- Ask the participants to count off 1-2-3. Sit with the people with the same number as you.
- Form 3 teams of 8 people each.
- It is your responsibility as a participant to complete all competency checks with your team

Leadership Keys to Success



Restorative Nursing Program

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Activity

As a team (best to break the teams in half for this activity so you have 6 teams of 4 participants each), discuss the following four questions as written on the index card (there are no right or wrong answers)

1. One thing I know for sure about the RNP is _____
2. One question I have about the RNP is _____
3. One thing that scares me about the RNP is _____
4. I think facilities with an RNP are _____

Allow 5-8 minutes to complete

Debrief results of each team's responses

Write answers for each questions on a flip chart

Use the results to guide you through the Leadership section, focusing on the class' pertinent issues.

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.

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Emphasize *NURSING* v. *Lic Therapist*

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.

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Emphasize:

- special skills that the RNA has been trained to do (vs. C.N.A)
- a better understanding of the disease process
- the importance of building relationships with the residents that will facilitate improved or maintenance of physical functioning.

Rehabilitation Definition

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

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Licensed therapist will:

- Evaluate/screen resident
- What his/her limitations are;
- What their potential is
- Treat and evaluate progress;
- Stabilize
- Train RNA in transitional skills required for individual resident;
- Discharge from skilled therapy

Scope of service

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

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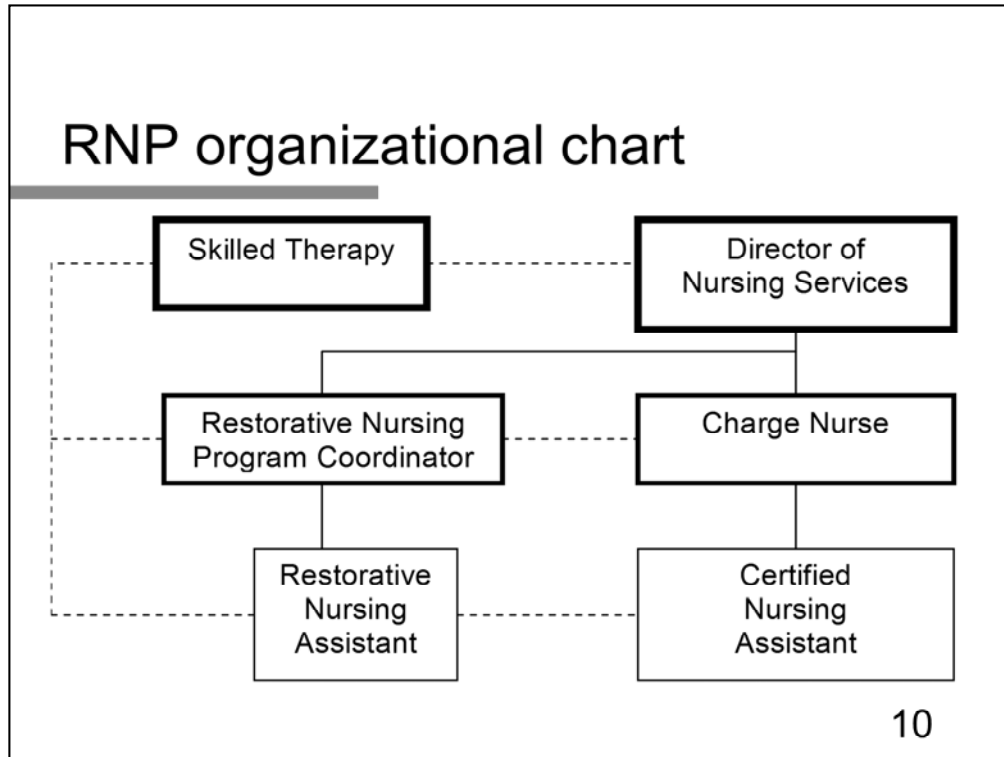
Many areas of function may be addressed by the RNP, including but not limited to the following:

Scope of service (cont'd)

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

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It is important to offer RNP services to meet the needs of your resident population and which you can manage based on staffing allocations and competencies. Add new programs as your staff demonstrates a comfort level and willingness to expand and as residents' needs change.



This is all about the TEAM. Explain direct reporting (solid lines) and indirect (solid lines) or lines of communication. Team building should start at the very beginning. Communicate elements of the programs to all staff as part of your role out plan. Practice effective communication skills. Remember you can get a lot more with honey than you can with vinegar. Do you perceive any obstacles?

Roles & responsibilities RNPC

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

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Emphasize the need for consistency and commitment.

