The Long-Term Care

Nursing Assistant’s Guide to Advanced Restorative Skills

Barbara Acello, MS, RN
THE LONG-TERM CARE

Nursing Assistant’s Guide to Advanced Restorative Skills

Barbara Acello, MS, RN
# Contents

**Chapter 1: Introduction to Restorative Nursing** .............................................................. 1  
- History of Restorative Nursing Care .................................................................................. 1  
- Independence ....................................................................................................................... 2  
- Long-Term Care Facility Resident Profile in the 21st Century .............................................. 3  
- Interdisciplinary Team .......................................................................................................... 3  
- Introduction to Restorative Nursing Care ........................................................................... 7  
- Complications from Immobility .......................................................................................... 9  
- Declines ................................................................................................................................ 12  
- Responsibilities and Essential Skills of the RNA ............................................................... 12  
- Motivation ............................................................................................................................. 13  
- Principles of Restoration ...................................................................................................... 14  
- Task Analysis ....................................................................................................................... 15  
- Purpose of Restorative Goals .............................................................................................. 17  
- Residents with Cognitive Impairment .................................................................................. 22  
- Early and Late Loss ADLs .................................................................................................... 23  
- Steps to Success .................................................................................................................. 23  

**Chapter 2: Applying Evidence-Based Practice and Critical Thinking in Restorative Care** ........................................................................................................................................... 27  
- Evidence-Based Practices ................................................................................................... 27  
- Critical Thinking .................................................................................................................. 27  
- Risk for Worker Injury ......................................................................................................... 28  
- Sensory Problems ............................................................................................................... 31  
- Ergonomics ............................................................................................................................ 32  
- Techniques of Body Mechanics .......................................................................................... 33
Chapter 3: Musculoskeletal and Nervous Systems, Part 1: General Conditioning .... 39

Area Procedural Guidelines ................................................................. 39
Progressive Mobility ........................................................................ 40
Paralysis ............................................................................................ 40
Contractures ....................................................................................... 41
Splinting ........................................................................................... 43
Other Treatments .............................................................................. 47
Therapeutic Exercises ..................................................................... 47
ROM Exercises ................................................................................ 50
AROM Exercises ............................................................................. 52
Passive ROM Exercises .................................................................. 56
Isometric Exercises .......................................................................... 59
Stretching ......................................................................................... 60
Muscle Strengthening ..................................................................... 62
Active Individual or Group Exercise ................................................. 68
Exercising for Fun ........................................................................... 68
The Importance of Distractions ........................................................ 69
Gross Motor Exercises ................................................................... 69
Fine Motor Exercises ...................................................................... 70

Chapter 4: Musculoskeletal and Nervous Systems, Part 2: Bed Mobility ............... 73

Progressive Mobility ........................................................................ 73
Moving and Positioning Bedfast Residents ....................................... 73
Bed Mobility .................................................................................... 82
Equipment and Devices Associated with Bed Mobility ...................... 86
The Bedfast Resident ....................................................................... 91
Foot Care ........................................................................................ 93
Restorative Care for Residents After Hip Surgery ................................. 95
Traction ............................................................................................ 99
The Next Step ................................................................................ 102
  Resident Transfers .................................................................................................................. 103
  Levels of Lift/Transfer/Repositioning Tasks .................................................................................. 104
  Legal Concerns .......................................................................................................................... 105
  Manual Resident Handling .......................................................................................................... 106
  Importance of Positioning the Wheels .......................................................................................... 109
  The 90-90-90 Position .................................................................................................................. 110
  Pressure Ulcers in Chairfast Residents ...................................................................................... 111
  Transfer Belt/Gait Belt ................................................................................................................. 114
  Assistive Devices ......................................................................................................................... 117
  Transfer Procedures ..................................................................................................................... 121
  Lifting Residents ........................................................................................................................ 131

Chapter 6: Wheelchair Mobility .................................................................................................. 133
  Wheelchairs ....................................................................................................................................... 133
  Wheelchair Evaluation ................................................................................................................... 135
  Measuring Wheelchairs to Fit Residents .................................................................................... 138
  Optional Accessories ................................................................................................................... 138
  Wheelchair to Car Transfers ......................................................................................................... 146
  Wheelchair-Free Facilities ............................................................................................................. 148

Chapter 7: Ambulation .................................................................................................................. 149
  Ambulation and Gait ........................................................................................................................ 149
  Balance .......................................................................................................................................... 150
  Progressive Ambulation ............................................................................................................... 152
  Orthoses ......................................................................................................................................... 155
  Amputations ................................................................................................................................. 158
  Weight Bearing ........................................................................................................................... 160
  Clinical Information Alert ............................................................................................................ 161
  Ambulation Assistive Devices ...................................................................................................... 161

Chapter 8: Introduction to Pain Management in the Long-Term Care Facility .......... 171
  Introduction to Pain ...................................................................................................................... 171
  Definitions Associated with Pain in Long-Term Care Residents .............................................. 171
Identifying and Managing Pain in Elderly Persons .......................................................... 172
Effects and Results of Pain ............................................................................................... 173
Other Barriers to Pain Identification and Management .................................................. 174
Pain Management Plan ..................................................................................................... 176
Using a Pain Assessment Scale ....................................................................................... 176
Nursing Comfort Measures and Other Potential Care Plan Interventions ....................... 177

Chapter 9: Restorative Fluid Balance and Bowel and Bladder Management .......... 183

Bladder Management ....................................................................................................... 183
Beginning a Continence Management Program ............................................................... 183
Incontinence Assessment ................................................................................................... 183
Management Options ....................................................................................................... 185
The Management Plan ...................................................................................................... 185
Residents with Catheters ................................................................................................. 189
Residual ............................................................................................................................. 190
Other Strategies ................................................................................................................ 190
Importance of Fluids in Bowel and Bladder Management ............................................... 192
Bowel Management ......................................................................................................... 192
Evaluation .......................................................................................................................... 193
Intestinal Ostomies .......................................................................................................... 194

Chapter 10: Pressure Ulcers and Other Skin Conditions ............................................. 195

Pressure Ulcers ............................................................................................................... 195
Staging Pressure Ulcers ................................................................................................... 197
Skin Tears ........................................................................................................................ 198
Caring for Wounds ........................................................................................................... 200
Lice and Scabies ............................................................................................................. 203

Chapter 11: Restorative Care in Bathing, Personal Hygiene, Dressing, and Grooming .......................................................... 207

Activities of Daily Living ................................................................................................. 207
The Resident’s Shoes ....................................................................................................... 210
Restorative Bathing ......................................................................................................... 212
Restorative Grooming Programs ................................................................. 214
Restorative Dressing Programs .................................................................. 216
Lack of Progress ...................................................................................... 220

Chapter 12: Restorative Meal Service and Dining ...................................... 221
Meal Service ............................................................................................ 221
Ambulation and Restorative Dining .......................................................... 222
Restorative Meal Service .......................................................................... 224
The Restorative Dining Program ............................................................... 225
Neuromuscular Diseases .......................................................................... 229
Restorative Feeding Retraining ................................................................. 232
Residents with Dysphagia ....................................................................... 234

Chapter 13: Restorative Nursing Care of Residents with Cardiac or Respiratory Conditions ................................................................. 243
Basic Human Needs .................................................................................. 243
Caring for Residents with Common Cardiopulmonary Disorders .............. 244
Monitoring the Resident .......................................................................... 245
Oxygen ..................................................................................................... 248
Breathing Treatments .............................................................................. 250
Suctioning ............................................................................................... 254

