

*Illinois Department on Aging*  
Illinois Long Term Care Ombudsman Program  
Supplemental Training Curriculum

**Supplemental Module # 9**

**A Quality Activity Program Indicates a  
Quality of Life for All Residents**

Pre-publication Edition I

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## **PROCESS FOR USING THIS MODULE**

The supplemental modules for ombudsmen have been created to accommodate different learning styles and are based on research about how most people learn. The premise on which this module is based is the idea that new information is learned best when there is an opportunity for discussion and to ask questions. This module incorporates individual reading, group discussion, questions on what is not clear to you and an evaluation of what you have learned.

This module is designed to be adaptable to various teaching methods and settings: training/ in-services for ombudsmen or presentations to families or facility staff. This module can be divided into as many training sessions as needed and a variety of methods can be used, including a lecture method.

After the discussion, you will be asked to write:

- 1) As a small group, develop a proposal the ombudsman would recommend to help improve the activity program in a facility, including recommendations for starting or maintaining a family council. Consider your role as a change agent.
- 2) At least five questions, but as many questions as you have, about the information in this module.

## **PURPOSE OF THE MODULE**

The purpose of this module is to:

- Provide the federal regulations and guidelines and state regulations pertaining to the provision of activities for residents.
- Provide awareness that an appropriate activity program is critical to a resident's quality of life. In addition to promoting a resident's health and emotional well-being, the extent of a resident's participation in activities can assist the facility in identifying a resident's functioning abilities: physically, mentally and socially.
- Identify the role of the ombudsman program to promote family councils, as family participation is essential for improvement in all aspects of quality of life and care in the operation of a facility, including an activity program. Families and the community bring life into a facility.
- Identify a quality activity program as a comprehensive, planned, systematic and ongoing program.

- Identify the facility supervisory staff as having the responsibility for implementing a quality activity program. The administration of the activity program is usually implemented by members of the “quality assurance committee,” in which the activity director plays a prominent role.
- Identify how an activity program should be observed by an ombudsman. An activity program should not only be evaluated by the involvement of the residents in activities. A successful activity program provides ongoing activities appropriate for each resident, based on each resident’s past and current interests and abilities.
- Identify an appropriate activity program as one that conforms as closely to the resident’s past lifestyle as possible. In order to provide such a program, the facility must maintain a healthy long term care system. If a facility is unable to care for the daily physical needs of a resident, such as cleanliness, adequate nutrition and hydration, and medical treatments, then the activity program will not be adequate either. The direct care staff must be involved in the activity program, since daily activities can be enhanced to become “spontaneous activities.” For example, encouraging a resident to take an active role in selecting her clothes and combing her hair allows the resident to take pride in her appearance.
- Identify the Pioneer Movement cultural models that support spontaneous activities for residents.

# SUPPLEMENTAL MODULE #9

## A QUALITY ACTIVITY PROGRAM INDICATES A QUALITY OF LIFE FOR ALL RESIDENTS

By Margaret Niederer and Erin Strotheide

*NOTE: This module applies to nursing facilities. This includes skilled care, intermediate care nursing homes, and hospitals licensed under the Illinois Nursing Home Care Act.*

### I. INTRODUCTION

The ombudsman needs to understand the importance of a diversified activity program that meets the needs of long term care facility residents. With the support of all facility staff, family members, and the community, residents are given the opportunity to live healthier and more active lives. In order to determine how to best cooperate with facilities in supporting resident, family and community involvement, this module was developed in cooperation with the Illinois Council on Long Term Care, which provides substantial support for its member facilities in the area of resident activities. This association represents over 200 facilities in Illinois and provides content-laden, quality materials on how to involve families in a facility's activity programs.

Although residents enter a long term care facility for medical treatment and/or help with daily living skills, it is critical to the maintenance or enhancement of each resident's quality of life, and also their well-being, that there be activities that allow them self-expression and choice.

The "health" of a facility and its residents can be measured by the "health" of the activity program.

Staying active, pursuing past hobbies, and discovering new interests are all components of a living, growing person. Facilities are required to incorporate these components into their care systems. It is no longer acceptable for residents to sit for long periods of time with nothing to do.