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

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Emphasize the need for self initiative, good communication skills and organizational skills.

Referral pathways

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

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Review RNP flow chart

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.)

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A resident may be involved in more than one RNP functional areas concurrently. Frequency is dependent on resident need, motivation and outcomes.

Assessments

- **Functional skills of all residents are assessed at admission**
- **Reassessed quarterly or with decline in function**
- **Documented throughout the MDS**
 - Section P3 for RNP

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The assessments are mandated for Medicare facilities and are documented on the MDS. The MDS, section P3, is used to document resident's RNP activity. If you are a high Medicare facility you might want to review RAI regulation for further information.

Discuss Joint Mobility Assessments. A licensed nurse must oversee quarterly Joint Mobility Assessments. However, the RNA may be involved in the measurement process. Successful joint mobility management is dependent on consistent measurement practices.

RNP orders

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

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State and federal regulations are vague in the terms of whether or not physician orders should be obtained for Restorative Nursing Services. A good rule of thumb is to obtain a physician order for any service that is not routinely given to all residents. Most facilities have opted to require physician's orders to minimize their legal exposure in the event that something goes wrong and an injury occurs. You may have to input orders as part of your computerized systems for producing your documentation forms.

Caution: If an order exists for a service to be performed, it must be provided.

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

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Discuss use of referral forms that initiates care plan; Activity Record and summary

Documentation forms (cont'd)

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

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Documentation forms (cont'd)

RNP Activity Record

- RNA summarizes regularly (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

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RNP Activity Record

Example entry

- **“Resident maintained skills this week. Complained three times of lack of energy. Walked 100 feet with FWW 2/5 days. Resident follows swallow protocol when supervised at meals.”**

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Documentation process (cont'd)

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

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Licensed Nurses should review your documentation specific to activity, distance, tolerance, progress and outcomes before completing their weekly nursing notes.

Reminder to allow time to complete documentation. Set up system for Medical Records to audit completion of documentation records to assure compliance.

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

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Documentation forms (cont'd)

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

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Explain recapitulation:

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**

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Leadership Keys to Success

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

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In order to implement a successful RNP the leaders of the program must not only have the vision and commitment but also be able to motivate staff and facilitate change. There must be support from Administration and Nursing Administration. This support will improve the chances of the program's success.

The RNPC is a critical element of gaining Administration's support. The RNPC's role is to assure that Administration understand the RNP, the roles of the RNPC and the RNA and the importance of attaining resident and program goals.

Refer to Leadership and teamwork in handouts

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

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Refer to Regulation's handouts in the manual. Emphasize the importance of reviewing the regulations on their own time. If any questions ask their RNPC.

Continuous Quality Improvement (CQI)

- **Systematic approach to monitoring the success of the RNP**
- **Evaluate functional status**
- **Conduct routine chart audits**

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CQI (cont'd)

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

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Review monitor tools and management summary.

Demonstrating Clinical Competencies



Show me!

- Post Test

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Medical Overview



Restorative Nursing Program

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Medical Overview Objectives/Standards



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

Basic anatomy & physiology

- **Muscles**
- **Joints**
- **Nerves**

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Types of joints

- Hinge – knee, elbow
- Pivot – hip, shoulder

Types of movement

- Pure – flexion, extension
- Combined – functional movement (e.g., touching back of head)

Function of nervous system

- Knowing where your body is in space
- Ability to detect pain or pressure or temperature

Muscles work as a group and perform gross motor actions such as:

- Flexion
- Extension
- Rotation

Normal aging

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

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Success with aging comes with:

- Being familiar with normal changes
- Accepting these changes
- Working around these changes

Normal aging (cont'd)

■ Biological aspects

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

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Skin:

- Of primary concern is the decreased sweating and temperature control (e.g., need sweater in summer)

Skeletal:

- Osteoporosis
- Normal postural changes – head forward, shoulder/upper back hump and flat back
- Stiff joints

Muscle:

- Decreased muscle strength (18-20%) and increased body fat (40-50%) by age 80
- Anti-gravity muscles lose strength first (your “stand up” muscles)
- Remember...inactivity weakens and activity strengthens
- Think about your residents daily schedule

Nervous system:

- The slowing of reactions and motor responses can relate to falls

Senses:

- Visual changes and decreased depth perception lead to falls as well
- Auditory reactions to sound can impair communication and safety

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

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ORIF/THR

- Hardware varies between ORIF/THR
- ORIF has plate, screws, nails, etc.
- THR has ball and/or socket prosthesis (hardware)
- Pain and weight bearing limitations are characteristic of both diagnoses
- THR must follow precautions to decrease risk of hip dislocation

