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Hello everyone. I would like to welcome you to preventing the decline in ADL mobility enhancement and restorative nursing program. This webinar is intended for providers working with Alaska Colorado Illinois Iowa Kansas mission and many states. All lines will be muted during this webinar. At the end of the webinar that will be a short time for questions. You may also ask questions in the chat box.

Hopefully many of you are familiar with the national nursing home cooperative change package. This change package is a collection of great ideas and practices to create lasting change in your nursing home. It was developed from a series of 10 site visits across the country and the themes that the emerge are how they approach quality and carried out their work. In addition to the change concept and action items in the change faction -- package one of these of change and those that shares a practices to maintain and improve resident mobility. A use the link at this slide to review. One of the change of package strategies is included here. We are pleased that our guest speaker Jeri Lundgren will be sharing with us ideas on how to prevent a decline as well as enhance residents mobility. Ms. Lundgren has been working in line can term care since 1990 specializing in wound care nationally since 1994. She is a board certified by the American Board of the wound management and her extensive national background includes a survey management litigation support program development and clinical expertise for several -- federal state programs. Currently Ms. Lundgren is the president of senior providers and resource. I will now turn this presentation over to you Jerry.

Thank you so much Christie and good afternoon everybody. Welcome. At the end of today's program we will describe mobility and this is a good starting point for your staff to understand why immobility is a such an issue. We will also talk a little bit about exercise programs and interventions that will help the as residents improve their mobility strength and balance and also demonstrate how to document the progress and for those folks who need documentation. It is very important to try to keep residents of mobile and I think in particular in our care study is definitely eight challenge for us. Typically in the nursing home studies they come in for therapy and we tend to have a knife isolation between therapy and what is happening with the nursing and once there appears discontinued what got them to the point of a mobility is sometimes not

continued to happen. It is is important to have that clinical foundation as to why immobility is something we should be looking at and why it is an issue.

Overall we are met to be upright and mobile. It is not natural for us to be a or sitting position for long periods of time. All of our systems have optimal body functions when we are up for at least 16 hours per day. Nursing home residents are like if they are up for a couple of hours. They be up for meals or back in bed or in wheelchairs for long periods of time.

What is interesting is when I began looking at immobility it started with calls and what was the route calls -- cause the realization is that the issues that we deal with with our residents started with balls and falls in and of themselves are a mobility issue. That is the cause. As a wound care specialist I never even thought of it, obviously someone is immobile and at high risk for skin breakdown and many times we would just put integration to combat the pressure but if we just get people more mobile it would help. In continuity UTIs can help them get to the bathroom for physical impairments or lack of muscle control. Development of diseases I will talk about how immobility contributes and is a root cause two diabetes and the effects on cardiac systems. Weight loss and muscle wasting you would think that if you are not active your muscles would not waste away but they do. It leads to depression, delirium, confusion it is the root cause of infections in the respiratory system constipation and the staff injuries. In our industry we have one of the most dangerous industries to work in as far as staff injuries because of the back injuries of moving residents. So when we have to move people it can be a very unsteady and unsafe procedure to do and can lead to back injuries because the residents themselves cannot move so turning, repositioning, transferring and walking residents is also a cause of staff injuries.

When you look at the causes of immobility when you look at the diagnoses that lead to immobility most of the primary admission diagnoses of that we see coming into the nursing home already need to render the residents who are immobile also are a lot a lot of them are coming into two fractures, strokes, obesity, Parkinson's, cardiac disease, overall weight this, respiratory diseases or maybe a new amputee. If they have a visual impairments that may lead to them not moving and maybe that history of also or the fear of falling and so therefore they don't want to move. So the point of this is that many times the diagnoses themselves is going to render them immobile. One of the biggest issues that we have in long-term care studies is that the residents may be moving too slow or taking too long. Ironically we as a staff caring for the residents are the root cause or the cause of the person becoming very immobile. We tended to do for them which is much faster to pop them into a wheelchair and put them down to the dining room to take the then taking their time to actually walk them

down to the dining room and even simple functions of such as brushing their teeth or doing their daily care of those are all forms of exercise and many times if we do those for them we are further impairing or rendering the president immobile.

