A Dedicated Approach to Restorative Nursing

ABSTRACT
This study was conducted to determine whether a dedicated restorative nursing program fostered improvement in residents’ functional status and quality of life. Restorative nursing assistants were selected, provided with special training, and under RN supervision, were solely responsible for the delivery of restorative care. The dedicated program was provided to 50 residents in a long-term care facility. Data were gathered using the Minimum Data Set, which measures activities of daily living, continence, and mood status in long-term care facilities. The data parameters included functional status and depression. The results indicated that a dedicated restorative program did foster improvement in some areas of functional ability. Dedicated restorative nursing staff were able to complete assignments in an efficient, timely manner and document results. The program led to more consistent care delivery and a higher quality of care.

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Nursing facilities across the nation have been providing restorative nursing care to residents as part of their compliance with federal regulations for long-term care facilities. The Centers for Medicare & Medicaid Services (2006) defines rehabilitative or restorative care as “nursing interventions that promote the resident’s ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning” (p. 3-191).

BACKGROUND

Restorative nursing is not based on a medical disease model. It is “nursing-conceived and nursing-delivered, and must be carefully crafted to meet the individual needs of the resident” (Klusch, 2005, p. 5). In defining the basic elements of rehabilitative or restorative nursing, Routasalo, Arve, and Lauri (2004) stated that the main point of interest “is not with a specific disability and how it can be cured; instead, the focus is on the older patient for whom that disability is causing problems” (p. 212). McCloskey (2004), in her study of restoration of functional ability of participants age 80 and older, found that older adults are able to regain functional ability following significant decline. Roehl et al. (2006), after a 3-month pilot study, concluded that their dedicated restorative nursing program may have a favorable impact on falls, activities of daily living (ADL) scores, walking, and bowel incontinence. In Resnick et al.’s (2006) study, the author found that if older participants believed they could perform an activity, they were motivated to do so.

Even if restorative nursing care maintains a person’s level of functioning instead of increasing it—therefore delaying decline in functioning—it is still worthwhile. According to Rensburg, Armacost, Radu, and Bennet (2001), “maintaining and slowing or delaying functional decline may be just as important as improving function, and may be a more realistic goal for restorative programs” (p. 278).

The provision of restorative nursing is based on a mandate in the U.S. Code of Federal Regulations (“Requirements,” 2002) that long-term care nursing facilities “must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being” (p. 509). Because of this requirement, it is probable that multiple restorative programs or approaches currently exist in nursing facilities. However, there is still comparatively little information about these programs’ effectiveness in helping residents achieve their optimal level of functioning. Nursing facilities may choose to provide restorative care through the integrated efforts of all nursing assistants or through a dedicated program that uses only specially trained nursing assistants.

In addition to evaluating effects on residents, it may also be beneficial to look at the efforts and responses of nursing assistants, the staff who typically provide restorative nursing care. According to Resnick et al. (2006), the success of any restorative intervention “depends on nursing assistants’ receptiveness to learn new skills, and their motivation to use these skills regularly” (p. 40). Rensburg, Armacost, Radu, and Bennett (1999) stated that the nursing assistants in an integrated model of restorative care complained of insufficient time to provide restorative activities. This situation could negatively affect resident outcomes. Collard and Krechting (2004) also concluded that the success of a restorative program should be measured by identifying and celebrating nursing assistants’ efforts and successes. It follows that such positive results may in turn depend on the kind of support that nursing assistants receive from peers and supervisors.

PURPOSE

In complying with the mandate to provide restorative nursing care, our nursing facility had been using all nursing assistants to carry out all restorative interventions with residents. Each assignment included specific restorative activities designed to help residents live as safely and independently as possible. The expectation that the nursing assistants could meet the regulatory requirements of providing two different restorative activities for 15 minutes per day for 5 to 6 days per week proved unrealistic. Although willingness to provide this care was evident, the nursing assistants became frustrated that their efforts often had to be sporadic and incomplete because of other care responsibilities, insufficient time, necessary scheduling changes, and other variables. For example, a nursing assistant assignment of 8 to 10 residents may include 4 to 5 residents on a restorative program. If the nursing assistant were to provide two restorative programs at 15 minutes each, it could require 2 to 2.5 hours devoted solely to restorative activities.

Although the nursing staff recognized that a successful restorative program would ultimately help both the residents and staff, they agreed that the inconsistency of the current restorative efforts formed a barrier to success. Nursing administration decided to focus on developing a dedicated model of restorative care to meet the needs of residents most effectively and consistently. The purpose of this article is to describe a dedicated restorative nursing program provided by a selected staff of restorative nursing assistants (RNAs).