CVA -- Emphasize “CHARACTERISTICS”, patterns of effects:

- More than just one-sided weakness
- Depression, labile
- Pain
- Tone, spasticity
- Dysphagia
- Fear of another CVA

LEFT HEMI

- Visuo-perceptual deficits, neglect
- Lacks insight, denial, distractible, decreased attention, impulsive

RIGHT HEMI

- Language slow, cautious, jargon
- Depression (secondary to awareness of deficits)

NEURO

- A whole pattern/group of impairments

Case studies

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

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NOTE: Focus on RNP goals and RNP POC

Demonstrating Clinical Competency



**Cognition, Hearing &
Communication**

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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

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Cognitive disorders

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

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Discuss definitions of cognition, dementia, and memory.

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 from this approach
- Example: "What did you have for breakfast?"

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Cognitive disorders

Treatment techniques (cont'd)

■ Indirect

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

Cognitive Disorders

Etiology

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

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Provide examples, situations, and scenarios associated with realistic residents participants might encounter during their work day.

Etiology – diagnosis and medical conditions. Discuss reversible and irreversible as related to a variety of conditions and as they apply to the definitions.

Cognitive Disorders

Specific characteristics

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

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Provide examples, situations, and scenarios associated with realistic residents participants might encounter during their work day.

Specific characteristics – compare and contrast. General discussion comparing Parkinson and Alzheimer type characteristics.

Cognitive Disorders

Communication approaches

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

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Provide examples, situations, and scenarios associated with realistic residents participants might encounter during their work day.

Communication approaches - reversible vs. irreversible. Discuss approaches for each type.

Alzheimer disease

General guidelines

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

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Overview the Stages of Alzheimer disease.

Role play Stage 1, Stage 2 and Stage 3 of Alzheimer disease.

For example, assign one Instructor the role of the mom while the lead Instructor of this section takes on the role of the daughter. Demonstrate communication scenarios of Stage 1, 2 and 3 showing the progression of the disease process in mom and the daughter's appropriate response.

Alzheimer disease

Creating the best environment

- Turn off the TV or radio
- Use adequate lighting
- Have a positive attitude

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Alzheimer disease

Behavior characteristics

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

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Suspiciousness: each moment is new ----the first time they have seen their room

misplaced items are perceived as stolen

may perceive you as a new person they have seen for the first time causing suspicion and you may be there to harm them

Tips: don’t argue or confront the resident. Confrontation creates further agitation.

Alzheimer disease

Communication tips

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

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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

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Cueing/compensatory systems
May include direct and indirect

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

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Demonstrating Clinical Competencies



Show me!

■ Post Test

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Hearing in geriatrics

Objectives/Standards



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

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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

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Hearing in geriatrics

Suggestions for communication

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

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Hearing in geriatrics

Gestures

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

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Demonstrating Clinical Competencies



Show me!

■ Post Test

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Communication Objectives/Standards



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

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Communication

Left hemisphere problems

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

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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

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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

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Communication tips

Right CVA

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

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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

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Communication tips

Motor speech disorders

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

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Demonstrating Clinical Competencies



Show me!

■ Post Test

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Demonstrating Clinical Competency



Dysphagia & Eating

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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

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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

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Dysphagia

Common diagnosis

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

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Swallow function stages

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

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Review of the anatomy and function of a normal swallow. Emphasizing each body part and having the participants “feel” their own anatomy. i.e. pursed lips, tongue at roof of mouth during a dry swallow.