I personally had an experience with a friend who was out of state and their father -- father was 98 years old and he was independent and on his own he was alert and orientated, continent and he actually had a mild heart attack and he drove himself to the ER. He ended up being ended admitted into a nursing home because they were having difficulty managing his medication and he had gotten very week in the hospital so we came for rehab. My good friend walked him into the facility and stated that he was a very slow walker. Over time what happened with him was because they were afraid he would fall they told him not to get up and go to the bathroom and essentially told him not to get out of bed without help and due to walking too slow they put him into a wheelchair point. Long story short he degenerated within a quick period of time in three months and basically passed away Wednesday the diagnosis of failure to thrive but one of the biggest issue was due to the fact that he was so immobile he declined. Rapidly.

This is an extreme example and one I will walk-through is the effects of immobility on on a study that was colleges students of that was put on bed rest. We are talking also athletic individuals in good in their 20s in bed rest. They looked at the side effects of it and it is amazing what I will walk you through of what they saw that affected the body systems that proves that are bodies all the need to be mobile. Only talk about some of these time frames of these effects can you imagine if you are in your 70s 80s or 90s how quickly these effects can start hitting.

One of the main effects of that hits is lost of independence and the psychosocial effects related to that. There is always that fear of being admitted to the nursing home because they are no longer mobile at home. Overall the effects on the balsams is a 12% rate of loss of muscle strength and atrophy in as quickly as one week on healthy adults. In as little as 3 to 5 weeks immobility of almost half of the normal muscle strength is lost. That is incredible and again is on somebody who is healthy.

I was going to use the analogy to if when I exercise all of you have been on an exercise program it takes forever to get up to a certain point and then heaven forbid you stop for a week or two or you go on vacation and 20 go back to do the same exercises many times you cannot do that performance level that you did the prior week or two. It takes your while to get that back so we have all experienced the sensation of losing strength and ability quickly.

The very first muscles to become week are unfortunately be lower limbs so if that leg strength will further render that ability to get up and to move. Keeping a muscle in a contracted position walks significantly increase the atrophy some not only if they are not using the limbs if you hold it in a lower and in stroke paralysis or immobility tutus splinting muscles atrophy about 30 to 40%. With that being said the healthy adults that were in this study it took four weeks to recover from that but the -- atrophy with exercise. The unfortunate thing is that muscles are permanently affected and once they're gone you cannot get them back and in the study even though it took them four weeks to get back from the atrophy none of them went back to the performance level they were prior to the study.

The disuse of the muscle will also affected that neuromuscular functions so essentially the body forgets how to properly coordinate the motor function. If you look at a dancer or a figure skater and they have to practice that routine over and over again and what happens again as they get muscle memory. You talk to athletes who don't practice consistently they will lose and forget the routines. We see it in elderly. You always wonder what you go to transfer somebody okay Mr. Smith can you move your right leg and you can see that hesitation or that leg shaking and you can see that thought process and they are having difficulty doing something as simple as the transfer and that is due to the effect of losing that neuromuscular function and that muscle memory.

Also what happens is complete rest so it will cause in it gives you a secular effects so once you lose the endurance levels it will cause even more fatigue which affects the motivation which will then lead to greater inactivity. If you rest I will have more energy is exactly the opposite. A body in motion stays in motion. And I know personally when I don't exercise it is very hard for me to get back into the retained and trying to stick with it and keep going.

On the connective tissue can consist of tendons, ligaments, and articular cartilage which covers the joints. This is as quickly as 4 to 6 days after immobility changes in the structure and function of the connective tissue became apparent. On these young adults. The unfortunate thing is these changes remain even after normal activity has been resumed.

When it comes to contractures the contract the decrease in the normal range in the parts of body responsible for motion so the joints ligaments and tendons and related modules and in as little as 2 to 3 weeks of immobilization a firm can structure can develop and we see that all the time with our stroke residents coming in and by the time we get them at many of those contractures are already well set in and after 2 to 3 months in ability surgical correction may be needed.

The bone is also affected. What happens is even if the person wasn't prone to osteoporosis they can get what is called diffuse osteoporosis -- this use osteoporosis which is that the long bones of the vertebrae long bones of the legs heels and wrists which are very susceptible if somebody falls.