METHOD

A team of nursing management consisting of the Vice President of Health Services, the licensed Nursing Home Administrator, the Director of Nursing, the Director of our Outpatient Department, three Nurse Managers, the RN Assessment Coordinator, and the Education Coordinator convened to thoroughly discuss the situation and
decided that a dedicated restorative approach could better serve the nursing staff’s commitment and the restorative needs of our residents. The team believed that developing a small core of trained nursing assistants, instead of using all nursing assistants, could be the key to achieving consistency and continuity in restorative nursing care. RNAs were trained by the physical therapy department in restorative care procedures. They were given training in providing active and passive range of motion, the use of various kinds of walkers and gait belts for ambulation, and applying and removing splints. Minimum Data Set (MDS) data were used to measure outcomes of this new program at 3 and 6 months after implementation.

**Nursing Assistant Selection**

The nursing management team agreed that setting the groundwork for selecting a core of RNAs was important in assuring fairness and making the best choice possible. The decision was made to draw from our present pool of nursing assistants, but it was emphasized that it would be the nursing assistants’ choice whether or not to apply for an expanded nursing assistant position. Initial requirements included the completion of an application stating why the individual sought the new position and what skills he or she would bring to the role.

Each candidate also had to acquire written recommendations from two supervisors. The Director of Nursing reviewed each applicant’s personnel file for disciplinary actions, excessive absenteeism, and lateness. Representatives for the nursing management team then interviewed each candidate informally. Other criteria for acceptance included at least 18 months of employment as a nursing assistant in the facility and passing a basic skills examination. Subsequently, the nursing management team collectively chose six candidates as the new RNAs. In addition to being selected initially for their qualifications and enthusiasm, the RNAs were chosen for their initiative, excellent attendance, and absence of disciplinary problems.

Each one received specialized training and a certificate of completion from the rehabilitation department. Two of the RNAs were assigned to the day shift in the 148-bed facility, and one to the evening shift, 7 days per week. The six RNA positions were over and above the current nursing assistant staffing levels of the facility. They were dedicated to the program and could not be reassigned to other duties.

**Resident Selection**

Residents were selected for the restorative program on the basis of two criteria: Some were included by the nursing staff because of their physical decline, and some were recommended by physical or occupational therapy staff after more formal rehabilitation programs were finished. Length of stay in the program depended on residents’ ability to reach goals and perform restorative tasks. Discharge from the program was based on the residents’ reaching set goals or a plateau.

**Resident Data**

A total of 50 residents receiving the nondedicated restorative program were transitioned to the dedicated restorative program and included in this study. Decisions for individualized restorative programs were made by the Director of Nursing and the Nurse Managers. The residents’ ages ranged from 65 to 85+ (15% were ages 65 to 74, 35% were 76 to 84, and 50% were age 85 and older). Thirty-six women and 14 men were included in the program. Primary diagnoses included 15 residents with cerebral vascular accident, 10 with dementia, 7 with Parkinson’s disease, 4 with chronic obstructive pulmonary disease, 4 with congestive heart disease/coronary heart disease, 4 with status postfracture leg/hip, 2 with brain injury/tumor, 2 with multiple sclerosis, and 2 with peripheral vascular disease.

Residents were in the program for 6 to 20 weeks, with an average of 12 weeks. Programs included ambulation, passive range of motion (PROM), active range of motion (AROM), balance and strength training, transfer and mobility training, splint use, and ADLs. Data for the study were derived from the MDS, taken at baseline, 3 months, and 6 months, with baseline data being the start of the restorative program. Parameters observed were ADLs (e.g., dressing, toilet use, transfers, eating), walking, locomotion, indicators of depression, bladder and bowel incontinence, contractures, and falls.

The MDS provides reliable, objective data to measure these parameters. Coding is standardized and...
comprehensive care plans and for federal reimbursement. Measurements Several different scales on the MDS were used to measure the data observed during this study. The ADL score is based on a formula derived from four categories of section G on the MDS. The coder completes section G, which measures the resident’s ability to perform ADLs, namely the tasks of dressing, transferring, toileting, and eating, along with the amount of assistance needed. The ADL score is calculated from the completed section G. The higher the ADL score, the more dependent the resident is on assistance from the nursing facility staff. ADL scores of 4 to 9 indicate that minimal assistance is needed with a particular ADL task. ADL scores of 10 to 14 indicate moderate assistance is needed, and scores between 15 to 18 indicate maximum assistance is required.

