# Instructing Nursing Home Personnel in Rehabilitation Techniques

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IN ILLINOIS, as in most other States, complete and intensive rehabilitation services are limited to a few urban areas, notably Chicago and Peoria. Elsewhere in the State public and private nursing homes are expanding rapidly to care for chronically ill and disabled persons. Some of these persons at other times and under other circumstances would have been hospital patients. But hospital care for such patients is frequently inappropriate, unavailable, or economically prohibitive, or no agencies are available to help them obtain hospital care.

In many sections of Illinois hospital care is not available in the patient's community, and the local physician must rely upon the nursing home for inpatient care when care at home cannot be provided. The shrinking size of private dwellings and the dwindling number of family members available to provide home care has further increased the use of commercial and county nursing homes for both private pay patients and recipients of public assistance.

Likewise, there is frequent evidence of the need for general hospitals to concern themselves more with measures to prevent the development of conditions which may require nursing home care after a hospital stay.

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The vocational rehabilitation of residents of nursing homes presents several significant problems. For instance, in the average Illinois community there is often little knowledge or appreciation of the philosophy and techniques of rehabilitation and the vocational potentials that may emerge from physical rehabilitation. Similarly, there is often little knowledge of the interests or services of the Federal Office of Vocational Rehabilitation and its counterparts in many of the States.

The Office of Vocational Rehabilitation, the Forest Park Foundation of Peoria, through the Peoria Institute of Physical Medicine and Rehabilitation, and the Illinois Public Aid Commission joined forces to conduct a 3-year research demonstration project, the rehabilitation education service. Begun in February 1957, the project, the first of its kind in the United States, proposed to look for the answers to these questions.

- What are the rehabilitation needs among patients of a selected group of public and private nursing homes?
- Can the existing staffs of these homes, in cooperation with local physicians and services in the local community, meet these needs if they receive adequate training in the philosophy and techniques of rehabilitation?
- What kind of training can be developed to provide staffs with a knowledge of rehabilitation techniques and to increase their appreciation of the philosophy of physical and vocational rehabilitation?
- What kinds of teaching materials can be developed that other agencies and schools can

use to increase the competence of nursing home staffs to share in vocational and physical rehabilitation?

### Framework of the Project

The Peoria Institute of Physical Medicine and Rehabilitation provides medical supervision for the project. A grant from the Forest Park Foundation enables the director of research and education of the institute to devote 1 day a week to such activities as visits to cooperating nursing homes, meetings with their staffs, direct medical supervision of the project staff, and, upon request, giving more detailed interpretation to the patients' attending physicians.

The project staff consists of four rehabilitation nursing consultants, two occupational therapy consultants, and a supervisor. Two nursing consultants and an occupational therapy consultant, with one of the nurses as supervisor, form a training team.

Because the rehabilitation education service is a staff training program rather than a direct service to patients, the project's particular combination of professional staff does not include a physical therapist or a vocational counselor. The teaching of physical therapy is confined to aspects which the various professions involved have agreed can be legitimately carried out by nurses properly trained and supervised in rehabilitation. Therefore, the teaching embraces such care as passive range of motion exercises and gait training which the nursing home personnel can carry out within the framework of a nursing home program. However, if intensive physical or other therapy for some patients seems indicated, homes are encouraged to employ a physical therapist part time, or, at the request of the attending physician, to obtain the services of a physical therapist who can treat a patient.

Experience seems to indicate the need for a medical social worker on the project staff in the near future. Most nursing homes are not prepared to provide professional casework services for patients or families, but certain techniques for interviewing and other intake procedures are not only useful but needed in many homes. Certainly, basic casework concepts are invaluable to nursing home personnel, particularly in patient approach and motivation. However, it is our opinion that a patient who needs the integrated services of all the disciplines associated with rehabilitation should be in a rehabilitation center.

During the first 4 months of the project the staff, under the supervision of the institute, designed the materials and procedures to be used in the nursing homes. Fieldwork began June 15, 1957, and we are now conducting the program in the 36th and 37th cooperating homes. The homes have ranged in size from 15 to 243 beds.

The applicant nursing home must meet certain criteria. The administrator or governing body of the home must voluntarily request participation. The home must be currently licensed by the Illinois Department of Public Health. A full-time registered nurse or licensed practical nurse must supervise nursing. The home must accept public assistance patients and currently have such patients.