Within three weeks of immobilization calcium clearance is 4 to 6 times higher than normal and hypocalcemia can occur. This can lead to kidney stones and can affect their appetite so they can get anorexia nausea and vomiting. That may be due to the fact that they are immobile.

Skin as they are sitting and listening to me your all squirming around and shifting your weight and you can do that subconsciously when we sleep. What happens with immobility is to decrease the sensation prevents the shifting of weight so if you sit in one area for prolonged period of time the pressure on that skin can lead to that pressure alternative among formation so new guidelines state that immobility is the number one risk factor for pressure ulcers. So when you think about it the only area on your body designed to bear weight is the slope of your feet and would you think about how small your feet are you should be thinking that your feet right now are amazing when used deal with residents who are sitting authors and their bottoms are much bigger than their feet so you think that they are prone to break down in those areas that is not case.

So very important is to keep those residents up and to be moving.

Also once they become cold totally dependent upon us to move them so they can no longer move themselves around it increases the risk for sheer and friction depending upon how the staff moves them so that can lead to further skin breakdown and at the skin next to the bed's cheesecake cause later skin concerns.

On the overall cardiac system

When someone is confined to bed they are shift of fluids away from the legs towards the abdomen thorax and head in as little as 24 hours you can have a shift of one leader of Lewis from the lakes to the chest. So think about all of York CHF residents are anybody with commentary issues and things like that how dangerous it is for them to be confined to bed so what happens is you get increased [NULL] return to the heart and elevated intracranial pressure.

The body's response to that is going to react to it so even if the actual fluid volume is normal because it has been shifted up to that thoracic area, it is going to respond and

once the [NULL] return a stretch of that atrium begins to happen they says we have too much fluid so what will simulate diuretics so it will increasing turnout with and decrease the blood volume so it actually leads to dehydration of our residents. We see it over a quick. And if you think that your residents are dehydrated look at what their routine is with a lying about over a long period of time.

Also immobility leads to atrophy and loss of muscle mass in the legs this impairs the muscle pump action which reduces your [NULL] return. A lot of the residents that have that lower extremity edema it could be secondary to the fact that they have been immobile and that they have lost that muscle pump action to get that led going.

Obviously your heart is a muscle too so it needs activity to stay healthy and immobility will lead to atrophy of that heart muscle. So we looking at those cardiac residents coming in especially with their whole rehospitalization we are looking at the cardiac program to make sure that exercise is an active part of that.

Another interesting piece of the cardiac is postural hypotension so a drop in blood pressure upon standing is it noted in as little as 20 hours of immobility. I think of any of you have ever had any kind of surgery done and you have ever worked you know in a post of surgical area I have never met anybody including myself that after surgery that don't experience that dizzy weakness. Imagine a registered two has been immobile for an extended period of time can get postural hypotension. Studies have proven that all happen around the bed. So definitely could be that hypotensive response that leads to dizziness and anxiety to falling and what is interesting about that hypotension is many times we contribute it to the medication. We draw a blank sometimes when we look at their activity level that could be why they are having that response. What is interesting that in even healthy adults it can take several weeks to fully recover once they start moving again so the effects can last for a long period of time before they stop having that sensation.

Overall on the respiratory system we don't think about the fact that our with cages actually joints and can actually have contractures on it leading to the inability to expand the lungs once you have the risk of legs collapsing and is certainly the pulling of the mucus in the lower airways so they have the increased risk of respiratory infections. Studies have shown that stroke patients confined to bed for 30 days or more and many times they spend the majority of time in bed are 2 to 3 times more likely to develop a respiratory infection than the mobile people so you need to be looking at that.

Also look at that mobility level.

Hematological effects is interesting because you will have a decrease in oxygen saturation and an increase in carbon dioxide concentrations which leads to hypoxia and it can happen in a short period of time so it can lead to acute confusion they can develop quickly over a number hours of being bedbound because of symptoms can fluctuate during the day and worse that night. I challenge you to look at some of your residents especially those who have the sundowner issues look at their act to be levels during the day and you might want to check their oxygen saturation levels. See where they are in it could be that they are having a hypoxia response from not being active all day.

Also 13% of patients in bed for long periods of time may end up developing deep vein thrombosis DVDs and at risk for on all of these mobilities effects it can lead to constipation and fico impaction so if you have a residents who is constantly constipated looking at fluid and fighter bourbon also look at their activity levels to see if that could help make a difference.