Overhead #1: Stages and anatomy

Swallow function

Normal swallow stages

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

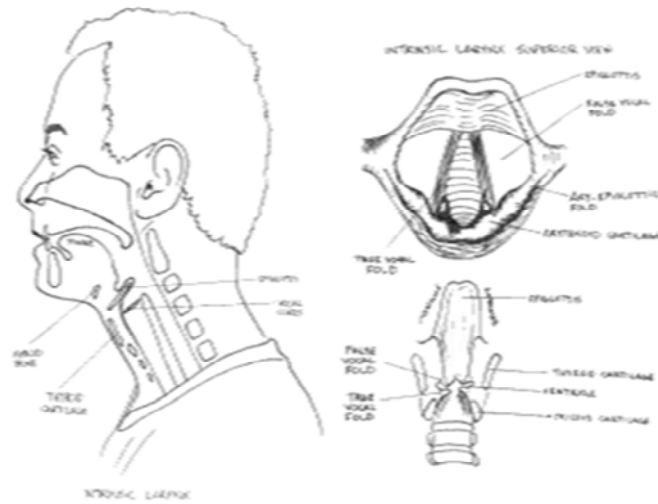
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Normal Swallow: Pass out Reese's pieces candies. (small bite size version) Two to each participant. Make sure they don't eat their candy before you are ready to provide instruction. As a group have the participants eat one candy. Walk them through the process of a normal swallow. Point out how the piece breaks apart in the mouth, falling to one side and/or between the cheek and gum. Identify how the tongue, jaw, cheeks control the bolus. Point out the difference between the soft center and the harder outside chocolate. Verbally identify where the oral structures are, how they work and feel. Lips, tongue, saliva, jaw movement, initiation of the swallow reflex, how the epiglottis is protecting the airway, laryngeal movement. Repeat, again emphasizing control, success and efficiency of a normal swallow. Also with the second try point out where potential swallow problems may exist. For example a right sided weakness may result in pocketing if that is the side of the mouth the resident's food normally fell too.

Impaired Swallow: Next pass out small powdered doughnut. As a group ask the participants to put the *entire* doughnut in their mouth. Point out the difficulties in the swallow. Lack of saliva, difficulty with chewing and jaw coordination, difficulty in breaking down the bolus and initiating the swallow. Relate these experiences to common swallow problems associated with the diagnoses reviewed earlier.

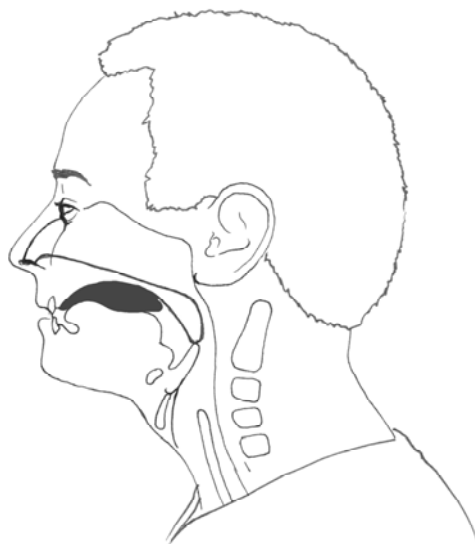
Overheads #2 & #3: Identifying bolus and anatomy positions.

Swallow function & the normal swallow



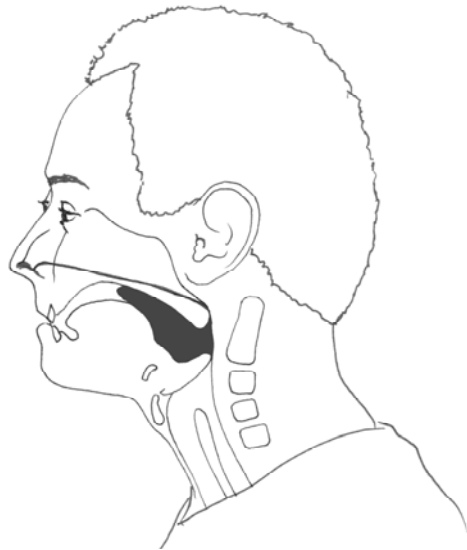
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Stage 1: Bolus in oral cavity



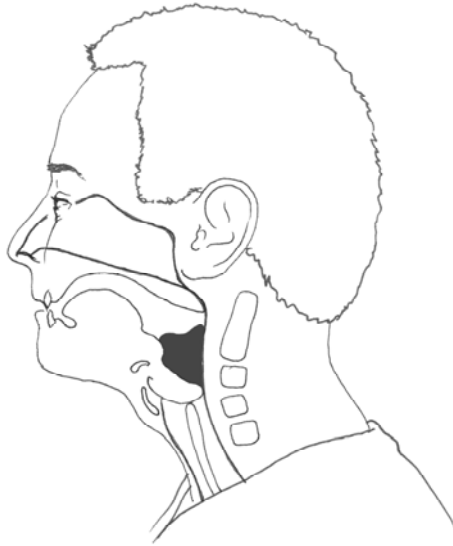
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Stage 2 : Bolus conveyed into oropharynx