Chapter 14: Restorative Nursing Care of Residents with Sensory Problems ................................................................. 257
Sensory Problems .................................................................................... 257
Communication ........................................................................................ 257
Residents with Visual Problems ............................................................... 258
Caring for a Resident with an Artificial Eye ............................................... 260
Assisting Residents with Hearing Loss .................................................... 261
Communicating with Residents Who Have Problems Speaking ................ 265
Residents with Cerebrovascular Accident .............................................. 266
Sensory Stimulation ............................................................................... 275
Sensory Processing Disorder ................................................................... 276
Heat and Cold Treatments ..................................................................... 277
Chapter 15: Restorative Documentation ................................................................. 281
  Documentation Standards .......................................................................................... 281
  Minimum Documentation Requirements ...................................................................... 281
  Documentation Policies and Procedures ................................................................. 284
  Restorative and Nursing Assistant Care Plan Documentation Format .................... 289
  Additional Documentation Concerns ......................................................................... 290
  Documentation Standards to Support Services ...................................................... 293
  Payment for Restorative Nursing Care .................................................................... 294
CD-ROM Contents

Advanced
- Blood Glucose Information
- Procedure for Adding Sterile Objects to a Sterile Field
- Procedure for Applying and Removing Sterile Gloves
- Procedure for Changing a Sterile Dressing
- Procedure for Creating a Sterile Field
- Procedure for Finger Stick Blood Glucose
- Procedure for the Hemoccult Slide Test
- Procedure for Inserting a Urinary Catheter
- Procedure for Removing an Indwelling Catheter
- Guidelines for Sterile Procedures
- Wound Drainage Definitions
- Moist Heat (Hydrocollator) Packs
- Paraffin Treatment

Certificate of Completion
- Form: Certificate of Achievement
- Form: Certificate of Attendance
- Form: Certificate of Attendance

Miscellaneous
- Form: Fall Prevention Plan of Care
- Patterns for Restorative Equipment
- Resource List of URLs
- Form: Walking Rounds Resident Audit Form
- Form: Wandering Resident Safety Flow Sheet
- Form: Survey Observation Form
- Stories and Videos That Make a Point
- *The Velveteen Rabbit*

Chapter 1
- Restorative Nursing Requirements Overview
- Form: Task Analysis (Blank form)
- Example Restorative Nursing Assistant Job Description
- Environmental Factors to Consider to Reduce the Risk of Illness and Injury
- The Grieving Process
- History of Restorative Nursing Care
- Restorative Program Structure
- Responsibilities and Essential Skills of the Restorative Nursing Assistant
- Steps for a Successful Restorative Program
- Comparison of Rehabilitation and Restorative Nursing
- Functional Activity
Chapter 2

Adverse Effects of Noise
Techniques of Body Mechanics
Form: MDS ADL Section (Version 3.0)
Instructions for MDS ADL Section (Version 3.0)

Chapter 3

Degree Measurements in Restorative Nursing
The Goniometer
Disinfecting the Permanent Whirlpool Tub
Guidelines for Culturing the Whirlpool
Disinfecting the Hubbard Tank, Low Boy, or Extremity Whirlpools: Guidelines for Disinfecting a Portable Whirlpool Tub
Procedure for a Therapeutic Whirlpool Treatment
The Story About Culturing the Whirlpool
Guidelines for Whirlpool Therapy
Whirlpool Safety Precautions
Form: Hydrotherapy Equipment Log
Procedure for Active Group Exercises
Residents with Post-Polio Syndrome
Range of Motion Terminology
Sequence for Joint Range of Motion
Nintendo® Wii™ Precautions
Is the Intervention a Physical Restraint?
Form: Restorative Exercise Program Courtesy of Our Island Home
Form: Range of Motion (Estimation/Screening) Form
Side Rail Safety
Pattern for a Wii Cabinet Courtesy of Erane T. Allen, MPA, RN, CDONA, CNHA

Chapter 4

Basic Body Positions
Hip Precautions
Form: Bed Mobility Task Analysis
Example Progressive Mobility Program
Positioning Residents
Procedure for Applying a Footboard
Procedure for Applying a Hip Abduction Pillow
Procedure for Continuous Passive Motion
Procedure for Making the Bed for Residents in Traction
Procedure for Palm Cones and Hand Rolls
Procedure for the Semi-prone Position
Procedure for the Semi-supine Position
Procedure for Setting up a Trapeze using a Claw-Type Basic Frame
Procedure for Supporting the Femur with a Trochanter Roll
Prone Position Padding (Bridging)

Chapter 5

Assisted Transfers
Lifting Residents
Mechanical Lifts
Procedure for Transferring a Resident Using a Mechanical Lift
Factors to Consider When Selecting a Lift
Mechanical Lift Preventive Maintenance Checklist
Mechanical Lift Competency Check
Mechanical Lift Dos and Don’ts
Mechanical Lift Suggestions
Mechanical Lift Troubleshooting
Mechanical Lift Sling Considerations
Risk Factors to Consider During Mechanical Lift Assessment
Sit to Stand Lift Competency Check
Recommended Levels of Assistance Bed to Chair/Wheelchair/Commode Transfers
Assessment for Safe Resident Handling and Movement
Decision Trees for Identifying Problems and Implementing Solutions for Resident Lifting and Repositioning
  - Transfer to and from: Bed to Chair, Chair to Toilet, Chair to Chair, or Car to Chair
  - Lateral Transfer to and from: Bed to Stretcher, Trolley
  - Transfer to and from: Chair to Stretcher
  - Reposition in Bed: Side to Side, Up in Bed
  - Reposition in Chair: Wheelchair and Dependency Chair
  - Transfer a Patient Up from the Floor
Bariatric Resident Moving Decision Trees
  - Bariatric Transfer to and from: Bed to Chair, Chair to Toilet, Chair to Chair
  - Bariatric Lateral Transfer to and from: Bed to Stretcher, Trolley
  - Bariatric Reposition in Bed: Side to Side, Up in Bed
  - Bariatric Reposition in Chair: Wheelchair and Dependency Chair
  - Bariatric Patient Handling Tasks Requiring Access to Body Parts (Limb, Abdominal Mass, Gluteal Area)
  - Bariatric Transporting (Stretcher)
  - Toileting Tasks for the Bariatric Patient

Chapter 6
  - Power Chair Safety Screen
  - Positioning for Wheelchair Measurement
  - Form: Wheelchair Task Analysis
  - Transporting Long-term Care Facility Residents in Wheelchairs by Bus or Van
  - Wheelchair Safety Check
  - Standard Wheelchair Sizes
  - Wheelchair Maintenance

Chapter 7
  - Above the Knee Stump Bandaging
  - Below the Knee Stump Bandaging
  - Wrapping a Bandage
  - Above the Knee Amputation (AKA) Exercises
  - Procedure for Ambulating a Resident with Crutches
  - Procedure for Applying an Arm Sling
  - Procedure for Caring for a Resident with a Cast
  - Procedure for Applying an Elastic Bandage
  - Risk Factors for Falls
  - Selecting Assistive Ambulation Devices
  - Weight Bearing Terminology

Chapter 8
  - Nursing Comfort Measures and Care Plan Interventions
  - Procedure for Giving a Backrub
  - Nursing Comfort Measures and Care Plan Interventions
  - Forms: Pain Scales

Chapter 9
  - Caring for Residents with Intestinal Ostomies
  - Myths and Facts About Incontinence
  - Types of Urinary Incontinence Seen in Adults
  - Form: Assessment for Bowel and Bladder Management Programs
  - Form: Initial Incontinence Evaluation Voiding Pattern Assessment
  - Form: Admission Bladder Assessment