The other interesting thing is the method that so it can actually decrease in the difficulty in following and then also it can affect the and Eric so it reduces the sense of taste smell and loss of appetite.

Overall on the endocrine system is a decrease in metabolic rate in as little as 10 hours. Of being immobile you develop insulin resistance. You can having paired close call color its and the subsequent development of type II diabetes. This is very impactful and especially if you have residents and you are have trouble controlling their blood sugar despite having a controlled diet and insulin really looking at their activity level and getting them up and moving to help with that insulin distribution.

On the renal system we already talked about the kidney stones but again your bladder is a muscle so it can lead to urinary retention overflow which can lead to urinary tract infection and it can also urinary tract infections because of the immobility could lead to incontinence due to the ability to get themselves to the bathroom and therefore increases that risk or UTIs and urosepsis.

The nervous system has a tremendous impact. Basically we become sensory deprived of when that deprives it leads to depression, disorientation, confusion, restless, anxiety. You would think again if you are resting that you would be, then relaxed but immobility is stressful on the nervous system. When you think of a lot of your residents who are having residents education you might look to see what the activity levels were. It is also interesting because it will reduce the pain threshold so if you have that residents of that is constantly sensitive to pain it could be due to the lowered mobility.

They will have difficulty problem-solving and they can have an overall loss of motivation.

The other system that is affected is the nervous system and it will lead to insomnia so the more you lay around of the more difficult it is for you to get a full good night's last so that leads to insomnia. 16 hours of activity is what we need for optimal function and 78 hours of truly uninterrupted sleep. I don't know any resident who gets truly in nursing home settings that are allowed to get seven or eight hours of either corrupted sleep at night and that are kept active for 16 hours out of the day. It just doesn't happen. Studies have shown that with sleeping for more than nine hours or fewer than eight hours has a negative impact on not only the physical function but the psychosocial, cognitive functions of the residents as well and some newer studies are showing that the importance of actually being very active and getting good sleep has an impact on the gray matter that it backs the plaque and affects Alzheimer's and dementia.

So another motivation to look at the activity level and what is happening at night.

So with all of those goodies that we have look forward to with being immobile how do we prevent the effects of immobility?

First and foremost it starts with the leadership having buy into that and that is very important to. It is a very challenging thing to do especially with our staffing levels and ratios with rabbit residents and facilities of the really do need to have the administrative review and management fully supporting the program and being actively involved with it and committed to the program. Making sure that the right resources are there and that you are working with those folks.

So a starting point to that you might be worth is to assess the current programs happening right now in your programs what is the overall mindset of staff? To even think of it? Has immobility even been something that has blip on the radar scale and has anybody been concerned about the mobility level of your current residence? Look at how many residents depend on milk wheelchairs for mobility. How many of them truly need a wheelchair and should be using a wheelchair and if they are supposed or truly do need a wheelchair are we allowing them to sell rappel and be mobile if they are capable of doing that?

Very important is the relationship between nursing therapies and activities and that is a very important relationship so it is interesting to me when I was working in nursing homes if someone were to ask what the residents were doing to get the residents into

therapy I had could honestly say I had no idea. Many times while what is therapy doing with them and there is a huge disconnect there and many times they get discharged from therapy and they go out with great functioning and maintenance level and they are brought to nursing and it is not continued or brought forward.

We really don't look at it it doesn't just have to be the nursing therapy concern. There is a lot we can do with staff during activities.

Another question to ask is do you currently have a restorative nursing program at what does that actually provide? Right now are you actually doing the minimum? Is your nursing staff understand the importance of promoting independence of the resident or are the nursing program to to be self orientated and to get the job done? So looking at do you even have a basics right now in the restorative and promoting that independence for that residents and that might be the place that you need to start and do your nursing assistants know how to identify the residents of that should be and restorative nursing and working on those interventions?