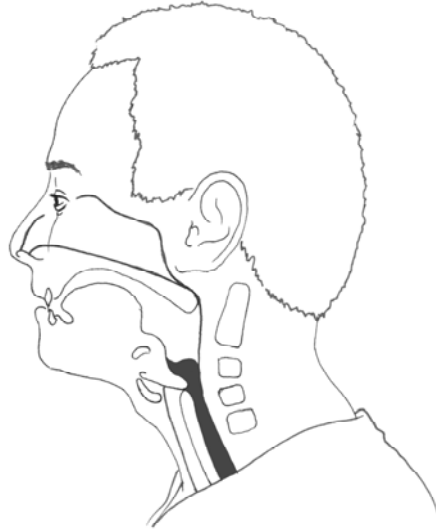
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Stage 3 : Bolus extends into the laryngopharynx



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Stage 4 : Bolus penetrates opened
pharyngoesophageal segment



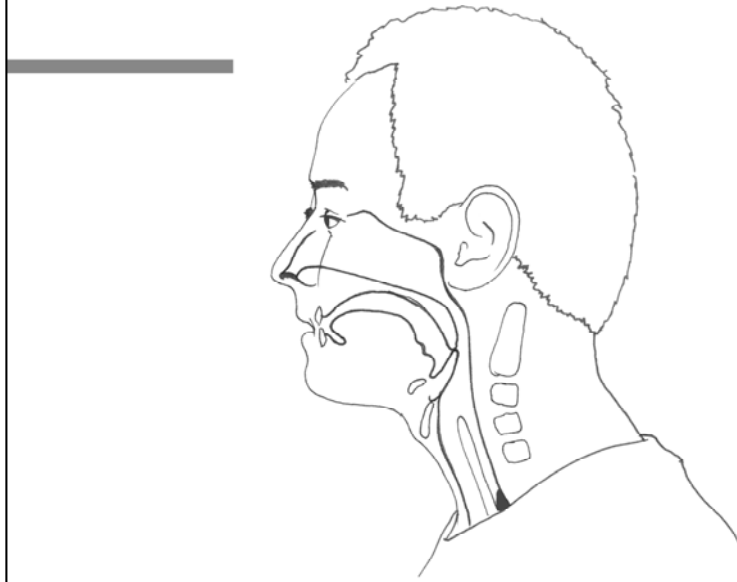
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Stage 5 : Bolus nearly transversed the pharynx



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Stage 6 : Pharynx returned to referenced position



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Swallowing

Common problems

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

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Swallow function

Eating and safety strategies

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

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Point out that these are strategies for prevention or decreasing the risk of aspiration.

Explain silent aspiration.

Emphasize that these are resident specific and are introduced only after a SLP has determined which strategies are best for that particular resident.

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**

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Emphasize 90° and positioning!

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

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Discuss who in the facility mixes the thickened liquids. Discuss importance of the kitchen doing this and never the RNA including risks, consistency and time it takes. Recommendation is pre-thickened products.

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

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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

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INTRO TO SELF-FEEDING

What is human's most essential need?

How do we celebrate?

What do we look forward to?

Adaptive equipment

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

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Self feeding

Other considerations

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

91

NOTE:

Verbally cue step-by-step prior to physical assist

Visual presentation of food may alter resident's recognition of food on plate

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

92

Clues that the patient may be losing their independence in self feeding – decrease intake, weight loss, lack of interest in food, decreased attendance to social dining,

Demonstrating Clinical Competencies



Show me!

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

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Demonstrating Clinical Competency



Joint Mobility

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Joint Mobility Objectives/Standards



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

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Joint Mobility Objectives/Standards (cont'd)



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

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Range of motion (ROM)

Purpose

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

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Muscles only strengthen if the activity is active, or resistive (as with use of Theraband, weights or pulleys).

If the motion is passive, there will not be any strengthening of muscles.

If the motion is active/assistive, there will only be minimal strengthening in the ranges where the motion is active. This is more of a motor learning activity.

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

98

Visualize that you have 4 inch long fingernails – use a palmar grasp, not a fingertip grasp.
If the patient is fearful, start on the uninvolved side first when you do ROM.
If pain meds are routine, plan around their medication schedule.

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

99

Report ANY and ALL of these signs immediately to the Charge Nurse or Therapist – don't wait several hours, days or weeks for the report.

Ask participants how they would distinguish “expected” discomfort from “extreme” pain on movement.

Define, or ask participants to define “crepitation” .

Ask for or list signs and symptoms of inflammation.

ROM

Types & definitions

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

100

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

101

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

102

Types of exercise should be determined by prescribing physician or therapist.

Use of resistance via thera-band, pulleys, cuff weights, etc. should be patient specific.

Give examples of exercises which improve balance, gait, transfers and which promote functional independence and mobility.

Give examples of exercises which decrease pain and promote well-being and improved quality of life.