*It is critical to the maintenance or enhancement of each resident's quality of life, and also their well-being, that there be activities that allow them self-expression and choice.*

Long term care means caring for residents in all aspects of their lives. The passage of the Omnibus Budget Reconciliation Act 1987 (OBRA), the relevant portion called the Nursing Home Reform Law, was the first step toward making much-needed changes in the nursing home system. This law initiated a whole new way of thinking about long term care. The long term care field began to hear terms like quality of care, quality of life, dignity, choice, and self-determination. No longer could care consist of providing the bare essentials of medical treatment. OBRA brought standards and regulations that would insure residents' rights to "care and services 'to attain or maintain the highest practicable physical, mental, and psychosocial well-being'" (42 USC Sec. 1396r (b) (2)).

This program believes there are four prerequisites to the provision of an activity program that is compliant with the spirit of the law and promotes a quality of life:

1. The culture and the environment of the facility must support and focus on the activity program.
2. The culture and environment of the facility must promote self-expression and choice.
3. An activity director must be knowledgeable about individual care plans and must know the psychosocial needs of each resident to provide appropriate programs.
4. Although family councils are not required, an active council is critical to encouraging families and the community to support the residents' activity program.

## II. THE FEDERAL AND STATE REQUIREMENTS

### **A. THE FEDERAL LAW: QUALITY OF LIFE AND QUALITY OF CARE REQUIRE ACTIVITIES FOR RESIDENTS**

The two standards of **Quality of Life** and **Quality of Care** have been the impetus for the current state and federal regulations regarding long term care facilities. According to OBRA, **Quality of Care** means residents receive services that allow them to attain and maintain the highest practicable well-being. Any decline in a resident's condition is unacceptable unless it is due to an unavoidable clinical condition (42 USC, Ch. 7, Subchapter. XVIII, Part A, Sec. 1395i-3 (b) (2)).

The **Quality of Life** standard established residents' rights, including the right to a "reasonable accommodation of individual's needs and preferences" (42 USC, Ch. 7, Subchapter. XVIII, Part A, Sec. 1395i-3 (c) (1) (A) (v) (I)). Long term facilities can no longer be thought of as institutions where the elderly are treated as nameless patients. Residents must be able to pursue a life that most resembles their life before admittance. The **Quality of Life** federal regulations are not specifically about activities but do impact activity departments. The **Quality of Life** requirements establish a responsibility for the facility to create an environment that humanizes and individualizes each resident. Residents have the right to dignity, self-determination, and the accommodation of their needs. These include the right to choose activities in which to participate, as well as the right to choose where, when, and with whom to interact.

The goal of these regulations and of a healthy activity program is to look beyond the physical needs of residents and incorporate the mental and psychosocial well-being of residents as well. Long term care must help residents maintain and enhance their self-esteem, self-worth and independence and care for the whole person.

## **B. FEDERAL REGULATIONS FOR ACTIVITY PROGRAMS (42 CFR 483.15 (F) (1))**

The federal regulations state that each facility must provide an ongoing program of activities designed to meet the interests (past and present) and well-being of each resident, in accordance with the comprehensive assessment.

- The program should reflect the schedule, choices, and rights of residents.
- The activity department must offer activities at hours that are convenient for the residents and activities should occur as planned.
- A variety of activities must be provided so that the needs of all ages, sexes, and cultural and religious interests of the residents are met.
- Resident responses to the programs should be included in the resident progress reports.

Facilities are required to take the residents' interests and preferences into account when developing activity programs. The following is an excerpt from the *State Operations Manual* (U.S. DHHS, Appendix P, Part 1, II, Task 5, F, p.58) regarding the survey of a facility giving examples to surveyors about how prior life occurrences are to be taken into account when planning activities for residents to comply with the quality of life provision:

- A resident is ambulatory with Alzheimer's Disease. Her prior life included meeting the school bus at 3 p.m. every day to pick up her children. Now she attempts to leave the facility around that time. What is the facility doing to accommodate this agenda of the resident?
- A resident enjoyed being outdoors and the family member stated she believes this resident would still like the opportunity to go outdoors. Is the facility responding to this preference?
- A resident liked to ski but no longer does so due to her condition. However, she may like to see a movie on skiing, have a skiing picture in her room or go outside in the snow. Has the facility noted this preference?
- A resident always watched a certain soap opera every day. The family member says that even though she is now confused, this show may still attract her interest. Is this now being made available to the resident?
- If a resident is temporarily separated from other residents, does the resident have meaningful activities?