Chapter 10
  - Facts About Head Lice
  - Guidelines for Treating Head Lice
  - Pressure Ulcer Definitions
CD-ROM Contents

Care Plan Approaches for Pressure Ulcer Prevention
Bridging
Infection Control Precautions for Dressing Changes, Clean Procedures, and Using the Treatment Cart
Guidelines for Removing a Soiled Dressing
Guidelines for Cleansing and Observing a Wound
Wrapping a Bandage

Chapter 11

Adaptive/Assistive Devices for Hygiene, Dressing, and Grooming
Form: Bathing Task Analysis
Levels of Bathing Assistance
MDS Definitions for Bathing
Bathing Performance and Support Needed
Form: Dressing and Undressing Task Analysis
Form: Handwashing Task Analysis
Form: Showering Task Analysis
Form: Toothbrushing Task Analysis
Form: Seven-Day Resident Self-Ability Evaluation

Chapter 12

Form: Restorative Dining Evaluation
Assistive/Adaptive Eating Utensils
Care Plan Approaches for Dysphagia
Dysphagia Facts
Establishing and Managing the Feeding Retraining Program
Policy and Procedure for Thickened Liquids
The Restorative Dining Program
Form: Feeding Task Analysis
Special 1:1 Mealtime Assistance

Chapter 13

Guidelines for Oxygen Safety
Procedure for Setting Up an Oxygen Cylinder
Procedure for Administering Oxygen Through a Nasal Cannula
Discontinuing an Oxygen Cylinder
Procedure for a Small-Volume Nebulizer

Chapter 14

Animal Assisted Therapy
Types and Causes of Stroke
Special Problems of Residents with CVA
Characteristics of Right and Left Hemiparesis
Approaches to Use When Caring for Residents with CVA
Approaches to Use with Memory and Behavior Problems in Residents with CVA
Predicting Stroke and TIA Risk
Suggestions for Assisting Residents with Multiple Sclerosis with ADLs
Suggestions for Assisting Residents with Parkinson’s Disease with ADLs
Guidelines for Care of the Resident with ALS
Nursing Care for Residents with Huntington’s Disease
Common Terms Associated with Paralysis
Procedure for Caring for the Eye Socket and Artificial Eye
Residents Who Have Problems with Speech and/or Understanding
Terms Related to Speech and Understanding
Guidelines for Communicating with Residents with Disabilities
Guidelines for Caring for a Resident with a Hearing Aid
Music Therapy
Music and Singing
Therapeutic Activities
Procedures for Cold Treatments
Procedures for Heat Treatments

Chapter 15

Abbreviations Used in Rehabilitation and Restorative Care
Definitions to Use in Summary and Restorative Nursing Charting
MDS Definitions
Type of Assistance Provided with ADLs
General Restorative Summary Information
Physical Therapy Terms
Form: Seven-Day Resident Self-Ability Evaluation
Form: Activities of Daily Living Daily Flow Sheet
Form: ADL Data Tracking Tool by Shift
Form: ADL Flow Sheet
Form: Restorative Nursing Flow Sheet
Form: Restorative Care Plan Courtesy of Our Island Home
Form: Nursing Assistant Care Plan (Front Side)
Form: Nursing Assistant Care Plan (Back Side)
Form: Restorative Nursing Assistant Care Plan (Front Side)
Form: Restorative Nursing Assistant Care Plan (Back Side)
Form: Nursing Restorative Program Individual Program Plan of Care
Form: Master Signature Log
Form: Nursing Assistant Communication Log
Form: Restorative Nursing Record
Form: Restorative Nursing Weekly Record
Form: Nursing Restorative Care Program
Form: Restorative Nursing Transfer and Referral Form
Form: Task Analysis (Blank Form)
The Long-Term Care Nursing Assistant’s Guide to Advanced Restorative Skills

Introduction and Definitions

The federal government defines restorative nursing as “nursing interventions that promote the resident’s ability to adapt and adjust to living as independently and safely as possible. This concept focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.”

Restorative nursing does not require a physician’s order, but there are times when physicians will order restorative care, as well as times when the nurse will request an order because of a special situation or resident condition. Residents may enter restorative nursing programs:

- After discharge from physical, occupational, or speech rehabilitation therapy
- Upon admission to the facility with restorative needs, but the resident is not a candidate for therapy
- When a restorative need arises during the course of a custodial stay

Restorative care is a nursing program. The scope of restorative nursing assistant (RNA) practice varies markedly from one state to another and from one facility to the next. There is no universal curriculum, job description, or scope of practice. Your supervisor will guide you in your role and responsibilities, the laws in your state, and facility policies.

Titles and Semantics

This book is written for experienced nursing assistants. This writer has great admiration for the work you do. Each state seems to have its own title or designation for nursing assistants. Using a number of different abbreviations to refer to nursing assistants is too confusing. For purposes of this book, nursing assistants are those who have completed an approved nursing assistant course and passed the state test. They are referred to as certified nursing assistants (CNA) in this book.
The restorative nursing assistant (RNA) has been trained in restorative nursing by taking an additional class and/or has completed on-the-job training. His or her instructor has verified that the RNA is proficient in certain skills used in the provision of restorative care. This caregiver is called an RNA in your book. Since restorative is a nursing program, this book refers to the restorative nurse as the supervisor.

There are also many names used to refer to the recipients of care. Restorative nursing can be given in any setting. It is required by law in long-term care facilities. The 16,100+ facilities in the United States are the largest single group of providers. This book is written to meet the needs of these facilities and their workers. Because of this, your book refers to the recipients of care as residents.

**Scope of Practice**

The users of this book are experienced nursing assistants and restorative assistants. The basic nursing assistant class provides a wealth of basic restorative nursing information. Those who provide restorative care are advanced-level caregivers. With few exceptions, material you learned in your CNA class has not been included in this book, so we can focus on the more advanced skills that will be part of RNA practice. However, with 50 states and 16,100+ facilities, the scope of practice varies markedly.

All nursing assistants should provide basic restorative care. The problem is that some procedures are very time-consuming, and many require more advanced knowledge and skills that are not taught in the nursing assistant class. In some facilities, all nursing assistants are given additional restorative education, so the entire staff is RNA qualified. This is an ideal situation, but due to turnover, few facilities can maintain a full staff of RNAs. Because of this, facilities often have dedicated restorative assistants who provide restorative care 100% of the time. They do not carry a regular assignment. The procedures they provide are nursing procedures that do not fall under the auspices of therapy. These are the focus of this book.

In some facilities, the RNAs work with both therapy and nursing staff. They use the basic and advanced restorative skills they learned in both their nursing assistant and RNA classes. When they are working in the nursing department, they provide restorative nursing care. When they work under the supervision of the therapy department, the care provided is not considered to be part of the restorative nursing program.

Everything in this book is being done by RNAs somewhere in the United States. If a procedure does not apply to your facility, skip it. You will find a great deal of information that is relevant. If you need to review basic restorative procedures, refer to your nursing assistant book. We have also placed some of the important basic procedures on the Web site to accompany your book.
One goal of this book is to provide CNAs and RNAs with a handbook that can be read at home or used at work as a reference for needed information. This material could easily fill 1,000 pages, but a book of this size would be too large and heavy to be practical. Because of this, your print book contains only essential material. HCPro, Inc., has created a Web site for information and supplemental materials you may need, and there are many. You may print the online information for reference.