Routine exercise program

Indications

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

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Discuss examples of functional versus limited strength and activity tolerance with each area of concern.

Routine exercise program Contraindications

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

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Discuss examples of functional versus limited strength and activity tolerance with each area of concern.

Splinting indications

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

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Indications

Bad odor, swelling, skin breakdown, stiffness, decreased function, difficulty feeding self, increased or new pain during care [and cleaning of the hand]

Flaccid hand s/p CVA, dementia contractures with muscle shortening, arthritis, SCI or quadriplegia

Each splint is an individualized therapy program designed to address a specific concern or problem

Hand care

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

106

Only with an order

All part of a comprehensive hand/splinting program

Soak and range - luke warm H₂O, use lotion, DRY THOROUGHLY

Review shoulder positioning in bed and wheelchair

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)**

107

Application of a splint

Check skin before application

Ensure it is clean and dry

Perform ROM or soak and range program

Inform resident what you are doing

Care of Splint – washing and drying

Storage

All areas apply with all types of splints upper and lower extremity. Should never be tight or ill fitting or too loose or difficult to apply

If it is - remove and see your therapist

See sample schedule in manual

Demonstrating Clinical Competencies



Show Me!

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

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Demonstrating Clinical Competency



Functional Mobility

Mrs. Connelly - an orthopedic case study

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Functional Mobility -- Ortho Objectives/Standards



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

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Functional Mobility -- Ortho Objectives/Standards



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

111

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**

112

Take care of your back – it's the only one you have!

Look at your own set up and positioning

Know what you are doing – what is the expected outcome/goal?

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

113

Grasping, pulling or lifting a resident by their arms is considered an “illegal” technique. The COG of the body is near the waist. When you control the COG, you have better control of how a resident’s body moves.

Gait belt

Contraindications

- **Abdominal aortic aneurysm**
- **Severe heart or breathing problems**

114

Check the chart to determine if a AAA is present.
Check with the Charge Nurse, or Therapist if in doubt.

Gait belt Precautions

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

115

Check the date of onset on surgeries – staples/sutures must be out and full wound closure must be present.

Check the date of onset of fractures – if beyond 6-8 weeks, it may be OK.

Check which ribs are fractured – if upper ribs are fx'd, it may be OK.

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

116

Putting the belt around the waist keeps your hand grips closer to the resident's COG.

Remember that the gait or transfer belt is not used to LIFT the resident but rather to control direction of movement

Levels of assistance

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

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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**

118

Position changes will increase circulation to body parts, as well as decrease pain and pressure.

Having the resident participate in position changes promotes functional strength building for the resident, in addition to giving them increased responsibility for their body.

Keeping the hips back and level in the chair is the most important component of upright positioning for all residents (except THR pt's). Once the hips are level, the rest of the body is easier to align and keep in alignment.

Always explain to the resident WHAT you are doing to avoid startle, resistive behavior and fear.

In wheelchair – ensure even foot support to facilitate even hip alignment.

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**

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If pressure reducing mattresses or chair cushions are used, short term pressure over open wounds may be permissible.

Watch out for resident's with painful/arthritis joints.

Watch out for resident's with acute fractures.

Watch out for resident's with osteoporosis.

Watch out for resident's with hemiplegic arms.

Ask your Therapist for positioning assistance.

Pressure Areas Risk factors

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

120

Always observe skin for redness or breakdown – may need to use pressure reducing devices or if under a splint, a therapist can address fit and edges

Observe for excess moisture – may need to keep area drier – check frequently.

Avoid sliding a resident's bare skin over bed linens.

Avoid letting a resident's body slide down in bed or chair by correct positioning, or more frequent position changes.

Ask your Therapist for assistance.

Major Pressure Areas

■ Most common areas of pressure

- Sacrum
- Coccyx
- Buttocks
- Heels
- Greater Trochanter - hips

121

Ask participants WHY these may be the most common

Point to areas of pressure on their body

Tube feeders are at very high risk as they are positioned in bed at 35-45 degrees placing increased pressure on the sacrum and heels with increased shear – constantly sliding down the bed, its good to raise the knees in bed

Positioning devices

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

122

These can improve functional positioning – for feeding, communication, mobility

They can provide support for joints and weak muscles s/p CVA ie leaning, slumping, dangling UE,

They can be used for safety as cues to prevent unassisted transfers

They are considered a restraint if the resident is UNABLE to remove the device independently

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

123

Many caregivers find it difficult to provide basic ADL care and follow the THR precautions. Keep the abductor pillow in place for static positioning as well as position changes – or use pillows between the legs; hips to knees.
For safety, it will often be necessary for 2 caregivers to assist with mobility.