Looking at your activities during the day and in the evenings there is a lot of things during the day that you can do to promote activity or being actually mobile and active and not only attend a lot of the activities help with being active there is also a lot they can do it activities that also have things with coordination that you actually have to use brain functions of thinking ability as well depending upon the level of your residents you might start with more of the physical act that he but then you might be able to add to that activity different mental challenges as well. So look at that as well. And the very last gold standard out there is once you get through everything else in the program is do you have a sleep hygiene program? Do we train automatically to knock on doors every two hours and interrupt that sleep? So look at the night time and is your facility putting everybody to bed by seven at night? And not getting them up until seven or eight? Is so looking at that sleep program.

One place to start if you decide that this is a stopping that you want to do in your home is you need to get your staff on Ward so I just don't have time is not a good answer. So really starting out with the first half of the presentation and the clinical foundation is to fly immobility is such an issue and why we should address it will help to get the body and especially when you bring it back to the issues with balls and breakdowns and people are declining it could be due to the fact of them being immobile. Your overall gold goal is to aim towards independence on how to rather than doing for the residents so having a mind set with all staff and if you see them struggling or taking me a while for them to do something it is very important that they have the mindset that you want to promote that independence.

First thing you might want to look like as your team and you should not only your interdisciplinary team but you also need to make sure that you have therapy your restorative nursing your lead nurses and lead to nursing assistants. With that being said many of the facilities without work with the one aid and one nurse cannot possibly have the impact on a home as if you involve all of your nursing assistants and all of your floor nurses and you would have those restorative nursing assistants and to oversee the program and work with all of the staff. Also very important is adding in exercise programs and restorative nursing's to be a low bit more fruitful you really need your physicians and nurse back petitioners on board so that they can make sure that they are writing orders and making sure that they are on board with it and that they are getting the green light that it is safe it okay for the resident to actually participate.

Activities dietary maintenance and housekeeping are all very important items to take into consideration. Also another thing maintenance and housekeeping we will take talk about the environment on how to set that up in medicine important to happen the environment that promotes mobility and sometimes environments that look the most pretty don't promote mobility so we will talk about that.

So best practice for the coordination of the program what I strongly recommend is that therapy start with working together and pull in activities but I recommend that a therapist to do an innate initial assessment and the setting up the individual residence program for the nursing or designee to make sure that it is safe and appropriate. There than therapy turns it over to nursing at what therapy should do then is competency test that nursing department on implementing the individual residence program so whatever it is they came up with for that individual residence that mercy does competency testing to show that they are broke performing appropriate for that individual resident. From their they should if the resident needed adjustments so that individual might say if they are having time or if they need more aggressive exercises or if they are starting to have pain associated with abnormal exercise use or change ability to perform exercises so having understanding of when you need to go back to therapy to or readjust that program.

There making sure that Prince physicians approve and ordered the exercise program and then to make sure that that dietary is ensure to a proper calories and protein intake for the level of exercises prescribed.

Now with any program you obviously need benchmarking so for the facility the global benchmarking data you might want to look at your quality measures to make sure that with long-term stays the percentage of residents experience one or more false with the my major industry has increased so that might be some benchmarking that

you might want to start within you can even look at pressure ulcers or even what cause might be due to immobility's.

They're what I strongly recommend is that you set up individual resident benchmark goals and this is very important for goals you have to have a measurable goal for the resident and so you folks in Minnesota particular is because you don't have measurable goals. So I will quickly walk you through some test but you might want to consider for benchmarking data for your residents. Many of these types of therapies are already being used and there is no reason why nursing can't continue to duties in it is great benchmarking to see if the residents are improving. They are all evidence-based and as we walk through them you will see that it is creepy that they have deductibility of adverse outcomes depending upon where you resident false.

So the first one is the short physical performance battery test and it involves the chair rise task, the balance test and the usual gait speed.

Again they are at high risk for these are the residents could potentially have issues so if they are up approaching higher risk outcome and then 9 to 11 is more acceptable and that the desirable. Is the individual resident at a gait speed below the one they have a very high risk for poor health and function and gait speed has been very highly related to that shorter mortality that they actually have so it is very important to look at that gait speed and if you can improve it will improve the health and overall function.