Acknowledgments

I am sincerely grateful for the cooperation of my colleagues:

- Erane T. Allen, MPA, RN, CDONA, CNHA
- Gail H. Ellis, RN C
- Jeni Gipson, NA RN MEd RNC
- Ken Reynolds, FACHCA, CNHA
- Steve Warren, Skil-Care Corporation

Adrienne Trivers, managing editor at HCPro, Inc., is careful and conscientious, and has given much of herself to bring this project to fruition. I sincerely appreciate her cooperation, assistance, and commitment to ensuring the book you hold in your hands is of high quality. Many unnamed individuals at HCPro handle the manuscript as it makes its way through the production process. Each makes a contribution that ultimately enhances the value of the book, and I sincerely appreciate their efforts.

Good luck with your mission to provide quality restorative care. Nothing worthwhile is ever easy. I sincerely admire those who work in the difficult financial and regulatory environment we call long-term care. I believe in you, admire your commitment, and sincerely hope this information is useful to you. Please feel free to contact me through HCPro or by e-mail if you have questions or comments.

Barbara Acello

bacello@spamcop.net
 Disclaimer

The authors, editor, and publisher have done everything possible to ensure that this book is current, accurate, and in compliance with the standards of care. The authors, editor, and publisher are not responsible for errors or omissions or for consequences from application of the book, and make no warranty, expressed or implied, in regard to the contents of the book. The practices described in this book should be applied in accordance with professional standards and the individual circumstances that apply to each resident encounter and situation.
History of Restorative Nursing Care

The care you give involves both art and science. Restorative nursing provides a good example of how science and art converge. Restorative nursing care is holistic care. In this model of care, the facility views its residents as individuals for whom quality of life and quality of care are necessary and important. Each resident is a functioning whole, even if some parts do not work properly. The care should be well balanced and consider each resident’s physical, mental, emotional, social, spiritual, psychological, and environmental needs. Holistic care helps residents attain and maintain the highest level of health and well-being possible.

Nurses who made a difference

As an art, restorative nursing is about 65 years old, but for many years there was no formal name for this type of care, and restorative practices were not considered different from other nursing care. In the 1940s, Sister Elizabeth Kenny, an Australian nurse, first introduced restorative nursing practices in the United States as a treatment for polio. Many of her practices formed the foundation of restorative care that we use today. In 1968, Vera McIver, a Canadian nurse, gave us the name “restorative care.” McIver changed the course of nursing home care from clinical to residential. In doing so, she provided an example of how to improve quality of life in a long-term care setting. She never rested on her laurels; throughout her career, she studied and fine-tuned her restorative philosophy and practices. We owe her a debt of gratitude for beginning the trends that lead to holistic care, a homelike facility environment, and many of the principles of a movement that we know today as culture change.

For a more complete history of restorative nursing, see your CD-ROM.
Independence

The dictionary defines “independent” as “not subject to control by others, not requiring or relying on someone else (as for care or livelihood).” However, independence is relative. Being “self-sufficient” may be a better definition because we all depend on others for some things. People who are independent can move about at will and care for themselves. Independence is also a state of mind that involves being free to do what we want, when we want, within the confines of personal ethics and the law. Independence is intangible, and most people take it for granted. Loss of independence can be devastating. When such a loss occurs, independence suddenly becomes very tangible, and its absence is tremendous.

Loss of independence is associated with many conditions, such as trauma, chronic disease, reduced mobility, skin breakdown, and contractures. Newly disabled residents may be ashamed to call for help. Some are in denial about their abilities and thus continually create safety risks. Some will try using mind over matter to make their bodies respond the way they did previously. When they fail, the frustration is overwhelming.

Restorative care enhances self-image and self-esteem, promotes independence, enhances dignity, improves confidence and mood, and reduces dependency and the level of care required. Additional benefits are determined by the nature of the program and may include reduced risk of complications of immobility and reduced risk of injury. In most situations, the program also pays off in reduced workload for the caregivers. There is a wealth of positive evidence that restorative care works! Being a restorative nursing assistant (RNA) is the toughest job you’ll ever love in which you are doing the impossible each day. Begin by doing what is necessary, then what is possible, and suddenly you will find you are doing the impossible.

The grieving process

You learned about the grieving process when you studied death and dying, but it applies to any major loss. For example, residents and families might grieve because of disability, loss of independence, loss of control, and admission to the long-term care facility. Grieving affects rehabilitation and safety. Some residents are in denial and use poor safety judgment, taking risks because of anger or apathy. Some take risks to test their higher power during the bargaining stage. During the depression stage, they may say they are giving up: Rehabilitation is much too difficult. We often label residents as being “difficult” or “trying” when in fact they are grieving. Keep this in mind and try to understand that the resident is not just being difficult. Provide emotional support during grieving.
Long-Term Care Facility Resident Profile in the 21st Century

A snapshot of long-term care facility residents reveals that:

- 96% of long-term care facility residents need help with bathing
- 87% need help with dressing and grooming
- 66% require help with bed-to-chair transfers
- 66% need assistance with ambulation
- 63% need toileting assistance
- 46% require assistance with eating

Interdisciplinary Team

Today’s long-term care facilities promote wellness and focus on preventive care. The personnel in each facility work as a team to benefit the residents. The expression “It takes a village to raise a child” also applies to restorative care, because the expertise of a team of workers from many disciplines is needed to care for each resident. Team members must use good communication and follow the chain of command. A care plan lists guidelines to ensure consistency. Documentation must also be very accurate.

“Do no harm” is another old expression in healthcare. Allowing residents to develop pressure ulcers, contractures, become incontinent, and other declines is doing significant harm. Providing restorative nursing care prevents harm. It is part of what we do, who we are, and what makes us nurses and nursing assistants. Nurses depend on skilled nursing assistants to provide restorative care to the residents. Responsibilities of the restorative team members are summarized in Figure 1.1.
Restorative nurse
• A licensed nurse with education and experience in long-term care, restorative nursing, and OBRA requirements
• Coordinates and supervises the entire restorative nursing program and all participating team members (you will find an example job description on the CD-ROM accompanying your book)
• Coordinates interdisciplinary team involvement

Restorative nursing assistant (RNA)
• A certified nursing assistant who has successfully completed a formal or on-the-job (or an approved external) restorative nursing educational program and has experience in long-term care and restorative nursing
• The RNA content is not covered in depth in the basic nursing assistant class; the personnel file should contain proof of additional education, as well as a job description and competency checklist
• Acts as a resource for other team members in restorative techniques

Charge nurse
• Oversees restorative activities provided by unit personnel, such as pressure ulcer prevention, ambulation, positioning, and bowel and bladder management
• Documents restorative services provided by unit personnel
• Coordinates with personnel from other departments
• Encourages and motivates residents in restorative programs

Certified nursing assistant
• Does not have to be classified as an RNA to provide basic restorative care, such as range-of-motion exercises and procedures taught in the basic nursing assistant class
• Contributes to restorative environment on the unit
• Follows care plans and provides restorative activities, such as pressure ulcer prevention, positioning, ambulation, and bowel and bladder management
• Provides restorative care to assigned residents
• Encourages and motivates residents in restorative programs
• Documents daily care for assigned residents
• Reports observations, problems, and improvements
### Responsibilities of Restorative Team Members (cont.)

