LONG-TERM CARE RESIDENTS AND THERAPY

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- Long-Term Care residents in SNFs are often the ones who need therapy intervention the most
- They are often unable to identify changes in personal function, be unaware of how to seek a therapy referral, or be suspicious of therapy intervention
- SNF staff should never assume that a Long-Term Care resident will decline in function because of diagnosis, cognition, age, or injury
- It is the role of the SNF therapist to either rehabilitate lost skills, modify the environment to adapt to them, train caregivers/staff how to safely and effectively provide care, and/or put interventions in place to prevent further decline

THERAPY SCREENS

- A screen can be completed by a therapist or an assistant
- If completed by an assistant, the OTA/PTA collects data and reports information back to the supervising therapist who makes the decision whether or not further evaluation is needed
- Screens determine the need for an evaluation ONLY. Based only on a screen, a therapist/assistant CAN NOT:
  - Make recommendations
  - Prescribe/change positioning equipment or splints
  - Prescribe/change adaptive equipment
  - Transition to a higher diet texture/liquid consistency
  - Add a restorative nursing program (RNP)

EVALUATION-ONLY

- The evaluation-only is used to officially document the current level of function of that patient.
- The evaluation-only can also document the effectiveness of current interventions (equipment, splints, RNP, diet texture, etc)
- NO TREATMENT CAN BE PROVIDED WITH AN EVALUATION-ONLY! EVEN ON THE DATE OF THE EVALUATION!!
- Based only on an evaluation-only, a therapist CAN NOT:
  - Alter a current program
  - Prescribe/change positioning equipment or splints
  - Prescribe/change adaptive equipment
  - Transition to a higher diet texture/liquid consistency
  - Add/alter a restorative nursing program

EVALUATION AND TREATMENT

- If therapy is making recommendations, training caregivers/staff, adding/altering RNP, modifying diet textures/liquid consistencies, adding/altering equipment or splinting, etc, the patient should be placed on therapy caseload for treatment:

1. Determine goals based on needs of DC
2. Rehabilitate patient deficits to reach goals
3. Make recommendations, add or alter equipment/program/splints/etc
4. Insure effectiveness of recommendations/programs
5. Provide training and safe/effective carry-over to caregivers and staff

QUESTIONS TO ASK DURING EVAL/SCREEN:

- Has this resident been referred for an evaluation and, if so, for what?
- How has this resident's function changed (for the better or the worse):
  - In the last month
  - In the last 6 months
  - In the last year
  - Since the last therapy intervention
  - Because of an injury/incident
- Has something changed about the resident that would make them more likely to benefit from therapy? (ex: cognitive change, medication change, decreased pain)
- Is the patient currently on a Restorative Nursing or Functional Maintenance Program?
  - If not, would they benefit from one?

ROLE OF THE PHYSICAL THERAPIST

"I don't know why this patient is on my schedule for evaluation. They haven't walked in years"

<u>Areas of Focus for PT Eval/Screen</u>

- Ambulation
- Transfers
- Falls
- Bed Mobility/positioning
- Wheelchair mobility/positioning

- LE ROM/Joint Integrity
- Pain
- Wounds
- Sitting/Standing Balance

ROLE OF THE OCCUPATIONAL THERAPIST

"This resident can not dress themselves. They do not need an OT eval"

<u>Areas of Focus for the OT Eval/Screen</u>

- Dressing
- Bathing
- Self-Feeding
- Bed mobility/Positioning
- Wheelchair mobility/Positioning

- Pain
- UE/Hand ROM/Joint Integrity
- Wounds
- Sitting/Standing Balance

ROLES OF THE SPEECH THERAPIST

"Nursing can increase diet textures without me"

<u>Areas of Focus for the ST Eval/Screen</u>

- Receptive Language
- Expressive Language
- Communication Devices
- Upgrading Diet Texture
- Upgrading Liquid Consistency
- Cognitive Programs
- Etc

PLAN OF CARE/DISCHARGE PLANNING

- Be THOROUGH during the evaluation/screen and address all aspects of that resident's function, strength, joint/skin integrity, cognition, etc.
- If patient was referred for a specific concern, make sure it is addressed on the screen/eval, as well as any other deficits areas that your discipline can address
- Think about the resident's daily routine within the facility, as well as their own needs and preferences. They are people and this is their home.
- Be sure to document your plan for follow through after therapy DC (if no RNP, therapy should train staff/caregivers and document it)