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*The surveyors complete one hour of observations per selected resident, divided into short segments in at least three settings, at different times of the day. The resident should be observed in other locations such as the dining room, activity rooms, other common areas and therapy rooms.*

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### **C. STATE REGULATIONS FOR ACTIVITY PROGRAMS IN SKILLED AND INTERMEDIATE CARE FACILITIES**

*(77 Illinois Administrative Code section 300.1410)*

The state regulations mirror federal regulations but are more specific in most areas. State standards for activity programs include:

- The activities should be coordinated with other services and programs to make use of both community and facility resources.
- Activities shall be available daily and according to the residents' interests, needs, capabilities, and choices.
- Activity programs must provide stimulation or solace, promote physical, cognitive, emotional health, and self-respect.
- Assessment of each resident must include
  1. Background information—education, cultural/social issues, etc.
  2. Current functioning status—communication, physical, cognitive, behavioral.
  3. Leisure functioning—attitude towards leisure, social interaction skills, past and present activity interests, etc.
- Residents should have the opportunity to contribute to the planning, preparation, conducting, and critiquing of the program.
- Staff time must equal an average of 45 minutes per week per each resident, including planning and conducting activities. This is a staffing ratio. It is not the time staff spends with each resident in an individual or group activity.
- Activity programs may include
  1. Physical activities
  2. Cognitive simulation and intellectual activities
  3. Religious activities
  4. Service activities for both the community and the facility
  5. Sensory activities
  6. Community involvement
  7. Expressive and creative arts/crafts
  8. Family involvement
  9. Social activity
- Documentation of residents' participation and responses shall be documented at least quarterly and included in the clinical record.

### **The Tool for Achieving the New Standards of *Quality of Life and Quality of Care* is the Care Plan. (42 CFR 483.20 (k)) (IL Admin. Code 300.1220 (b) (3))**

A care plan is theoretically a tool that specifies a resident's individual needs and sets forth an interdisciplinary plan of action that will support a resident's recovery or maintenance of health. The plan must address the strengths and preferences of the resident in treatment, activities of daily living, and psychosocial functioning. A care plan must be written to avoid declines in functioning and manage or eliminate risk factors.

The care plan has to take into consideration all of the resident's conditions, including hearing and vision loss, other special needs, drug and/or other therapy. With the resident's condition, abilities and preferences identified, the care plan sets forth the plan of care that is individualized for each resident.

Included in the plan, along with medical and psychosocial, is a resident's needs and preferences concerning activities. Residents and their families have the right to participate in care planning conferences in order to supply information regarding the resident's activities and routine before entering the facility. Facility staff should know and understand the times a resident likes to be active, the type of activities he/she enjoys, the need for adaptive equipment, the preference for large or small group activities, or the preference to refrain from social activities. If residents are offered the opportunity to pursue the hobbies and activities they enjoyed before entering the facility, they maintain their identity and a quality of life. Research has shown that the more active and happy a person is, the more likely he/she will recover faster from illness and stay healthy.

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*The ombudsman needs to "sweep out any cobwebs" that may cover his or her perception of the current operation of the facility that prevent his or her ability to see that it is critical that nursing home residents have a vital activity program. The ombudsman cannot, in good conscience, uphold a "Model T" version of a nursing home with little to no activities for each and every resident every day when an "SUV" version should be available.*

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The National Long Term Care Ombudsman Resource Center describes the activity program, if OBRA is implemented correctly and care plans are used correctly, as one that offers:

***individualized daily activity pursuits that promote increased self-respect by providing opportunities for self-expression, personal responsibility and choice; promote physical, cognitive, social, and emotional well-being; and provide stimulation and solace as needed.***

#### **D. FEDERAL AND STATE REGULATIONS ON ACTIVITY STAFF REQUIREMENTS**

The federal regulations require that a qualified professional must provide activities.

1. A person that meets state and professional accreditation requirements; or
2. has two years experience in a social or recreational program (one of which was full time in a health care setting); or
3. is a qualified occupational therapist or assistant; or
4. has completed a state-approved training course.

The state regulations (IL Admin. Code 300.1410 (c)) specify that an activity director must

1. Have the minimum of a high school diploma.
2. Be a certified recreation specialist, occupational therapist registered and licensed, therapeutic recreation specialist, a licensed social worker or licensed clinical social worker (both types of licensed social workers need specialized coursework in social group work).
3. If the activity director is not registered in one of the professions as listed in Item #2, the person must complete a 36-hour basic orientation course and be provided with professional consultation every month.
4. Have a minimum of 10 hours of continuing education every year.
5. Consultation only needs to be provided quarterly, if the activity director has met the high school education and basic 36-hour course requirements (but does not meet the qualification listed in #2), and has
  - five years of full-time experience, **or**
  - 10,000 hours of part time experience with 3 years of that experience as an activity director, **or**
  - a two-year associate's degree with 3 years experience as an activity director **or**
  - a four-year degree with one-year full time experience as an activity director.