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

124

These restrictions are ordered by the MD, and are just like a medication order. They are to be followed 24/7 until the MD changes the order – often 6-8 weeks after surgery.

Ask your therapist for assistance if you have questions.

Most CNA's follow the orders with bed positioning and wheelchair positioning BUT often make errors with shower chair positioning.

Supine positioning THR

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

125

The involved leg must be strapped in for most residents

The uninvolved leg can be left out of the straps if there are no safety issues.

If pillows are used under the legs to float the heels, make sure they are under the entire calf and knee – this prevents stress on the back of the knee.

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

126

Following the THR precautions as well as comfort are the key points of positioning. Several pillows will be needed to be positioned at the resident's back to keep them in good sidelying position.

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

127

Watch your body mechanics while you are doing this mobility.

You control the position of the involved leg – you can maintain the THR precautions.

Your arm across the resident's waist prevents them from sitting up to 90 degrees or more.

You are in control of this mobility.

Always explain to your resident what you are doing and what they can do to help.

Involving the resident helps them learn their precautions.

Wheelchair Positioning

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

128

Locking of brakes

Use of Correct positioning devices

Always transport with footrests in place – do not let feet dangle

Transfers

OSHA Guidelines 2003

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

129

When the resident sits at the edge of the bed or chair, it is easier to avoid too much hip flexion with sit<->stand.

It is best to have the resident PUSH up off the bed or chair to stand – next choice is the hand on the uninvolved side up on the walker and the involved hand on the bed or chair. Last choice with a confused patient is hands on the walker.

Use one to two caregivers to assist with the transfers, depending upon the resident's; cognition level, pain level, strength, endurance, size, other medical conditions, etc.

If 2 caregivers are needed, position one on each side of the resident.

Give CLEAR, CONCISE instructions to the resident. You may have to demonstrate the technique first for some residents.

Always follow the prescribed weight bearing status.

AVOID letting the resident pivot with transfers as this increases the risk of hip dislocation.

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

130

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Transfers With Non-Rehab residents

- **Purpose:**
 - Maintain and/or improve functional level of transfer
- **Candidates:**
 - Non-Rehab residents who are not expected to significantly improve in their skill level
 - Non-Rehab residents with total dependent assist typically use a sling mechanical lift
 - Non-Rehab residents with extensive assist level typically use a weight-bearing mechanical lift or a sling mechanical lift 131

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Always follow the prescribed weight bearing status.

AVOID letting the resident pivot with transfers as this increases the risk of hip dislocation.

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**

132

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Always follow the prescribed weight bearing status.

AVOID letting the resident pivot with transfers as this increases the risk of hip dislocation.

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

133

If it's not safe, don't do it.

If you have questions, ask.

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

134

If these signs are noted, STOP the activity and report it to your Charge Nurse or Therapist.

Do not advance an ambulation program without permission from your Therapist.

Do not let a decline in ambulation go unreported to the Therapist or Charge Nurse for more than a couple of days – this is a change of condition.

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

135

This is not a strength or skill test for the caregivers – the level of assistance given needs to reflect what the resident is capable of doing in a safe manner.

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

136

This is not a strength or skill test for the caregivers – the level of assistance given needs to reflect what the resident is capable of doing in a safe manner.

Ambulation

Weight bearing definitions

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

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Weight bearing status is determined by the Physician – it is just the same as a medication order and must be followed 24/7 until changed by the MD.

If a resident is non-compliant, for any reason, report it to the Therapist and the Charge Nurse.

Ambulation

Gait sequence

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

138

Different assistive devices for ambulation are chosen depending upon the residents strength, weight-bearing status, cognition level, balance, coordination, activity level, etc.

Do not change an assistive device for a resident without checking with the Therapist.

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

139

Review toileting – managing clothing

3in1 commode with angled seat

Whenever possible, have resident dress on edge of bed or in arm chair

Be sure shoes are on before standing to pull up on pants

Adaptive devices

Ortho

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

140

Identify and demonstrate use of each item

Pacing for low endurance

■ Identify early signs of fatigue

- Breathing – SOB, ↑ rate
- Cooperation
- Judgment
- Pace
- Balance

141

Do not rush the patient or the activity this can increase their stress, tone, mood, participation and decrease their safety and YOURS

You may be in a rush – so you may want to work on a shorter activity

Finish with success!

Demonstrating Clinical Competencies



Show Me!