#### Feeding (nutrition) assistant
- Assists with Walk to Dine and simple restorative feeding programs
- Practices standard precautions and infection prevention techniques
- Documents daily care and food and fluid intake for assigned residents
- Reports observations, problems, and improvements

#### Physical and occupational therapist
- Acts as a consultant to the restorative program for ambulation, progressive mobility, exercise, seating, positioning, range of motion, gross motor skills, fine motor skills, feeding, activities of daily living, adaptive devices, orthotics, and splint fabrication; some specialize in additional procedures, such as advanced wound care
- Identifies resident needs for restorative nursing at the time of discharge from therapy
  - Maintenance begins when therapy ends and no functional progress is expected to occur
  - A maintenance program consists of activities, skills, techniques, and exercises that preserve the resident’s current level of function
- Recommends complementary restorative nursing programs for residents who are receiving skilled therapy services
- Teaches and in-services staff about the principles and practice of restorative nursing

#### Speech-language pathologist
- Acts as a consultant to the restorative program in both swallowing and communication disorders
- Identifies resident needs for restorative nursing at the time of discharge from therapy
- Teaches and in-services staff

#### Respiratory care practitioner
- Acts as a consultant to the restorative program related to the care of residents with disorders of the cardiopulmonary system, respirations, and sleep disorders that affect the resident’s breathing
- Consults on problems related to oxygen consumption, respiratory procedures, and needs of residents with respiratory disorders
- Identifies resident needs for restorative nursing at the time of discharge from therapy
- Teaches and provides in-services for staff
Responsibilities of Restorative Team Members (cont.)

Social services

- Acts as a consultant to the restorative program in behavior management and mental health issues
- Addresses issues such as income, family relationships, and the environment that affect restorative care
- Coordinates all discharge planning and community resources
- Teaches and provides in-services for staff

Activities

- Assists residents with programs related to grooming, homemaking skills, and similar areas of need related to preparation for discharge
- Coordinates volunteers who work with residents on one-on-one visits
  - Some states will reimburse activities provided by volunteers, such as grooming and applying makeup, if the assessment and plan of care meet the requirements, although in several states, the only recognized volunteers (for reimbursement purposes) are the resident’s own family members who have been trained by staff; group activity size is limited to four residents for every worker

Dietitian and dietary services manager

- Acts as consultants to residents by providing diabetic teaching and dietary programs and determining special dietetic needs
- Plans strategies for residents with special feeding or nutritional needs
- Ensure that adaptive feeding devices are clean and available at mealtime

Resident and family

The resident and family members of her choosing (if any) are always members of the interdisciplinary team.

Other members of the interdisciplinary team

Many individuals can participate in providing restorative care. Much depends on their willingness, talents, time available, and resident needs. Anyone with the expertise needed by a resident can participate in an assessment-based, nursing supervised program.
Variations in program delivery

Facilities structure restorative nursing programs in many different ways. In some facilities, restorative programs are separate from routine nursing care, but in most the two services are integrated in some manner. There is no right or wrong way to manage the program. Facilities are free to plan and implement a program that works for them and is accepted by the survey team. Many factors influence the facility’s selection of the type of program to use. The types of program structure are limitless.

You will find additional information on various restorative program structures on your CD-ROM.

Introduction to Restorative Nursing Care

Restorative nursing care is a philosophy of nursing care, not a specific task or different type of care. Certified nursing assistants perform many skills that are restorative in nature each day. Restorative nursing care is the use of nursing practices to help residents attain and maintain the highest level of physical, mental, and psychosocial function possible in light of their individual conditions. Restorative nursing and therapy are distinctly different services. They complement each other and do not compete. The PowerPoint slides available for download at http://tinyurl.com/ylezcd may help you understand how the services are alike and how they differ.

You will also find a comparison of restorative nursing and therapy on your CD-ROM.

Therapeutic modalities

For the most part, restorative nursing involves practices the nursing department does each day. They are not new, different, or “make work” activities. Restorative nursing is simply good nursing care. When compared with general nursing, the primary difference is that, in a formal restorative program, routine activities of daily living (ADL) are regarded as individual therapeutic modalities. They are not mixed into other care and are not new procedures. “Therapeutic” means a “treatment to cure or restore to health.” A modality is a method of treatment that is designed to make a person better. For example, surgery and chemotherapy are treatment modalities for cancer. Modalities are usually small individual parts of a more complete system of care. Thus, restorative procedures are one part of each resident’s total nursing care. Restorative procedures are treatments that maintain or improve health.
You have confidence in your ability to provide quality nursing assistant care. Placing an emphasis on restorative care is just a different way of viewing things that you do each day. This restorative focus has become increasingly important in today’s healthcare environment, in which residents have many needs and are often weak and fragile on admission.

**Effects of restorative nursing care**

As a rule, people in our culture have higher self-esteem and feel better about themselves when they are independent. They want to blend in. They do not want to be different from others. Restorative nursing care is given to restore as much independence as possible. You will teach, encourage, remind, and enable residents to practice ADL skills to maintain or improve function. Practice and repetition cement the information into the brain and body. The resident may be relearning a skill lost due to disease or injury or learning a new way of performing a skill.

Identifying risk factors is very important to providing restorative care. A risk factor is a condition that has the potential to cause a resident’s health to worsen. It does not make the condition inevitable; rather it is a red flag that complications may develop. Once the risk of developing a complication is known, nurses can plan care to reduce the risk.

Restorative approaches are used to teach the resident how to adapt his or her body to a change of function. When planning care, the nurse considers the whole person, including risk factors; needs; strengths; limitations; and physical, psychosocial, and personal problems that affect the residents’ self-care ability.

Restorative nursing care:

- Is affected by the residents’ culture and our overall culture of independence
- Is a nursing program that is planned, ordered, and supervised by nurses
  - Therapists, social workers, dietitians, and others act as consultants
- Restores or helps compensate for lost skills
- Helps meet residents’ psychosocial needs
- Reduces or eliminates risk factors
- Improves the quality of care
- Improves the quality of life
  - Quality is whatever the residents believe it to be
• Aims to eliminate restraints, catheters, and many negative factors of care
• Is given in a homelike environment
• Has both tangible and intangible benefits to residents and staff
• Is based on the holistic nursing model of care

Complications from Immobility

Immobility rapidly causes serious complications in elderly persons. Bed rest is the norm in the hospital, where staying in bed is often essential to treating medical problems. However, even in acute care hospitals, early activity and ambulation are provided whenever possible. The primary causes of immobility are:

• Pain/discomfort
• Sedentary lifestyle, such as watching television all day
• Chronic disease, such as diabetes, heart failure, and neurologic disease
• Deconditioning from using modern conveniences such as elevators, escalators, or other modern devices that reduce activity (including unnecessary wheelchair use)
• Injuries, musculoskeletal problems
• Loss of stamina and joint mobility/flexibility, overall weakness

Thanks to Vera McIver, residents can be up and dressed in street clothes each day. They are encouraged to be active and involved in community life. Any bed rest must be medically prescribed and requires a physician order. If bed rest is necessary, it is used for a limited period of time. Restorative nursing and rehabilitative care get residents moving as early as possible to prevent complications from immobility. Do all you can to keep the residents active. The systems of the human body depend on each other. One weak system will eventually affect the whole person. Use holistic care to look at the whole person and avoid isolating the care of one system from the total care of the resident.