Approximately 20 percent of the eligible nursing homes in Illinois have applied for the service. The applications on hand are somewhat fewer than the initial number, but the present backlog necessitates a waiting period of approximately 6 months.

After receiving an application from a nursing home, the coordinator of the project visits the home to meet the administrator and staff and to explain in detail the content and procedures of the rehabilitation education service. The project staff then discusses the application and informally consults the regulatory agency to ascertain the home's administrative attitudes, atmosphere, and history of patient care. If acceptance of the application seems indicated, the training team visits the home to work out the details of introducing the service.

### Conducting Training

In conducting the training, a project team spends 4 days a week for 4 to 7 weeks at the cooperating home. Mondays of each week are reserved for monthly followup visits to homes that have already received the service. During the training period, daily 1-hour lectures are held for all persons on the staff who are in contact with patients. If necessary, the lecture is repeated so that the entire staff can at-

tend. These lectures cover the following subjects:

Philosophy of rehabilitation and rehabilitation nursing.
Occupational therapy.
Patient approach and motivation.
Body alignment, bed positioning, deformities, and contractures.
Body motion and exercise.
Activities of daily living and training, including devices.
Bladder and bowel control and training.
Ambulation activities.
Passive range of motion, group exercises.
Personal hygiene, speech and hearing rehabilitation.
Recreational, functional, and group activities.
Prevocational services.
Physical environment.
Social services.
Community and volunteer programing and services.
General nutrition.
Role of the family in a patient's rehabilitation.
Resource material for the nursing home staff.

Team members spend most of each day in demonstration, return demonstration, and bedside work with individual members of the nursing home staff. We have found that nursing home personnel tend to be uncomfortable when dealing only with concepts, and that it is most effective to teach specific, concrete techniques and to let philosophical concepts of rehabilitation emerge as lecture material is put into practice.

The length of the team's stay depends largely upon the size of the nursing home and the number of persons to be trained. In practice, the training period has averaged approximately 6 weeks; the range has been from 4 to 8 weeks.

One nursing home staff member, assigned by the administrator, is trained by the occupational therapy consultant to be the activities director of the home. The activities director has primary responsibility for planning and conducting recreational and diversional programs, recruiting, training, and supervising volunteers, and for promoting community-related activities. The activities he heads embrace all aspects of occupational therapy except prevocational testing and functional work.

The project team presents a list of equipment for rehabilitation nursing and occupational therapy which the nursing home is supposed to provide. Patterns are included for items on the list which the home can make. The rehabilitation nursing equipment is limited to such aids as footboards, sandbags, and pulleys. Their total cost is approximately $7. The tools, equipment, and supplies requested for starting an occupational therapy program that includes 20 basic crafts and innumerable recreational program materials cost approximately $32.

Adaptations for toilets and tubs, parallel bars, and similar equipment are not on the list of requested items. We prefer to demonstrate various substitutions or less expensive improvisations which will help the home realize the value or need for such equipment. If the home believes that various pieces of equipment will be useful, we then provide patterns so they can be constructed as inexpensively as possible.

When the rehabilitation program has been operating for 1 year, the project team which conducted the initial training and made the monthly followup visits returns to the home for a 2-day exhaustive evaluation. Several weeks in advance, the administrator and staff are notified of the evaluation and of certain considerations to be discussed at staff meetings and during the evaluation.

Afterwards, the team discusses with the administrator the program's strengths and weaknesses. The team then remains in the home several days to give short-term intensive training to correct the weaknesses found during the evaluation.

Experience seems to confirm that providing training within the facility is most practical. The administrator and staff receive the same lectures and participate in the same discussions, thus improving communication between them. Clinical experience within their own institutions permits the staff to adapt training to the patients they routinely serve and to recognize and deal with problems and approaches in patient motivation.

Inasmuch as rehabilitation services call for a marked change in the nurse's attitude toward patient care and an appreciation of the importance of activities in the total treatment of the

patient, during full-time association with the staff the teaching team can demonstrate how the philosophy of rehabilitation must permeate every nursing activity extended to the patient.

Also, this approach creates an excellent opportunity to interpret further to physicians the nature and scope of the nursing home's services. Most patients in the cooperating homes have their own physicians, and we require the physician's prescription before a patient may participate in any phase of a rehabilitation program. Finally, in this setting the teaching staff can identify problems of patient care in the specific home and assist the administrator in working out a plan of care suitable for the individual patient in terms of staff capabilities.