RESTORATIVE NURSING PROGRAMS

Programs Recognized for Case Mix Indexing

- AROM/PROM (counts as 1 program)
- Bed mobility/Walking (counts as 1 program)
- Transfers
- Feeding/Dining
- Dressing/Grooming
- Communication
- Splint/Brace Care
- Amputation/Prosthesis Care

RESTORATIVE NURSING PROGRAMS

Other Possible Restorative Nursing Programms

- Sitting/Standing Balance
- Wheelchair mobility
- Exercise and Activities

- Regardless of plan, RNAs must receive DOCUMENTED TRAINING AND DEMONSTRATION prior to therapy DC
- Frequency does not always have to be 6x/week. Prescribe what you think is appropriate (3x/week, 5x/week, etc)

ELEMENTS OF THE RNP REFERRAL

1. Specific program identified
2. One referral sheet for each program
3. MEASURABLE goal
4. Specific precautions and instructions
5. Type of cueing and assistance needed
6. Type of equipment needed
7. Signature of THERAPIST (preferably)
8. Signatures of RNAs
9. SPECIFIC weekly frequency (ex: 6x/week). NO RANGES (ex: 3-5x/week)
10. Expected duration of program

PROVIDING/DOCUMENTING SKILL

- As with short-term Med A, documentation must demonstrate the skill (ie: can not be provided by non-therapy staff) and necessity of LTC therapy!
- DOCUMENT WHAT YOU DID THAT ONLY YOU COULD DO! NOT JUST WHAT THE PATIENT DID!!

Examples of Skill

- Task/Environmental modification
- Caregiver/RNP training
- Devising RNP/FMP
- Patient instruction
- Facilitation/Inhibition of muscle tone

- Joint approximation/Manual therapy
- Physical Agent Modalities

NOT SKILL

- Ambulating patients
- Dressing/bathing patients
- Performing PROM (even “gentle ROM”)
- Transferring patients
- Watching patients exercise/assemble puzzles
- Feeding residents

WHAT WOULD YOU DO?

- Patient due for quarterly physical therapy screen. She has been bed bound for the past year with no physical therapy intervention in that time. Prior to that, she had been transferring with RNP with minimal assistance. She isn’t currently on any RNPs and only interacts with floor CNAs for daily care.

WHAT WOULD YOU DO?

- Considerations
- Why did she lose her ability to transfer with no PT referral?
- Why did RNP discharge?
- Could she regain her ability to transfer?
- Is there another transfer technique (ie: sliding boards) that she could do?
- Could she do bed mobility?
- How is her skin and joint integrity?
- Is she in pain?
- SURELY she would benefit from 1 or more RNPs

WHAT WOULD YOU DO?

- Patient referred for Occupational Therapy due to steadily decreasing ADL skills. OTR is very familiar with this patient, as he typically refuses therapy sessions and/or doesn’t retain information. Recently, the patient’s Aricept dosage was changed and all departments are reporting that the patient is a completely different person.

WHAT WOULD YOU DO?

- Considerations
- Has the change in medication dosage changed the patient's willingness to participate?
- Has the change in medication dosage changed the patient's ability to retain information and tolerate therapy?
- Could the patient return to a long-lost PLOF to reduce reliance on caregivers?
- Would the patient benefit from RNP in order to prevent future decline?

WHAT WOULD YOU DO?

- Over the past year, patient has regressed from a PO diet and liquids to a PEG tube. SLP has never worked with the resident, but overhears dietary and nursing discussing that the family often brings in soft pleasure foods from home. Report is that the patient is tolerating these pleasure foods without issue.

WHAT WOULD YOU DO?

- Considerations
- How did the patient regress from PO diet to a PEG tube with no ST referral/intervention?
- Is the patient truly tolerating pleasure foods without issue?
- If so, could the patient tolerate a diet texture upgrade and reduce/eliminate dependency on the PEG?
- Is the family providing pleasure foods safely?
- Would RNP feeding be safer/more consistent?

REMINDERS

- Do not assume that LTC resident functional/cognitive decline is inevitable. It is YOUR job to prevent decline, modify the environment to mitigate effects of decline, train caregivers how to handle decline, and/or put measures in place to prevent further decline
- Be thorough and address all aspects of that resident's daily activities, mobility, wants, preferences, etc
- Establish a clear post-therapy discharge follow up plan
- DOCUMENT, DOCUMENT, DOCUMENT

QUESTIONS?

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