Many restorative nursing procedures are used to keep the residents moving. The effects of immobility on body systems can be very serious. The RNA must become familiar with the complications from immobility and work to prevent them. Many of these problems are also seen in residents with pain. The complications from immobility on the various body systems are summarized in Figure 1.2.
## System Complications

### Circulatory
- Pooling of blood, reduced circulation, increased pressure on legs leading to blood clots
- Increased risk of edema
- Increased workload on heart
- Decreased blood pressure when resident gets up

### Endocrine
- Changes in utilization of food leading to increased fat stores and glucose intolerance
- Increased insulin requirements for carbohydrate metabolism
- Changes in hormone balance
- Disturbed sodium-water balance

### Gastrointestinal
- Risk for heartburn, indigestion, and aspiration due to positioning and inability to sit upright during meals and for one hour after meals.
- Loss of appetite from reduced activity, depression, boredom, and illness.
- May have impaired taste and smell due to aging changes or drugs. This further reduces pleasure of eating, increases loss of appetite, and reduces intake of fluids.
- Weight loss and malnutrition from inadequate intake of nutrients.
- Decreased peristalsis, decreased intake of fluids, and unnatural positioning for having a bowel movement using a bedpan promotes and contributes to ileus (constipation, impaction, nausea, vomiting, colic (crampy pain), dehydration, and fever, and ileus).
- Difficulty pushing to eliminate stool when lying on back.
- Digestive enzymes break down food. They will cause skin breakdown with prolonged contact with feces.

### Genitourinary
- Calcium drains from long bones, causing kidney stones and osteoporosis
- Position may cause difficulty voiding and inability to empty bladder completely
- Frequency of urination or overflow incontinence may occur
- Urine pools in bladder, increasing the risk of infection
- Skin contact with urine increases the risk of pressure ulcers

### Integumentary
- Heat, pressure, and reduced oxygenation of skin increases the risk of pressure ulcers.
- Healthy adults normally change positions approximately every 11.6 minutes during sleep. The inability to reposition independently further increases pressure ulcer risk.
- Friction and shearing during movement promotes abrasions, skin injuries, and breakdown, leading to pain, infection, and other complications.

### Muscular
- Often the first system to show the effects of immobility; reduced muscle mass, strength, and oxidative capacity.
- Muscles begin to feel stiff and sore on movement; movement progressively becomes more difficult.
- Muscles weaken and atrophy. Most prominent problems usually affect muscles associated with ambulation and upright posture.
### Complications from Immobility by Body System (cont.)

<table>
<thead>
<tr>
<th>System</th>
<th>Complications</th>
</tr>
</thead>
</table>
| **Muscular** | • Immobility and disuse of muscles in abdomen and spine combined with uncomfortable positioning and aging changes may cause low back pain.  
• Contractures may begin in as little as four days. Range of motion is lost by day 14 or 15.  
• Contractures complicate care and cause pain.  
• Contractures cause capillary occlusion at bony prominences, contributing to pressure ulcers. As much as 50% to 70% of all pressure ulcers are related to untreated contractures. |
| **Nervous** | • Weakness, loss of independence, and limited mobility may cause depression, anxiety, restlessness, irritability, boredom, apathy, disorientation, passive-aggressive verbal and nonverbal communication, mood swings, listlessness, withdrawal, social isolation, regression, altered body image, and feelings of helplessness.  
• Lack of stimulation and social isolation increases the risk of delirium and disorientation.  
• The resident may sleep during the day and be unable to sleep at night.  
• Alterations in the sleep pattern may cause dissatisfaction, disorientation, and inability to participate in therapeutic programs and care during the day. |
| **Respiratory** | • Difficulty expanding lungs fully/taking a deep breath due to position  
• Weight of chest further limits lung expansion in large residents  
• Cough weakens, reducing ability to clear secretions  
• Retained secretions remain in airway, causing collapse of alveoli  
• Ability to exchange oxygen and carbon dioxide is impaired, causing under ventilation and inadequate oxygen level in blood (hypoventilation and hypoxemia)  
• Difficulty taking a deep breath causes anxiety and may result in dyspnea  
• Blood redistribution and fluid shifts increase the risk for pulmonary edema and blood clots  
• Pooling of secretions increases the risk of pneumonia and lung infections  
• Deaths have been reported when secretions block the airway |
| **Skeletal** | • Calcium drains from long bones due to immobility  
• Immobility and decreased weight bearing cause hormone imbalances  
• Risk for osteoporosis, pathologic fractures of the vertebrae, hips, pelvis, and shoulders is increased |
| **Pain** | Pain is not a major complication of immobility. However, residents who are having unrelieved pain often remain still and immobile. Thus, most of the complications listed here are also seen in residents who are immobile due to pain. Immobility is the primary cause of the problem. Pain is the secondary cause. |
Declines

According to the long-term care facility rules, declines are not permitted unless they are medically unavoidable. If a resident starts to decline, the facility must be able to prove that care was given to prevent, slow, or delay the problem, even if the resident has a chronic disease or worsening condition. However, some problems are so routine that staff may not realize they are declines. Recognizing declines and taking prompt, aggressive action to reverse them is essential. Common declines that may not be properly recognized are:

- Pressure ulcers and skin tears
- Hip fractures and other injuries from falls
- Bowel and bladder incontinence if the resident previously had bladder control
- Using a wheelchair if the resident was previously ambulatory

Responsibilities and Essential Skills of the RNA

Each facility has job descriptions for its workers that detail skills the worker can legally do according to state licensure laws and facility policies and procedures. The RNA is a state-tested, certified, licensed, or registered nursing assistant who has received additional education in restorative nursing care and who works under the supervision of a licensed nurse. For additional information about the duties, skills, and job description of the RNA, refer to your CD-ROM. You may also wish to review the PowerPoint slides available for download at http://tinyurl.com/ylezr6d.

Information the RNA must know

- The facility’s policies and procedures for nursing assistance and restorative care
- The problems, needs, goals, and approaches on assigned residents’ restorative plan of care
- How often the residents’ procedures must be done, and the time and duration of each procedure
- Procedures and techniques for providing restorative care
- The facility’s policies, procedures, and forms for documenting restorative care
Motivation

Knowing how to motivate and reward residents is an essential part of your job. Motivation is an internal driving force that initiates and directs behavior. It is an important factor in residents’ cooperation with restorative care. Negative motivation involves doing a task out of fear of undesirable outcomes. If you use negative motivators, residents will stop the behavior. However, they’ll also stop trying. Scolding and criticizing a resident are negative motivators.

Fear is another negative motivator. For example, many residents are inactive because they fear they will fall. This is very common in elderly persons. The fear can be so overpowering that the resident will refuse to cooperate with your attempts to help them become more active. If coaxed into cooperating, the resident will not put much effort into the activity. Fear of pain is also common. Some residents will not cooperate because it hurts to do so. Other negative motivators are pressure, tension, feeling helpless or powerless, low self-esteem, loss of control, boredom, dislike of the activity, and not understanding the purpose or benefit of the activity.

Positive motivation is a means of rewarding the resident. It is human nature to repeat behavior that has been rewarded. The most common rewards are verbal, or signs of affection such as a hug. Recognition, awards, and special treats and privileges are also positive motivators. Praise is the easiest motivator to use. You can use praise to encourage the residents to try new things and continue to work at their restorative skills. However, praise only the action that you want to encourage. Don’t praise residents for the sake of praising them. Be sincere and consistent. To provide choices, control, and positive motivation, you can:

- Adapt the activity to a resident’s individual needs to provide a sense of control.
- Schedule the activity around the resident’s pain medications, television shows, or other activities.
- Adapt the way the activity is done to meet a resident’s needs.
- Provide socialization with others. Residents are much more likely to participate if there is a social component to the activity. Exercise classes and walking clubs are examples of social activities.

Feedback

Another old expression is “No feedback, no motivation.” Think about what this means. You need to learn what motivates your residents. Motivation will not occur without feedback. Define your expectations up front and provide frequent, positive feedback. Giving negative feedback motivates the residents in the
wrong direction. Having small and attainable goals and giving the residents regular feedback about their progress toward those goals helps maintain motivation.