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

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Demonstrating Clinical Competency



Functional Mobility

Mr. Lowe - a neurological case study

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Functional Mobility -- Neuro Objectives/Standards



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

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Functional Mobility -- Neuro Objectives/Standards



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

145

Positioning

Hemiplegic tone and spasticity

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

146

Spasticity can cause pain and be increased by pain causing a vicious cycle

Describe spasticity and increased tone – what does it feel like?

Attempting a task that is too difficult can increase muscle tone and tension.

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**

147

Often following a CVA the shoulder may become subluxed as the muscles are not able to support the shoulder joint – the shoulder is at very high risk of injury and trauma from poor handling and poor positioning. This can cause extreme pain which can even be felt in the hand [shoulder hand syndrome] and eventually cause trophic and sensory changes to occur. This pain can be expressed in behavioral changes and avoidance behavior.

Encourage vigilance in all hemiplegic upper extremity positioning and handling
Patients with neglect or decreased sensation are at even higher risk as they are not aware of their arm and what position it is in – often see patients with their arm dangling or squashed beneath them without being aware of it

Self Range of Motion

- Overhead
- Lateral Chop
- Pronation / Supination

148

Self Range is often used for patients following a CVA

The patient can monitor their own pain and level of comfort

It must be performed slowly and with care

Make sure they are set up correctly in a safe and supported position – i.e. in bed or in the wheelchair – feet supported and nothing blocking their way such as the arm rests or troughs

All will involve the hand grasp technique – interlocking fingers vs. hand grip – follow therapist instructions

Overhead can be done in sitting and lying – shoulder flexion. An alternative is in sitting and leaning forwards

Lateral Chop works on elbow flexion and shoulder adduction

Pro/Supination - good to do with the forearm supported – on a table for example

Kind of repeats the lateral chop

Elbow flexion

El

Positioning Hemiplegic resident

- **Bed positioning**
- **Wheelchair positioning**

149

Supine the patient should be central in the bed

Side lying – move patient to side of bed AWAY from the one they will be facing to provide room for their arms

Specify small pillow /support underneath shoulder blade – demonstrate

Do not place any objects up against the feet

Affected Side lying – often find less tolerance for this position, may find painful – check with therapist. Can just go with a 1/4 turn and gradually increase over time

In sitting – prevent slouching or slumping – make sure any devices – cushions or UE supports are used and applied appropriately

Transfers

OSHA Guidelines 2003

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150

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Use one to two caregivers to assist with the transfers, depending upon the resident's; cognition level, pain level, strength, endurance, size, other medical conditions, etc.

If 2 caregivers are needed, position one on each side of the resident.

Give CLEAR, CONCISE instructions to the resident. You may have to demonstrate the technique first for some residents.

Always follow the prescribed weight bearing status.

AVOID letting the resident pivot with transfers as this increases the risk of hip dislocation.

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

151

Stronger side is allowed to do the work.

Resident can work on balance during the transfer.

Caregiver doesn't lose contact with the resident's weak knee.

No pulling on the arms – thus no shoulder injury to the resident.

Both caregiver and resident squat together as a resident sits.

Transfers

- One-person partial transfer
- Sliding board transfer

152

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Ambulation Hemiplegic resident

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

153

Increased activity tolerance = increased distance ambulated or less time needed to walk a specific distance.

Improved gait pattern = better balance, improved stride/step length, straighter path and improved foot clearance.

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**

154

Increased activity tolerance = increased distance ambulated or less time needed to walk a specific distance.

Improved gait pattern = better balance, improved stride/step length, straighter path and improved foot clearance.

RNP ambulation Discharge criteria

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

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Remember...always check with your Therapist or Charge Nurse before d/c of a program.
Always discuss any changes with your Therapist or Charge Nurse.

Dressing techniques

Adult hemiplegia

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

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Often called hemi technique or one handed techniques

Sit EOB or in wheelchair – often helpful to remove the armrests and sit forward in the chair but make sure they have sitting balance

Place yourself on the affected side to respond quickly to changes of position, leaning or LOB

Also can cue to side of neglect and provide support to affected UE

Only very high level patients will be able to complete activities in standing – make sure this is cleared by the therapist

To pull up pants can complete in supine with rolling, or stand with assist and the FWW and assist to pull up pants

Be sure shoes are on before standing to pull up pants.

Adaptive devices

Neuro

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

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Identify and demonstrate use of each item

Demonstrating Clinical Competencies



Show Me!

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

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Demonstrating Clinical Competencies



Show Me!

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

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Remember....



**“Activity strengthens.
Inactivity weakens.”**

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