The Dallas test is a great starting point for the exercise program so you might start with& Somebody might not even be able to have the sitting ability so there is no reason that they can't do some exercises in that supine position so that can help you determine where you are going to start them on their exercise program such as lying sitting or supported sitting standing positions how will they be independent? And

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Another test to consider is handgrip strength. Handgrip strength has been shown to be an indicator of overall muscle quality and strength so it sounds odd but it will tell you what the overall quality of the muscles throughout the body is so we definitely want them desirable so we are trying to make them stronger because we definitely don't want that week so it is an easy quick test that you can do for that handgrip for benchmarking. Body mass index also to make sure that they are in the healthy range. And another test is the muscle quality index and the formula is right here and is a strange little formula but the muscle quality index can determine if they will have adverse outcomes are not ended doesn't equate that if it equals this if they are going to have adverse outcomes that why you want to consider is a very sensitive test and it detects sensitive changes in the functional status of the individual so what it is a great

way to pick up subtle changes and really what your goal is to see an increase in the muscle quality index.

They're looking at steps per day and I know a lot of people will have a goal of 150 have a goal of 158. I would like to challenge you to have more than 10,000 steps per day for healthy adults however studies have shown especially in man to have at least 5500 steps today and women at least 4500 steps per day will increase the quality of life.

So a 10 minute walk is comparable to 1000 steps. From there what you might want to do is I would time them on their walk and track their actual steps. From there the goal might be to add 100 to 1000 extra steps per day depending upon the capability of the residents. And possibly get them up to 10,000 steps per day and what we do recommend is that the baseline is to put the pedometer on them for three days doing their normal activities and do it for three full days and track it because they may have one really good day of one bad day so you might want to do three days to get the average so from there it can help add different goals to that.

It is important to understand the coding if you are trying to capture the spirit there is a some capture the you can get them into a higher and it is important that the technique is done for 15 minutes in a 24-hour permitted and that 15 minutes can be broken up as long as it is the same task. So to remove and clean skin for two or more minutes three times a day budget could not do 15 minutes for five minutes of walking five minutes of splints and five minutes of practicing bench transfer. It has to be the same task. In order to have the hit the higher number you have to have to work the more 15 minute restorative ash restorative programs for 6 to 7 days per week and if you do it for four people or lower it can be counted for groups higher than for it can no longer be counted. And again that is a safety reason.

So when you look at the start of nursing programs that is something the highlight here and the ones that are on the screen have two stars count as one activity so you couldn't say that I am on a urinary program and that is considered one same with you cannot do passive on one side that they are doing an active range of motion on the other to that is considered one service and unfortunately mobility and walking training that also counts.

What is interesting and we don't think outside the box a lot is that restorative nursing programs NBS requirements for range of motion is exercises performed by the residents with cueing super basins or ethical assistance by the staff that are individualized to the residents needs plant monitored evaluated and documented in the residents medical record include active range of motion with active assisted range of

motion. Add some weights to it and make it become an exercise and an exercise program that can be coded under that.

Two examples then can be the active exercise that would garner the range of motion and the walking program that you might put together a range of motion and practicing transfers are banned mobilities and etc.

From there it is important that you have a expert restorative care plan and again measurable objectives and interventions which I just gave you some great benchmarking data and for that you have periodic evaluations and ensuring that churn trained on the techniques and that a registered nurse or LPN actually supervise the activities and you want but I recommend here is that you maybe once a month or quarterly actually the restorative nurse looking at the documentation but from there you might want to look at the benchmarking and you might want to start monthly and move it to quarterly when you are doing the benchmarking data for those different tasks to assess where they are at. I am not going to spend a lot of time on the spot what we will capture under part a you can that is a requirement and under part B don't forget about that because Joseph case they are off you can put them into therapy and there begins that the functional maintenance program and they can capture it under part B and transferred over to nursing and from there it goes to maintenance which is nursing doing it.

What is very important also is I have so many administrators say I don't get paid so I want to let. This should not drive it. Or I have a residents it is very wild I can only get them to do a three times a week these do not let your reimbursement drive what you are willing to do so still please implemented these programs if you can capture the reimbursement that is an extra benefit that the overall benefits that you will get are well worth it took

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What you want to do is look at act or sizes and you might want to look at local gyms if you have personal trainers in the area or work with the I can do this for you and develop exercises that can be done individually that are done in 15 minute increments. Make sure that the there is a difference between therapy and true exercise physiology there be many times is targeted to the hip fractures to set up an exercise program that utilizes the full-bodied that will promote strength range of motion lacks ability cardiac output blood flow postural awareness and balance it could looking at that.