For a successful restorative program, try to identify and consider the resident’s specific motivators. Encourage the residents and reduce negative experiences or activities the resident dislikes. Build a rapport with each resident and establish and maintain a safe and trusting relationship. Be pleasant and use humor and positive support. All of these factors will help to increase motivation and the likelihood of success. Positive motivation will help improve cooperation, functional performance, and quality of life.

**Principles of Restoration**

The restorative plan of care lists the restorative activities and how often they must be done. Each activity must be provided for at least 15 minutes per day. This can be all at one time or split into several small segments. You must document the minutes provided each day. Restorative care is usually provided as an individual (one-on-one) procedure, but can be provided in small groups of no more than four residents at a time.

**EAST**

EAST is an acronym that describes the primary principles of restoration:

- **E** = early treatment. The outcome is always better when restorative care is started early in the disease.

- **A** = activity strengthens and inactivity weakens. Your goal is to keep the resident as active as possible, considering the medical condition. Encourage the resident to be as independent as possible with each activity.

- **S** = stress what the resident can do. Avoid focusing on what the resident cannot do. Emphasizing what the resident can do is better than reminding her that she can’t do something. For example, say, “You can do this with your right hand” instead of saying “You can’t do this with your left hand.” Show the resident you are confident in her ability.

- **T** = treat the whole person. Restorative care recognizes each resident as a complex individual. Because of this, care must be personalized to the resident. Everyone has strengths and needs that cannot be isolated from the rest of the person. Consider the whole package. Build on and develop the strengths to overcome the needs. Modify the environment or break the task down into smaller steps if the resident is struggling. Keep the nurse apprised of the resident’s progress.
The restorative environment

A restorative environment is essential in long-term care facilities. The environment has been modified to care for persons with disabilities. However, some residents may need additional changes. If you believe a resident will benefit from a change in environment, inform the restorative nurse. Consider safety, factors that support independence, and barriers that prevent maximal function. For example, will the resident be more secure and have more space if you move the bed next to the wall? If a grab bar is installed next to the bed, can the resident use it to transfer independently? Take a close look at the room and ask the resident what would make his or her life easier. Often, many simple changes can be made at little to no cost to the facility.

Task Analysis

The restorative nursing assessment almost always involves completing one or more task analyses. A task analysis is an assessment of a resident’s ability to complete each step of an ADL procedure. The restorative nurse will evaluate the resident’s ability to perform each step of a procedure. For example, there are at least 14 steps in the handwashing procedure. (The number of steps varies with the form being used and the skill being evaluated; some have fewer steps than this, but others have many more.) The steps of the handwashing procedure are:

- Identifies the need to clean hands
- Goes to restroom area or other sink
- Approaches sink
- Turns on hot water
- Turns on cold water
- Adjusts water temperature
- Places hands under water
- Picks up bar of soap or dispenses liquid soap into hands
- Lathers soap on hands
- Rinses hands well
- Turns off cold water
- Turns off hot water
- Removes paper towel from dispenser or picks up cloth towel
- Disposes of used paper towel or places cloth towel in hamper or appropriate location

The nurse will rate the resident’s ability to perform each step of the procedure and:

- Determine whether the resident can sequentially complete the steps of the task analysis
  - If the resident cannot complete one step, he or she cannot complete the procedure
- Determine which steps the resident can do
- Write a restorative program beginning with the first step the resident cannot complete
  - List the instructions for the program on the care plan

As you can see, restorative care can be highly personal because of the type of assessment used. A more complete explanation of the task analysis process can be found at http://tinyurl.com/yzjx3ef.

You will also find several example task analysis forms on your CD-ROM.

After the restorative program has been written, you will:

- Begin the program with the first step the resident cannot complete.
- Keep communication open with the restorative nurse.
- Monitor the resident’s progress. When the resident masters a step, wait a day or two to be sure he or she retains the ability to do the skill before moving forward.

This process continues until the resident masters the entire procedure. If the resident cannot complete all steps in the task, you will take him or her to the highest level possible. When the resident can go no further, finish the activity. Even being partially independent enhances the resident’s self-esteem and ensures that he or she will function at the highest level possible in the situation.
Purpose of Restorative Goals

All residents will benefit from some type of restorative care, which may be given to:

- Improve residents’ condition(s)
- Maintain the residents’ current condition and prevent further declines
- Slow the rate of decline in chronic disease
- Complement a current therapy program
- Teach safety
- Address risk factors and reduce the risk that will cause complications
- Prevent new or additional complications
- Help a resident adjust to new problems or limitations
- Teach the resident a new way of performing ADL skills
- Enhance dignity and improve well-being and quality of life

Goals will be written so they are:

- Useful
- Outcome-based
- Realistic and attainable
  - Goals address things the resident can improve or resolve in a reasonable period of time
- Likely to be accomplished within 90 days
  - The nurse may break a goal into smaller pieces that are part of a larger goal (e.g., washing the forehead instead of the whole face). Setting a goal too high or making a goal too complex may overwhelm the resident.
  - Building on small steps to advance to a higher level is like assembling a puzzle one piece at a time.
- Focused on functional potential, not diagnosis or limitations
• Individualized to the resident

• Focused on strengths (i.e., they use strengths to overcome weaknesses)

• Measurable

  – Numbers are often used to make goals measurable. For example, the resident will walk 50 feet with the walker and a standby assistant. All team members can readily determine how many feet the resident walks.

  – Give the resident a reason to walk 50 feet! For example, walking to and from the dining room for meals or to the activity room for an activity are purposeful goals, whereas walking back and forth in the hallway is not.

• Important to the resident

• Based on real needs

  – Things that are important to the resident enhance quality of life.

  – Goals that help others are often very useful and enhance personal satisfaction and self-esteem, such as delivering mail, greeting visitors and asking them to sign a guest book, etc.

• Easy to understand; all staff should know exactly what the goal is

**Approaches**

The care plan will list approaches to use to reach each resident’s goals. Approaches are the things you will do when providing restorative care. Many approaches are listed sequentially on the care plan. This means they must be performed in the order written; you should not pick and choose which approaches to use. Approaches are designed to:

• Meet a need

• Enhance or promote quality of life

• Be likely to work

• Focus on the resident’s individuality

• Be in keeping with the resident’s wishes
• Be unique and specific to the resident
  – All residents should have personal goals and approaches; they should not be identical.

• Use the resident’s strengths and abilities

• Be purposeful
  – For repetitive goals, give the resident a task like shining shoes, folding towels, wrapping silverware, assembling a puzzle, or walking to activities of choice one or more times daily.

• Have input from the resident and caregivers at all levels, including nursing assistants

• List the frequency and duration of treatment (e.g., 15 minutes once a day)

• Identify potential barriers and how to manage them
  – Provide tips appropriate to the activity, such as “If the resident does not respond, do this …” or “If the resident refuses, do this …” or “If the resident says, ‘I can’t,’ do this …”

• Identify resident-specific motivational approaches and rewards

• Meet or exceed accepted standards of care and follow facility policies and procedures

• Be simple, specific, and easy to understand for both the resident and staff

• Allow enough time to complete the task

• Be done at the time of day the activity is usually done (if applicable), such as male residents shaving each morning or residents brushing their teeth before going to bed

• Be used each time the activity is done

• Give the resident as much control as possible

Common care plan approaches you will use are:

• Setup: preparing equipment and supplies

• Verbal cues: giving hints, clues, or simple commands that prompt the resident to act
  – Provide simple, brief, clear, and concise directions. Repeat each cue several times, if necessary.
  – Avoid long, multistep, or complex instructions.
– Allow enough time for the resident to respond before repeating the cue or trying another approach.
– Have an alternative plan in case the resident does not respond.

