Developing a Recreational Program for Patients in a Rural Nursing Home

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SKILLED NURSING FACILITIES (SNF) ARE REQUIRED by recent Federal Medicare regulations to have approved patient activities programs. The Anson County Hospital SNF, a nursing home in rural North Carolina that did not meet these Federal standards, was helped by the Area Health Education Centers Program (AHEC) to establish an approved program. The North Carolina AHEC Program contacted a consultant to work with the home. Patient care was improved and the components of an activities program in skilled nursing facilities as well as criteria for assessing its quality were specified. These outcomes were ultimately helpful to administrators, State government officials, and health providers concerned with integrating the programing of recreational activities into comprehensive patient care.

The Problem

The standards for certification and participation in Medicare and Medicaid programs state that skilled nursing facilities must provide an activities program that meets specific needs of individual patients through activities that are consistent with a patient's interests, encourage normalcy, promote optimal psychosocial and physical functioning, and do not conflict with medical treatment plans (*1*). The program must be directed by a patient activities coordinator who meets certain qualifications or who receives consultant services from a qualified person. The facility is also mandated to provide adequate space, supplies, and equipment to carry out the program.

Implicit in the activities program is the relatively new discipline of recreation therapy which employs play, music, hobbies, sports, and other activities in a patient's rehabilitative treatment. Although the Federal regulations on activities programing are accompanied by interpretive guidelines, both the guidelines and the regulations are vague and do not explain the purpose of such programs. The State governments, which enforce Medicare and Medicaid regulations, are left to determine their own standards.

In North Carolina, the Department of Human Resources' Division of Facility Services is responsible for interpreting and implementing the Federal standards on activities programs. The division does not employ a recreational therapist or use one as a consultant. The State's criteria for evaluating activities programs have been derived from a variety of disciplines, and their relevancy is not always understood by nursing home personnel.

Anson County Hospital SNF

The Anson County Hospital SNF is typical of many health care institutions in rural areas with limited resources. It is one of only two skilled nursing facilities serving a rural county with a population of 23,500. It is part of the county hospital and, although it maintains a separate nursing staff, the SNF shares the hospital's social worker. When the facility was reviewed for Medicare certification, the hospital's social worker, in addition to her other duties, was inservice education coordinator for the hospital and activities coordinator for the skilled nursing facility.

The social worker lacked the time and training to develop a comprehensive activities progam for the

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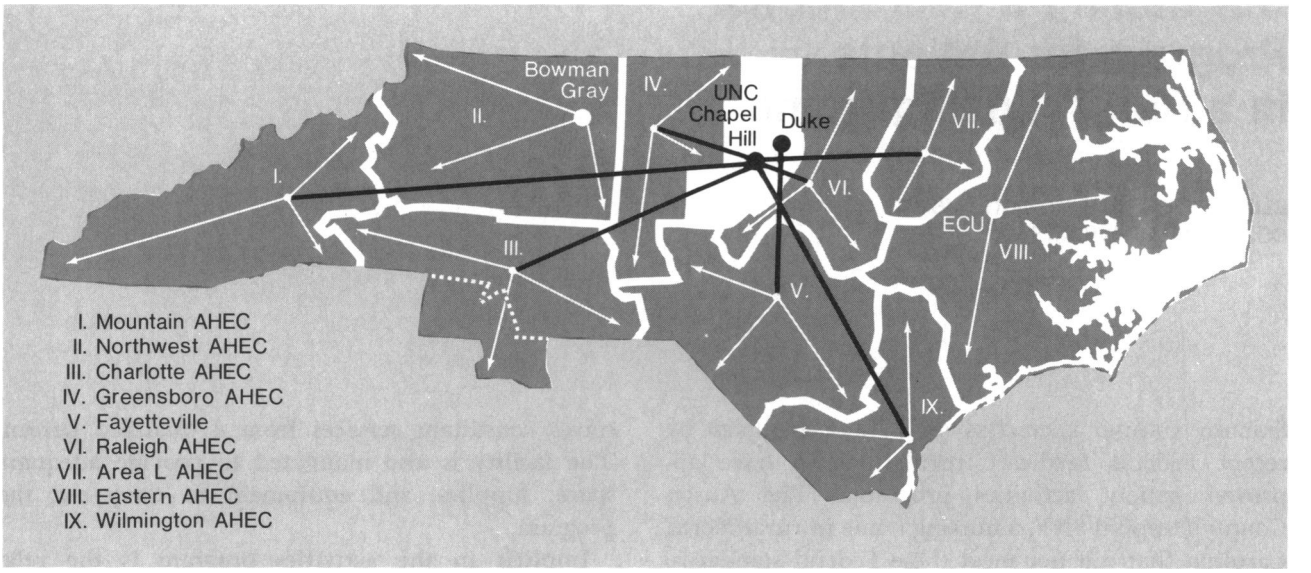