## Results

We are frequently asked our goals for a nursing home patient. Since this is not a treatment program but a training program for nursing home staff, goals are for the staff rather than the patient. No one can delineate absolute goals for an individual patient; his potential and response to treatment, frequently unpredictable, govern his rehabilitation.

In general, the patients' responses to treatment have fallen into three general categories. Approximately 5 percent of the initial patients indicated adequate potential to warrant a referral to the Illinois Division of Vocational Rehabilitation. However, this percentage is diminishing. Response to rehabilitation measures has resulted in the discharge or the pending discharge from the nursing home of approximately 25 percent of the patients. Rehabilitation measures have brought increased self-care and independence within the nursing home to about 60 percent of the patients. The attending physicians of the remaining 10 percent did not prescribe participation in rehabilitation activities. Most of these patients had severe cardiac disorders or terminal illnesses.

Nursing homes which have had this training are being used for maintenance rehabilitation or the completion of rehabilitation of some patients, permitting their early transfer from the Institute of Physical Medicine and Rehabilitation. The improvement of some patients would allow their return to the community, but they are unable to because they lack financial resources, the family is unable to fulfill its role in the situation, or community resources are inadequate.

In assessing the training, we find that every moment spent in a home is a demonstration of our conviction of the need and efficacy of rehabilitation. Indirectly, we see a new motivation for the staff stemming from the improved morale and health of the patients and a new reason for both patients and staff to do more than was formerly considered not only enough, but actually was thought to be good care.

Similarly, there emerges that almost inevitable change in attitude that goes hand in hand with the consciousness of improved technical skills, especially if the result is happier, healthier patients. This attitude is evident in comments from cooperating homes. None has expressed disappointment with the conduct of the training or the continuing program. However, on innumerable occasions staff members have said that it is a slow process for them to incorporate the philosophy of rehabilitation in all aspects of administration, planning, and care.

Frequently, staff members are discouraged because only a small number of the present patients can benefit dramatically from rehabilitation services. We endeavor to point out that if work is begun with a patient 5 to 10 years after the initial insult, there is rarely an opportunity to see as graphic a demonstration of the benefits of rehabilitation as with newly admitted patients. On monthly followup visits the teams have found that nursing home personnel are most eager to demonstrate their work with newly admitted patients and the gains they have seen these patients make.

## Evaluations

Administrators and staff of the first 10 homes in which the annual evaluations, described previously, were held indicated what they had gained from the project. Nursing staff members said they now know more about caring for patients, especially the patient with hemiplegia, a fracture, or arthritis. They felt that their training has also improved the quality of the basic nursing care they give to patients.

Administrators and staff members indicated that they are much more aware of patients' needs for social activities and motivation, and

that they appreciate more the role of occupational therapy in nursing care. They believed that their patients have gradually accepted the rehabilitation philosophy and have willingly accepted responsibility for increased self-care.

The nursing home personnel appraised as the program's two greatest benefits their own change in attitude toward goals for their patients and their acceptance and understanding of the basic principles of rehabilitation. They concluded that programs such as the one established by the project were feasible for a nursing home of any size, but felt that the program's intensity and scope depend upon individual attitudes of the administrator and the nursing personnel.

The administrators of 18 cooperating homes assisted in an exhaustive evaluation of the training content and methods of operation of the rehabilitation education service. For this evaluation, the project staff interviewed orally the administrator, the nursing staff, and selected patients of the 18 homes. They were asked 35 questions covering all aspects of the rehabilitation program.

Some generalizations regarding such training programs were drawn from their answers.

- It is essential that the program be requested voluntarily and desired by the home if the training is to be effective and the program continued.
- The staff must have stable employment, be highly motivated, and be experienced in nursing service if maximum benefit is to be derived.
- A training program can provide the staff with nothing more than specific tools and techniques to be used in medically prescribed rehabilitative care of patients.
- Most problems for staff members were associated with nursing aspects of the program rather than occupational therapy or activities, possibly because in nursing, outmoded techniques and procedures which have become habitual must be unlearned, but occupational therapy is new to them and is not resisted because of tradition or long-established practice.
- Rehabilitation services can be built best upon the soundest basic nursing possible. An institution with good administrative procedures and personnel policies and acceptable intake policies and procedures is the most promising setting for such a program.
- The cooperating homes considered the cost of such training and the maintenance of the program reasonable. The greatest expense was the staff time devoted to training sessions during the initial phase of the program. Generally, the cost for equipment and basic preliminary supplies has averaged about $40 per home. The homes have found various ways of absorbing the cost of materials for continuing occupational therapy. Most frequently, they use income from salable items to purchase additional supplies, or philanthropic groups and service clubs in the community supplement the crafts budget with donations.