Locomotion and walking are also scored in section G of the MDS on a scale of 0 to 4. A score of 1 indicates that the resident needs verbal cues, and a score of 2 indicates that he or she needs light hands-on guidance with the activity. The score of 3 indicates that this activity requires the staff to provide most but not all of the weight-bearing assistance. A score of 4 indicates that the activity requires full weight-bearing assistance, all of which is provided by staff. On this scale 0 is the most independent, and 4 is the most dependent.

Indicators of depression are measured from section E of the MDS. Coders have a choice of 16 indicators to check to identify possible depression. This alone does not diagnose depression but rather is an alert to possible mood changes. The study measured positive responses to any of these 16 indicators. The lower the number of total indicators, the less likelihood that the resident is experiencing an episode of depression.

Bowel and bladder incontinence data are taken from section F of the MDS. Scored on a scale of 0 to 4, 0 is the most continent, 1 is usually continent, 2 is occasionally incontinent, 3 is frequent daily incontinence, and 4 indicates incontinence most of the time. Contractures were measured using data from section G of the
MDS. The response of no indicates no contractures were present.

Falls were studied using data from section J of the MDS. The MDS requires the coder to give a yes or no response to whether the resident has fallen in the past 30 days. A yes response indicates that a resident had experienced a fall. It is important to note that the MDS only measures a yes/no response to the question of falls, not the number of falls that a resident may have had during a particular time frame. The individual number of resident falls was not measured in this study, only that a fall had occurred in the past 30 days.

RESULTS
Resident Results
3 Months. Initial function was measured before the restorative intervention. Baseline data were obtained for ADL scores, walking, locomotion, depression, bladder and bowel incontinence, contractures, and falls. At 3 and 6 months, scores did improve. Residents who had been more dependent became less dependent.

At 6 months, 33% of the residents had improved ADL scores (Figure 1). In the area of walking, 30% showed improvement. However, those who did not walk before and those most dependent in this activity showed only slight improvement (Figure 2). Overall, in locomotion, approximately 20% showed improvement, with those able to propel a wheelchair with assistance improving and those who propelled some of the time also improving (Figure 3).

The area of bladder continence showed little to no improvement with more than 60% remaining at the same functional level (Figure 4). Bowel continence showed 33% of residents with improvement (Figure 5).

The area of possible depression showed no improvement, with measurements remaining almost unchanged from baseline (Figure 6). A decrease in occurrence of new falls was noted, and the number of contractures remained the same.

6 Months. At the 6-month data collection point, there was minimal change in residents who were very dependent. Those residents who required light-to-moderate assistance now required less assistance. ADLs were improving, but residents who were initially dependent in ADLs remained dependent.
In the area of walking and locomotion, those who started very dependent on staff assistance remained dependent, showing little gains. Those who had some level of functional ability at the beginning made improvements. Bladder continence showed no improvement at the 6-month mark, falls remained the same, and contractures were unchanged (Figures 1-6). At 6 months, improvements in ADLs, walking, locomotion, and bowel continence slowed down. This may have been due to existing underlying disease progression, presence of infection, or new diagnoses.

**RNA Results**

We believed that a dedicated restorative nursing assistant staff was essential to the success of the program. RNA motivation was supported by regular meetings with nursing administration where RNAs could voice concerns and establish rapport. The meetings also provided recognition of a job well done. The RNA staff have also maintained open communications with the regular nursing assistant staff. This has enabled RNA staff to discuss with the nurse managers those residents who may benefit from the restorative program. Communication has improved among all staff involved in the program. RNA input was considered by the nurse managers when discussing residents’ participation in the program, progress, or discontinuation of the program.

Residents have anecdotally stated that they enjoy the consistency of having the dedicated staff, as well as the individual attention provided by this staff. RNAs have stated that they believe the residents involved in the program have benefited physically and emotionally. Benefits to the restorative program have included improved documentation, enhanced quality and content of the program, and consistent completion of RNA assignments. To date, there has been no RNA attrition from the program. Only one RNA developed a problem with absenteeism, but this was resolved and not repeated. All RNAs continue to attend monthly meetings with nursing administration and have provided helpful input on programs, equipment, and case load.