patients. Although almost half of the skilled nursing facility's 44 patients had some disorientation, only 3 were confined to bed. The others spent the day either in their rooms or in the solarium. Opportunities for group or individual leisure experiences were limited.

Officials of the State's Division of Facility Services notified the SNF's administrator that the home was threatened with loss of Federal reimbursement because of deficiencies in the activities program. Federal funding is essential to the operation of this SNF, yet the administrator did not know how to create an activities program that would meet Federal requirements, and he had no excess resources to devote to such a program. He appealed for assistance to the local Area Health Education Center in Charlotte.

Area Health Education Centers Program

The North Carolina AHEC Program is a statewide network of educational and health care institutions that was designed to address certain needs in the education of health manpower. The program began in 1972 as 1 of 11 similar research and demonstration projects funded by the Public Health Service's Bureau of Health Manpower (*2*). The projects were based on a concept proposed by the 1970 report of the Carnegie Commission, "Higher Education and the Nation's Health: Policies for Medical and Dental Education" (*3*). The purpose of these projects was to improve the quantity, quality, and geographic and specialty distribution of health manpower in rural and underserved areas by altering traditional approaches to health manpower education.

The AHEC in North Carolina is based on the joint tenets of decentralizing the education of physicians, dentists, pharmacists, and public health personnel and regionalizing the education of nursing and allied health personnel as well as the continuing education of all health care providers (*4*).

The program is administered by the University of North Carolina School of Medicine and has two tiers. The State's four university health science centers—the University of North Carolina at Chapel Hill, Duke University, the Bowman Gray School of Medicine, and the developing center at Eastern Carolina University—all participate. Through the AHEC, the universities have expanded both their clinical training capacity and their perspective on health care delivery beyond the limited environment of a tertiary medical center. Each school has revised its curriculums to give students an opportunity to train in primary and secondary care in community hospitals and offices in small towns and rural areas throughout the State.

In addition to the university health science centers, nine regional AHEC offices encompass all 100 counties of the State. Each AHEC office is based in a hospital or consortium of hospitals and is directly affiliated with a university health science center. The map shows the location of the nine AHECs and four universities and indicates the respective affiliations.

The staff of each AHEC arranges field placements of health professions students, organizes continuing education programs, and calls on the university faculty to provide consulting expertise, continuing and special education, and other educational re-

sources needed by local health professionals. The AHEC staffs facilitate communication between health manpower training and health care delivery institutions and, in general, the AHECs serve as referral centers for health manpower and related problems.

When the administrator of the Anson County Hospital SNF appealed to the health manpower experts at the regional AHEC for assistance, the agency's allied health coordinator contacted the Department of Medical Allied Health Professions of the University of North Carolina School of Medicine. In keeping with the AHEC pattern, the department sent a recreation therapist to meet with the administrator and the AHEC coordinator.

The single recreational therapist on the State AHEC's staff has responded to requests from all nine regional AHECs, working with recreation programs in a variety of institutions, including pediatric units of general and teaching hospitals, rehabilitation centers, mental health centers, psychiatric facilities, and skilled nursing facilities.