Again get exercise that you can do in a supine, sitting or if somebody has some balance issues they can't stand but they have balance issues you can use a standing device and put them in a standing device and they can still do their exercises and that

way they are still getting the benefits and having those that can do it on assisted on and did standing.

Very important exercise that can be during act duties treasure hunts and obstacle courses are one of the best ways to help prevent falls especially with your Parkinson's Alzheimer's dementia residents. One of the reason they fall as they lose the ability to pay of its. That will send off their sensations and it will lead them to fall so have them do little obstacle courses are treasure hunts can help those with pivot type motions pick a lot of your video exercise games are out there that can help with that even if something as simple as throwing a bell because that requires hand eye coordination ended his exercise.

Tai chi is one of the best things that can be done for the elderly so it has linked strength flexibility and body posture.

Yoga, dancing, walking courses and even doing activities while standing so cooking, arts and crafts do it at a high table and have them spread out the programs to operate during the day and get them active in the evenings. A lot of people thought and I was one of those that if you exercise and you should not exercise really at late that exercise after about 8 PM causes you to disturb sleep. Study shows that if you do it before 8 PM it actually helps sleep so keep them active in the mornings and then again active in the evening can help with their sleep patterns.

We all have those days were regarded all day and I am going to sleep really good at night and you think of those days really active is when you get the best rest. So make sure that you without he talked about training all of your staff and not just restorative, train all of your staff on how to do restorative nursing with exercise programs because it can actively involved everyone and environment evaluation is very important. Look at that shiny non-contrasting hallway. You wonder why residents slip and fall especially with poor vision. They don't have any depth perception here so make sure I know that the shiny floor was the cleanest facility and the glare of it was the worst thing that you could've done because it will lead to depth perception issues when they are trying to walk down the halls and so make sure that you don't have shiny slippery floors and make sure that the services don't change. I was in one building that had beautiful tile and it went to carpet and the portal residents going across with their walkers across that pile and then they hit the carpet and it was off all waiting to happen so it looked great but it was not functional so P make sure look at that.

Make sure that grab bars and handrails are position and easy to visualize and we need them. They need to be able to see where those handrails are. Looking to make sure

that you have clear bright lit walkways and very important to have those contrasting colors.

In the residence rooms make sure that the rooms are safe for mobility so proper egress to the bed and mattress is that fear on the floors and that DEP are just slightly above a 90 degree angle. Most falls are rounded near the bed. The beds it should only be put in a low position. If the resident cannot physically get out of the bed anymore then it is important so ensuring that the bed height is appropriate at all times that they have grab bars or a trapeze to help them move safely and securely balance themselves and making sure that their walkers and teams are at the right height fitted for them and are accessible right at that bedside for them.

Make sure that they have a clear path to the bathroom with the right lighting and make sure that there are grab bars at the right height for the toilet seat and for turning the water on they might need extra grab handles to be able to turn the water on and off themselves.

Very important is to have contrast to the bathroom so they can see the toilet if you have a white toilet with white walls and wife Lori they will not find the toilet so even a black toilet seat can help with that.

I also recommend stand assisted devices and have them dedicated to restorative nursing and even if you stand less or if you have it again folks with balance issue that they can stand and it is just a balance concern then you can exercise and that weight-bearing position.

Make sure you have accessible exarch exercise a quiz test equipment I've been to facilities that have beautiful gems and great equipment but nobody can get there that you don't need anything expensive you just look at the next couple of slides these are just the Temple simple tools the little body weight is all they need to have therapy with exercise programs exercises to so you use resistance bands with handles restorative ankle weights with straps ankle weights foam rollers etc.

From their make sure that they have appropriate footwear at all times and they are working out and then make sure you protect the skin from skin tears and longsleeved or protective garments when they are working out and very important is get input from the family members how did they like the programs would they like to do and you might be surprised how many family members are personal trainers and would help with the actual program so getting their feedback and having them actively involved in they can even come in if they have competency testing and many of us have that guilt of putting a loved one in the nursing home and if they did it they could

commit a doer nurse exercise programs with them what a great way to be actively involved.