One identified problem is the difficulty some RNAs experience after
particular residents are discharged from the program. The RNAs become emotionally attached to the residents and want to continue working with them even after the goals had been achieved. When residents are discharged from the program, they do receive specific maintenance activities (e.g., range of motion, walking programs) to be provided by the regular nursing assistants. This is to ensure that functional gains are maintained for as long as possible. However, it has been noted that the provision of maintenance activities by regular nursing assistants is often limited by time constraints. This indicates that further research is needed to determine the scope of follow-up maintenance to be provided by regular staff after residents are discharged from the restorative program.

**DISCUSSION AND RECOMMENDATIONS**

This study shows the benefits of a dedicated restorative program for nursing practice in the area of long-term care for older adults. From the residents’ viewpoint, restorative nursing can help delay decline and improve quality of life. Because the same RNAs provide the program daily, residents form a bond with them, and a continuum of care is fostered. Increased functional ability makes the provision of care easier for both staff and residents. On discharge from a restorative program, regular nursing assistants often find residents less dependent and therefore better able to participate in ADLs. A dedicated restorative program provides nursing administration with consistent documentation and helps meet regulatory requirements. Declines in function are quickly noted and can be addressed more rapidly, as RNAs voice concerns to the managers who decide program interventions.

Further study and research is needed to determine the scope of maintenance programs needed to help retain functional gains after a resident is discharged from the restorative program. It would also be beneficial to nursing practice to study more fully the role restorative care programs play in reducing the number of falls and injury incidents in this population.

Overall mood did not change with restorative care. It was our initial assertion that restorative care would improve mood and decrease depression. Although residents voiced that they were happier during the provision of restorative care, the data show that the program did not increase overall happiness. Further studies using a geriatric depression scale, medication review, and other parameters of social well-being, along with restorative data, are indicated. Related studies and research are needed to determine whether RNAs’ level of motivation and consistency remain strong after 6 or more months, when programs are perceived as mundane and residents’ progress tapers off.

**LIMITATIONS**

The authors realize that there were several limitations with this study. This study used only one data source, the MDS. Knowing that the resident is in a nursing restorative program may have affected the objectivity of the MDS coder. Coders should use direct observation, chart data, and resident and staff interviews for accurate MDS completion. The time frame of MDS completion, completed every 90 days on each resident, may not capture all changes in functional ability in a timely manner. This study could not determine the increase or decrease in the individual number of resident falls or the overall impact of a dedicated restorative program on falls. In addition, although residents enjoyed the program, depression indicators did not seem to improve with the program.

A major limitation of this study is that we did not test the results of adding additional staff to existing nursing assistant staff as a way of improving the restorative program. Although we believed a dedicated staff would work, no other alternatives were tested. Further research comparing dedicated programs with other alternatives, such as addition of nursing assistant staff, is warranted before the dedicated program can be recommended as the best or first-line approach for any facility.

Further studies using different tools to measure falls, contractures, and depression are needed to determine the program’s impact in these areas. A comparative study with another facility and larger resident and RNA samples would be beneficial in determining whether our results can be duplicated on a larger scale. Observation of responses to a dedicated

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**KEYPOINTS**

**Restorative Care Program**


1. This study was conducted to determine whether a restorative program with dedicated staff fostered improvement in residents’ functional status and quality of life.

2. Dedicated restorative staff were able to complete assignments in a more efficient manner, leading to consistent care delivery.

3. A restorative care program with dedicated staff did increase resident participation and functional ability and led to improved documentation.
restorative program among the different age cohorts of our resident population may also yield results that can be used to tailor individualized programs. As stated above, further studies comparing different approaches to improve restorative care delivery need be conducted to find solutions that will work for individual facilities.

CONCLUSION

A restorative care program with dedicated staff did increase resident participation in ADLs and functional ability and improve staff documentation. The traditional approach of using regular nursing assistants to provide restorative care was not working in an efficient manner. Staff nursing assistants are required to help residents with or perform numerous tasks, such as dressing, feeding, bathing, and toileting. Often, restorative nursing is given a lower priority as time constraints occur with assignments. Elaborate restorative programs (those with two or more exercises) are often difficult for staff nursing assistants to fit into daily resident schedules. It is also difficult to achieve a consistent level of staff restorative training with large nursing assistant populations. The dedicated RNAs approached the program with a stronger sense of ownership and consistency than did regular nursing assistants with the traditional approach. Because the RNAs were not responsible for all aspects of resident care, their priorities were clear and included only meeting the restorative needs of the residents.

Promoting and maintaining functional ability in a long-term care setting has widespread implications. Further studies of restorative care programs will not only increase our knowledge base but will assist us in maintaining residents’ functional abilities and improving their overall quality of life.

REFERENCES


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