The AHEC program and the facility arranged for the therapist to make monthly visits and consult with the home's activities coordinator until the coordinator could qualify under Federal requirements. The training was estimated to take 12 months. AHEC paid the travel expenses and no fee was charged, since such technical assistance is considered to be one purpose of the North Carolina AHEC Program. A written agreement between the AHEC and the SNF was acceptable to the State Division of Facility Services as evidence that the SNF met the Federal requirements by having a qualified consultant, and the threat of closing the home was thus averted.

Delivering Services in Activities Programs

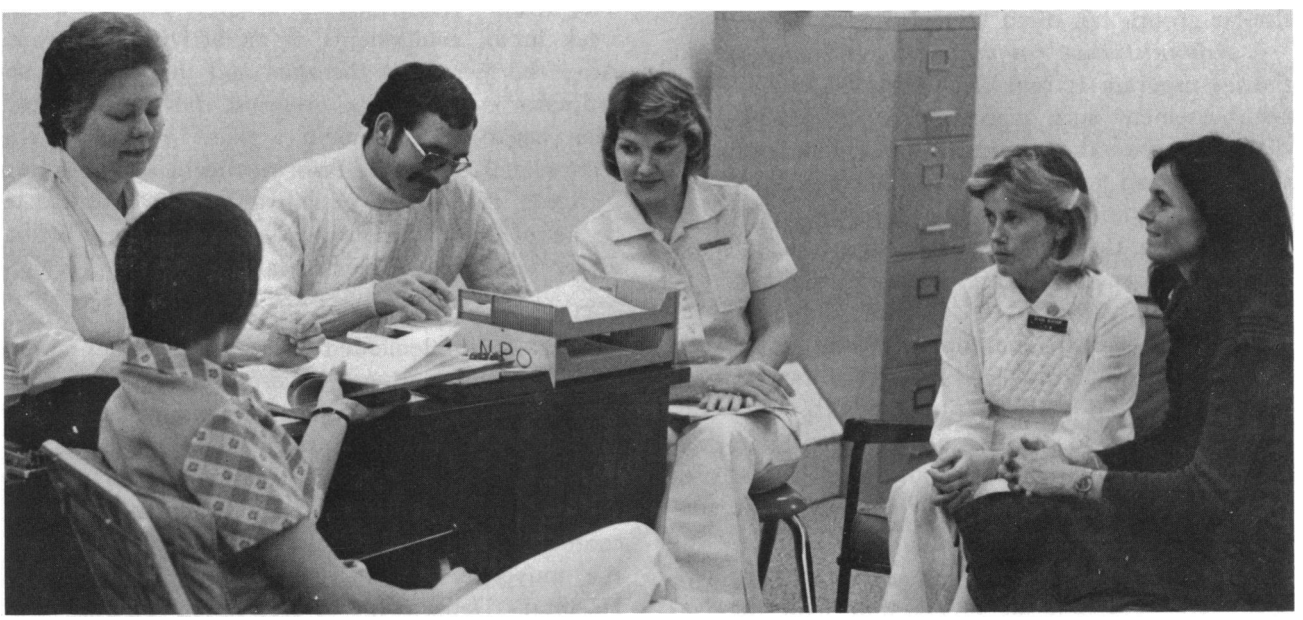
To understand the approach the recreation therapist used at the Anson County facility in developing an activities program consistent with the Federal regulations, it is helpful to look at four basic components of service delivery.

1. Facilities and equipment. Many nursing and health care facilities have been built to maximize bed or treatment space, but specific and adequate space is necessary for an activities program, particularly for group recreation and in facilities with large numbers of patients. Scheduling conversion of under-used space, such as a dining area, may be one option. Accessibility to patients is always an important consideration in planning locations of patient activities.

Similarly, basic equipment is needed. The types of materials depend upon the interest and mobility level of the patients. Resources may include a variety of games, gardening equipment, cooking materials, movie projector, and craft supplies. Because needs for supplies and equipment change, periodic reassessment of the condition and usefulness of materials is necessary. If financial resources are limited, churches, public service groups, or the general community may be enlisted as occasional donors.