• Demonstration: motioning, using gestures, and showing the resident what you want him or her to do
  – Simultaneously, give simple verbal directions.
  – Some residents will need a demonstration for each step of the procedure; others will remember more complete directions.
  – Individualize the demonstration to the resident’s needs.
  – Repeat the demonstration several times, if necessary. People remember more of what they see than what they hear.
  – Tell the resident that you will help and provide support if he or she is anxious.

• Hand-over-hand technique: placing your hand over the resident’s hand and guiding him or her through the step or activity
  – Doing so gets the resident started and reintroduces the activity. At this point, the resident may take off on his or her own. If not, replace your hand and guide the resident through the activity.
  – Work from behind or to one side so that your hand moves in the same direction as the resident’s.
  – Respect the message if the resident pulls away. Try another approach.

• Encourage independence
  – Allow the resident to struggle a little before intervening, but never let a resident struggle to the point of frustration.
  – Encourage and praise the resident for success, even if limited. Provide emotional support.
  – When the resident can go no further, complete the activity in a matter-of-fact manner.
  – Remind the resident of his or her abilities.

Examples of restorative approaches are listed in Figure 1.3.
<table>
<thead>
<tr>
<th>Type of Assistance</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setup</td>
<td>Preparing equipment and supplies for an activity: The resident is given items needed for the task, or the items are placed on a table or other location where the resident can reach them.</td>
</tr>
<tr>
<td>Positioning</td>
<td>The resident needs positioning assistance to complete the task. Examples of this type of assistance are:</td>
</tr>
<tr>
<td></td>
<td>• Assisting the resident to sit or stand at the edge of the bed or sink</td>
</tr>
<tr>
<td></td>
<td>• Transferring the resident into a chair or wheelchair</td>
</tr>
<tr>
<td></td>
<td>• Positioning the resident in the designated location to provide supports, such as pillows or props, to assist in maintaining the position for the duration of the activity</td>
</tr>
<tr>
<td>Physical assist</td>
<td>• Helping the resident initiate a task</td>
</tr>
<tr>
<td></td>
<td>• Completing a procedure when the resident cannot do so (the care plan will specify the type of assistance to provide and number of assistants needed)</td>
</tr>
<tr>
<td>Verbal cues</td>
<td>• Simple, brief, concise directions that prompt the resident to act (these may also be called prompts, clues, or hints)</td>
</tr>
<tr>
<td>Hand-over-hand</td>
<td>• Placing your hand over the resident’s hand and guiding him or her to perform the activity</td>
</tr>
<tr>
<td>technique</td>
<td></td>
</tr>
<tr>
<td>Coaching</td>
<td>• Gently urging or encouraging the resident to perform the activity</td>
</tr>
<tr>
<td>Pacing</td>
<td>• Allowing the resident to perform the task at his or her rate of speed, without rushing</td>
</tr>
<tr>
<td></td>
<td>• Allowing the resident to rest, if needed</td>
</tr>
<tr>
<td>Giving or receiving</td>
<td>• Giving feedback is paraphrasing or acknowledging your understanding of what the resident has told you</td>
</tr>
<tr>
<td>feedback</td>
<td>• Receiving feedback is having the resident explain, demonstrate, or tell you that he or she understands your instructions</td>
</tr>
<tr>
<td>Encouragement/</td>
<td>• Providing encouragement/emotional support</td>
</tr>
<tr>
<td>support</td>
<td>• Providing positive reinforcement and praise</td>
</tr>
<tr>
<td></td>
<td>• Commenting about the resident’s progress or ability</td>
</tr>
<tr>
<td></td>
<td>• Using words to motivate the resident</td>
</tr>
<tr>
<td></td>
<td>• Having a positive attitude and giving the resident confidence that he or she can do the task</td>
</tr>
</tbody>
</table>
Residents with Cognitive Impairment

Residents do not have to be mentally alert to benefit from restorative nursing. Cognitively impaired residents may surprise you. Avoid making assumptions about these residents. They can often do many things, if given the time and direction. They can also learn new things, although it may take time. Give them a chance to show you what they can do!

At one time, reality orientation was a popular care plan intervention. However, more recent research has shown that this approach is effective only in the early or mild stages of dementia. Understanding reality is not realistic for residents with advanced dementia. The reality is yours, not theirs. Attempting to force reality on the resident may cause confusion, frustration, and worsening of behavior problems. A better approach is to try to relate to the resident’s reality.

Residents with cognitive impairment learn best through repetition. Knowing this, a restorative program may work best if repeated several times over the course of a 24-hour day. For reimbursement purposes, the resident must spend at least 15 minutes on the activity. However, if the resident is distracted or uncooperative, three five-minute sessions may work better. (This applies to a single program; do not combine minutes from separate programs.) You will find information on remotivation, validation therapy, reminiscing, and reality orientation on your CD-ROM. These additional approaches are used in the care of residents with cognitive loss.
Early and Late Loss ADLs

The RNA works with ADLs. ADL loss tends to follow a succinct pattern. Skills that are lost first are early loss ADLs. These are:

- Bathing
- Personal hygiene
- Dressing

Late loss ADLs are those that are likely to be lost last in life; by the time late loss ADLs are affected, the resident already lacks independence because of the early loss ADLs. Late loss ADLs are:

- Bed mobility
- Transfers
- Feeding/eating
- Toilet use

Steps to Success

Restorative nursing is like a set of stairs. Each step upward means the resident has gained greater proficiency in the skill. Figure 1.4 shows the steps toward restorative nursing success.
1. Know and observe what the resident can do.

2. Use assistive devices, props, and aids, if necessary.

3. Modify the environment if it makes the job easier for the resident.

4. Break the activity into a series of small, manageable pieces beginning with the first step the resident cannot do.

5. Practice the steps over and over (and over) until the resident masters them.

6. Progress upward to the next level and repeat the process.

7. When the resident is at the highest level of function, follow the plan of care and work to maintain his or her gains.

The stairs to success in restorative procedures.
References

Order your copy today!

Please fill in the title, price, order code and quantity, and add applicable shipping and tax. For price and order code, please visit [www.hcmarketplace.com](http://www.hcmarketplace.com). If you received a special offer or discount source code, please enter it below.

<table>
<thead>
<tr>
<th>Title</th>
<th>Price</th>
<th>Order Code</th>
<th>Quantity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Your order is fully covered by a 30-day, money-back guarantee.

 yöntą Enter your special Source Code here:

Name
Title
Organization
Street Address
City  | State  | ZIP
Telephone  | Fax
E-mail Address

BILLING OPTIONS:

- [ ] Bill me  [ ] Check enclosed (payable to HCPro, Inc.)  [ ] Bill my facility with PO # __________________________
- [ ] Bill my ( º one):  [ ] VISA  [ ] MasterCard  [ ] AmEx  [ ] Discover

(Required for authorization)  (Your credit card bill will reflect a charge from HCPro, Inc.)

Order online at [www.hcmarketplace.com](http://www.hcmarketplace.com)

Or if you prefer:

MAIL THE COMPLETED ORDER FORM TO: HCPro, Inc. P.O. Box 1168, Marblehead, MA 01945

CALL OUR CUSTOMER SERVICE DEPARTMENT AT: 800/650-6787

FAX THE COMPLETED ORDER FORM TO: 800/639-8511

E-MAIL: customerservice@hcpro.com

© 2008 HCPro, Inc. HCPro, Inc. is not affiliated in any way with The Joint Commission, which owns the JCAHO and Joint Commission trademarks.

Code: EBKPDF