## Problems

Those concerned with the services of nursing facilities and the rehabilitative care of older patients should remember that a program such as the rehabilitation education service can never solve all problems. There is no question in the minds of the project staff but that the scope, quality, and philosophy of service have been markedly changed in each nursing facility in which the program has been conducted. But staff education cannot be expected to meet such problems as placement of patients in inappropriate facilities, conflict between high standards of service and low rates of payment, lack of counsel and casework services for patients and their families, and lack of appropriate facilities for discharged patients.

However, such projects as this are in a relatively ideal position to observe the frequency of such problems and indicate possible useful tools in exploring and developing solutions. Also, the project serves as an excellent unit for the finding of patients in need of certain facilities and services. The project staff constantly encourages nursing homes to see themselves as casefinding units with regard to patients, their families, and overall community needs.

Although stability of staff in the cooperating homes is extremely difficult to measure adequately, our observations indicate a trend toward reduced turnover in some facilities after such a training program has started. In others, continued turnover tangibly affects the efficiency of the rehabilitation services that

have been started. Eventually, a plan may be devised to give new staff members the same intensive training the rest of the personnel have already received.

The loss of a home's activities director would critically impair this phase of the rehabilitation work. During the remaining demonstrations, we plan to try to prevent or solve this possible interruption in a home's program.

In spite of the growing prominence of nursing homes in the total medical care spectrum of the community, far too few administrators or medical personnel appreciate adequately the appropriate role of nursing home care in rehabilitation. In the nursing home lectures, community interpretations, associations with related services, and discussions with patients' families, we stress the totality of services needed for realistic rehabilitation planning—social, economic, vocational, psychological, and physical. No other area of concern for people involves such a multiplicity of patient needs.

Because of their profit-making nature, proprietary nursing homes frequently are reluctant to consult with community agencies or to request direct services from them for patients. The rehabilitation education service staff assists these homes in contacting pertinent agencies such as the Illinois State Division of Vocational Rehabilitation and public and private agencies and establishing close working relationships.

This reluctance may perhaps be explained by the similar feeling of some agencies and programs to serve nursing homes which are operated for a profit. In some areas, the nursing home, as a medical care facility of the community, still does not enjoy broad understanding of its role in the care of the chronically ill, nor is it afforded its rightful position of respect by professional and lay people.

## Conclusions

Dr. Theodore G. Klumpp, in his paper entitled "Promotion of Health Maintenance and Restorative Services," stated, "The achievement of absolute and unquestioned scientific proof of the many basic facts concerning the aging process will take time, perhaps years and generations in the life of man. Are we to sit by and do nothing until the pieces of information are collated and nailed down as solid facts or are we justified in taking the best we have at the time as working hypotheses and apply them to useful ends? I think we are."

We feel the rehabilitation education service has proved to be needed and effective in the broad area of care for the chronically ill, disabled, and aged; but beyond this we believe that it demonstrates three important facts.

1. Public assistance agencies can be concerned with more than buying the best service at the lowest price. They can legitimately be concerned with improving existing services, offering new ones, and stimulating the development of those services which their clients need.

2. Whether this kind of service on the State or local level is offered by public health, public assistance, or vocational rehabilitation agencies, no one agency really offers the service. Only the combined, coordinated efforts of all make any such service in rehabilitation effective and worthwhile.

3. In a general way, such projects as this can do much to bring better understanding to the possible conflict between improved standards of care and reasonably low rates of care, particularly for the medically indigent.

With only 2½ years of experience in the project we are far from the answers to many questions. We may not even know some of the questions. But there is ample accumulating evidence that such a program can be effective and helpful to people.

We know that it calls for each agency concerned to inventory frankly its present services and its philosophy of program goals. Active participation in such programs enhances not only our skills but also our appreciation of how each agency is professionally and morally involved in comprehensive rehabilitation.