2. Comprehensive program planning. Activities should be oriented to the needs of the individual

Interdisciplinary staff discussion at the patient care committee meeting



person. Regular assessment of each patient's condition, a plan for his activities, and an evaluation to determine the extent and outcome of the patient's involvement in activities are inherent to the success of the program.

To address aggregate needs, the activities program should encourage participation. Scheduling activities for the time of day most conducive to involvement, having regular, publicized schedules so that patients can anticipate recreation, and varying the activities so that they can choose from several alternatives is important. A systematic evaluation and subsequent adaptations of the program are essential. Record-keeping and charting are necessary to maintain inter-staff communications and continuity of care.

3. Personnel resources. For optimal effectiveness, activities coordinators must be knowledgeable about the program's purpose, understand the need to relate the program to the goals for individual patients, and have the ability to accomplish this. Such knowledge may be gained through formal training or experience. As stated previously, programing of recreational activities is a new facet of patient care, and few persons have formal training in this discipline. As in the case of the Anson County facility, responsibility for the activities program has often been added to the duties of someone in another position.

The staff can easily dampen or heighten the spirit and success of patient involvement by their attitudes. Staff participation in activities with patients is an important extension of patient care. Large or understaffed institutions, extensive programs, or special events may require additional personnel. Volunteers, local clergy, community services organizations, and similar groups can often be recruited to help.

4. Administrative commitment. Although an activities program is required to qualify for Federal reimbursement, such a program is likely to be effective only when the administrator and personnel of the institution are committed to serving the recreational, social, and emotional needs of the patients.

Recreation therapy focuses on the nonacute, rehabilitative aspects of care, including the patient's social and emotional needs. Recreation therapy not only provides diversional opportunities; it is used in a planned, individualized manner to maintain or improve physical and emotional health, independence, socialization, skills, productivity, and ego strength. Recreative activities are developed according to each person's needs to achieve the basic goal of his or her optimal functioning.

The Federal requirements for skilled nursing facilities were developed in cooperation with the National Therapeutic Recreation Society and other allied health care professional associations and reflect the preceding four considerations. To help the Anson County SNF's administrator and staff understand the objectives of an activities program and identify problems with the existing program, the recreation therapist developed the following outline of the basic components of an activities program:

I. Facilities and equipment
  a. General facility description
  b. Activities area description
  c. Transportation of patients to activities
  d. Supplies and equipment: numbers, variety, condition, use
  e. Storage
II. Comprehensive program planning
  a. Patient assessment tools; individualized patient plans and evaluation procedure
  b. Documentation
  c. Program goals and evaluation
  d. Types, frequency, and schedule of activities; level of patient participation
  e. Orientation of patient, families, staff to program
III. Personnel resources
  a. Activities coordinator: training and abilities
  b. Nursing staff involvement
  c. Cooperation of other staff members
  d. Volunteer staff
  e. Community organizations
IV. Administrative commitment
  a. Organizational position of activities coordinator
  b. Budget and allocation of funds
  c. Amount and type of administrative support and involvement

This form was the basis for an initial report on the status of the activities program and for subsequent reports.

Changes and Outcomes

The Anson County Hospital SNF originally was weak in all components of an activities program. After the recreation therapist and the activities coordinator evaluated the program, they outlined and then began to implement a plan to improve the recreational activities. Priorities were set according to needs; that is, the patient assessment tool had to be adapted and administered to develop individualized activities treatment plans.

During the recreational therapist's monthly visits, the changes implemented during the previous month were reviewed and goals were set for the coming month. The therapist occasionally met informally with members of the nursing staff to discuss the activities program and its relationship to nursing care. The therapist also arranged for the activities coordinator to visit Chapel Hill to use resources at the university and at North Carolina Memorial Hospital's Department of Recreation Therapy and

to meet with other activities coordinators and recreation therapists in the area.