And last but not least if you want to look at promoting sleep some key things that you do have to get in places that at night you should only use amber tones because that will help promote sleep. Look at the lighting and make sure there is no noise to wake people up and if you are going to let them sleep uninterrupted safely you want to make sure they don't get pressure also so you have to have support services and make sure that those fields are up off the bed bed that they have appropriate address for overnight and that they are allowed to sleep for at least four hours or more. The end goal is keeping residents active during the day and promoting sleep at night.

So I have some resource references here and immobility studies that I went through in the first part and I only hit the tip of the iceberg a lot of the effects of you do take the time and read those over they are very interesting to read. So with that being said I would like to turn this over to questions.

Thank you very much.

You are welcome.

That is a lot of great information so if you could operator if you could remind everyone how to get into the queue for questions and comments.

Up to

If you have a question please oppressed star and then went on your touchstone phone.

Our first question is from Christina. Please go ahead.

I am sorry, I is trying to mute my phone so I do not have a question and I am so sorry.

Hello and thank you. [Laughter]

Our next question is from Louisa please go ahead.

I am just wondering if we can get a copy of the slides that were presented today?

That would be up to you I don't know if you want them to actually have your PowerPoint slides. Not to the PowerPoint slides but the handouts are just fine.

I will send the link for the handouts again in the chat.

That would be perfect.

All right. In the next questions from the mirror Burdette. Please go ahead.

That was my question as well. Thank you. [Laughter]

Our next question is from Cindy these go ahead.

My question is you talked about therapy and groups of four or less. So you are saying that we cannot do large group, we cannot count large groups of?

Right and the restorative so if you are doing group activities as a large group unfortunately cannot count that please still do it but if you are trying to track it on the restorative it has to be a group of four or less.

Thank you.

It is a safety issue when you are doing specific individualized versus activities such as tai chi or ball throwing up whatever.

Thank you.

You're welcome.

Our next question is from Mary ran. Please go ahead.

You were talking about individual goal tests for the benchmark. I wanted to know what the chair rise is and the balance. For the usual gait?

It is part of there is a three retest in there and I guarantee you your therapy is probably already doing those tests so you certainly can ask them if they have it and if not I have a physical performance test that we use where it is integrated and you can get that information but I would check with your therapy and asked them because you will have good benchmarking from their data.

So these are just certain test or is it like any chair test?

The what you do is time the person is you put them in a chair at the appropriate height for their feet and their legs at a 90 degree angle and what you do is you have them try

and stand up without using their hands and you time them and what you want them to do is stand up and down the fast they possibly in the chair and that is what you are looking is their ability to not use hands as weight that they can just physically get up and how quickly and how many can they do in one minute.

In a minute okay.

Yes.

There is a question and chat. Any suggestions for how to drive your quality measures down for a loss of ADLs and I guess you response is everything that we just talked about?

Yes this is one of the things that if you are in that area first I would do a little investigation so I would look at who had shown a decline in the ADLs and I always start so check first to see if it was a coding issue and it gets tricky on the ADLs on the MDS because you might have somebody that has actually very independent during the day but at night they will have a couple of instances where staff actually helps them so you code it at that highest level and sometimes it may look like they had even declined when they actually used to need assistance were now they don't so that peace gets a little sticky. So I would look at who is look at how they were coded and also look at what areas that they are declining in so you can target that and the biggest thing is getting them mobile as where you are going to hopefully prevent so that staff isn't having to try to reposition them or their anyway with the transfer etc.

Hopefully that makes sense.

Thank you and I think our time is about up there is one more question. Isn't it true that groups can be done as long as there is a 4 to 1 ratio?

Yes, absolutely. So you can have people throughout the room and you have your little groups of four and yes so as long as it is the one before Ray show than absolutely, yes you can do that.

It is just making sure that it is a 1 to 4 ratio actually being met.

Thank you very much. If you have further questions my contact information there and certainly you can definitely find me.

Thank you very very much. Lots of great information and we appreciate it. Thank you to all of the organizations who have participated in this webinar we had a great

turnout and I hope you can all take of what you learn back to your homes to improve the quality of the life of your residence. Hopefully you saw that there was some polling questions that came up on the screen and I hope you take the opportunity to answer those.

This concludes the webinar and everyone have a really great day.

Thank you very much.

[Event Concluded]