The recreation therapist met with the SNF administrator as often as necessary to insure that he understood the program's value and what was needed to develop it. She also provided him with a monthly written report that delineated the consultation activities and summarized the program's cumulative progress. The monthly report was available, through the administrator, to the officials of the State Division of Facility Services and provided verification that the nursing home met the activities program requirements to qualify for Federal reimbursement.

During the 12 months, the following changes took place:

1. The activities coordinator, who was also a social worker, was relieved of her responsibilities for inservice education at the hospital.

2. The coordinator gained an increased understanding of the purposes and techniques of recreation therapy programing through discussions and working with the recreation therapist, using an increasing library of resource materials, attending workshops, and contact with other activities coordinators.

3. A patient evaluation form was designed and used. The new considerations on the form included degrees of physical capability, social skills, psychosocial functioning, and primary treatment goals in the activities program. The form was used in conjunction with patient and family interviews and information gathered at patient care meetings to develop an individualized activities plan for each patient. The use of these plans in activities programing was new to the facility. The plan and subsequent progress were documented in patients' records and nursing care plans.

4. A formal program description was written covering its goals, objectives, philosophy, and activity descriptions.

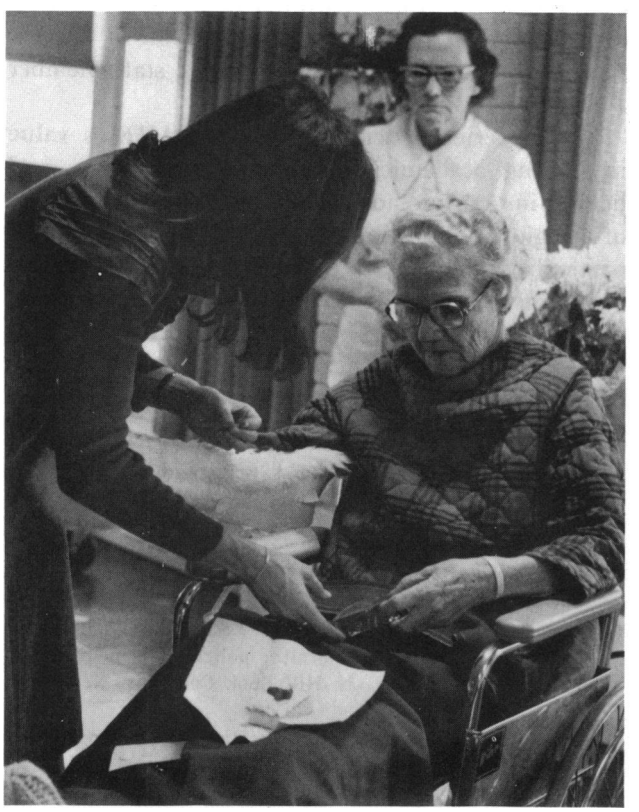
5. Daily schedules of patients were revised to lessen their time of confinement to their rooms or beds. The usual time out of bed for the ambulatory and wheelchair patients was increased from 6½ hours to 9¾ hours.

6. Patients were encouraged to take meals in the solarium rather than in their rooms. The number of patients routinely eating in the solarium increased from 1 to 15–20.

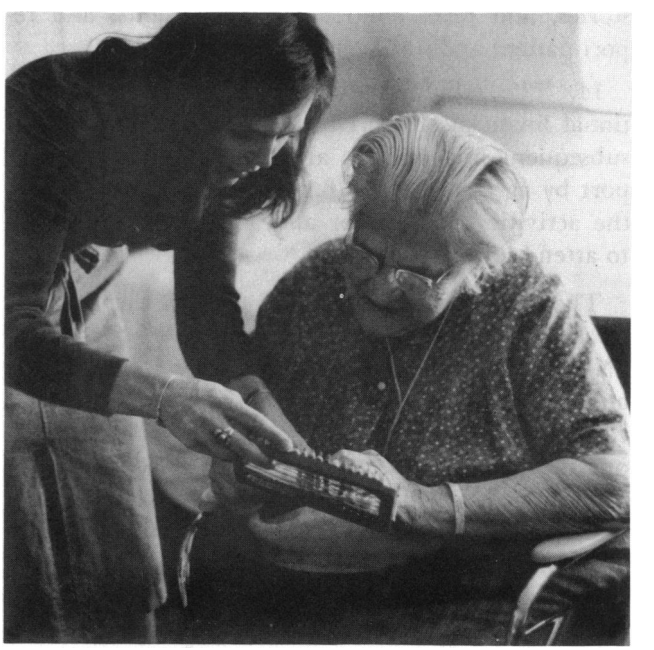
7. Group activities increased from 1 hour, four times a week to 2 hours, five times a week, in addition to special events.

8. The range of activities expanded from rhythm band, bingo, devotions, films, and a monthly craft project to include trips in the community, gardening, exercise groups, weekly craft projects, and more frequent presentations by community groups.

Activities coordinator assists a patient at a party



Activities coordinator and patient work on a crafts project



9. The importance of community participation was reviewed and the number of community service groups involved with the SNF grew from 6 to 16. Frequency of community group programs increased from major holidays only to once a month, in addition to holidays. A community resource file was started to identify a contact person for each organization and to keep a record of each group's activities.

10. Nursing staff participation in the activities program increased when their participation was incorporated in a revised job description. The activities coordinator and recreation therapist held a workshop for the nursing staff to increase their awareness of the needs of the activities program and its potential in developing skills in carrying out various activities.

11. Regular mechanisms for evaluation of the activities program were established. The form developed initially to evaluate the status of the program was used semi-annually and later, annually, to document progress and determine improvements needed. Accordingly, recommendations were made and action taken. The evaluation and recommendations were reviewed with the administrator. Previously, no systematic evaluation had been carried out.

12. Regular educational and professional contact with other activities coordinators in the area was established through informal meetings, observation of other programs, and attendance at regional workshops.

13. A facility newsletter was initiated to publicize upcoming events and programs; publish poems, stories, and jokes contributed by patients; and report patient and staff news.

14. The administrator agreed to commit additional financial support to the activities program in subsequent budgets. He also demonstrated his support by agreeing to pay for continued education for the activities coordinator and allowing her time off to attend formal programs.

The recreation therapist shared with the Division of Facility Services the experiences at the Anson SNF that would be helpful in specifying a format and criteria for evaluation of activities programs that could be used throughout the State. She also pointed out the need for a recreation therapy consultant as a permanent member of the division's staff.

During and after the year of consultation, the Charlotte AHEC continued to assist the Anson County Hospital. As the facility's activities program improved, the AHEC helped to publicize this success. The AHEC also facilitated communication between the home's activity coordinator and other activities program coordinators in the region. Finally, the Charlotte AHEC and the AHEC Program at the University of North Carolina ensured the availability of continuing education by sponsoring formal programs on recreation therapy and activities programing.

Conclusion

As often occurs when a new service is introduced by regulation, neither the Federal officials who adopt the basic concept, the local officials who must enforce it, nor the health facility administrators and providers who must implement it are adequately prepared for the changes which must be made. The plight of the Anson County Hospital SNF is typical of instances in which institutions suddenly required to change patient care practices lack both the resources and the knowledge to do so.

As a result of the assistance provided by the AHEC Program and the recreation therapist's work with the skilled nursing facility, the SNF now has an expanded comprehensive and individualized activities program that meets Federal specifications, and recreation therapy has been integrated in patient care. The recreation therapist contributed to the development of evaluation materials and criteria to be used by the State of North Carolina in interpreting Federal standards. In addition, the Division of Facility Services has realized the need for a staff member with expertise in recreation therapy.

The experience demonstrated the AHEC's value in linking academicians, government officials, and health institution administrators. The accessibility of a regional education resource center proved to be particularly effective in helping health care personnel define and identify the means of solving a critical problem and enabled sharing of university resources with those delivering health care.

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