*“Activity personnel shall be provided to meet the needs of the residents and the program” (77 Ill. Admin. Code, Section 300.1410 (b)).*

The activity director shall have a minimum of 10 hours of continuing education hours per calendar or employment year, directly related to activities programming. Activity assistants shall have a minimum of 10 hours of in-service training per calendar or employment year related to activities.

Besides the state requirement for the activity director to be in the facility four days a week, activity staff time each week shall be calculated at no less than 45 minutes multiplied by the number of residents in the facility; however, this number can be reduced if residents participate in regularly scheduled therapeutic, school or employment programs outside the facility. The “bottom line” requirement on the number of staff needed is based on the regulation: “Activity personnel shall be provided to meet the needs of the residents and the program” (77 Ill. Admin. Code, Section 300.1410 (b)).

### III. FAMILY AND RESIDENT COUNCIL REGULATION

Resident and family councils, both important to a viable activity program, are addressed in federal regulations, which state that residents and families have the right to organize and participate in resident/family groups in federally certified facilities. The facility must provide space for these groups to meet and provide assistance as necessary. (42 CFR 483.15 (c))

The state regulations (77 IL. Admin. Code 300.640), which apply to all facilities licensed under the Nursing Home Care Act, require that:

- Each facility shall establish a resident advisory council with at least five members.
- A staff member other than the administrator shall assist the resident council, but cannot be a member.
- The resident council members shall elect the minimum of a president and vice-president.
- Records of the meetings shall be kept in the administrator's office.

The state regulations do not mandate that each facility have a family council as in some other states. However, it is clear that family councils can be critical to the quality of life for residents. The resident council section of state regulations states that a facility must assure a connection with the local community. One choice for meeting this requirement is the establishment of a family council. Regulations for the ombudsman program specify that the ombudsman program should provide technical assistance to family councils (77 IL. Admin. Code Sec.270.110 (n)). Family involvement is also listed as a category of activity in state activity program regulation, which emphasizes the impact family involvement has on resident care (77 IL Admin. Code Sec. 300.1410 (h) (8)).

#### **IV. THE LEADERS IN THE STATE FOR BETTER ACTIVITY PROGRAMMING: THE ILLINOIS ACTIVITY PROFESSIONALS ASSOCIATION**

The Illinois Activity Professionals Association, an association that has taken a leadership role in developing materials for activity directors to meet the OBRA requirements, has established objectives and guidelines for activity programs: long term care facility activities should cater to the emotional, social, mental, and physical elements of its residents.

##### **Objectives**

- Socially, activities should provide opportunities for interaction in a group setting.
- There should also be an environment conducive to the formation of relationships with new companions.
- Some activities should supply links to the surrounding community through both outings and visits from community members.
- Activity departments are responsible for giving emotional support to its residents, in an effort to offset the isolation and loneliness commonly felt by those in long term care
- Activities can help restore self-confidence and self-worth by providing a meaningful role for the residents.
- Male residents, often overlooked as needing activities, especially need "meaningful work" as part of their activity program.
- Promotion of continued personal care and hygiene can support self-confidence.
- The opportunity of residents to participate in the many types of daily living activities lies with good cross-trained nursing and activity staff.

- One important aspect of activities is the opportunity for residents to continue their life-long interests and skills.
- Mental stimulation comes from regular reality orientation and focus on current events, as well as educational programming.
- Programs can also enhance cognitive functioning such as recall, application, and decision-making.
- Activities should help residents maintain and restore physical ability.
- Physical activities will help reduce health decline, prevent heart disease and stroke, and aid in digestion and elimination.
- Physical programs should incorporate education on the benefits of physical exercise.

### **Guidelines**

- Planned activities should be offered in a variety of group sizes—large groups, small groups, one-to-ones, and independent activities. With the general increase in cognitive disabilities, there is an increased need for small groups and one-to-one activities.
- The activity department must use a variety of media to notify residents of the activity schedule.
- A cross-trained staff is important for daily living activities and for providing planned activities when the activity staff is not present (Klauer 1-3).

## **V. THE PIONEER MOVEMENT AND CULTURE CHANGE**

A discussion of a healthy activity department model can only occur in the context of a healthy long term care system. It is only recently that some nursing homes have begun to see a vision for what constitutes a healthy system. Though OBRA was a major step in the right direction, many facilities did not know how to provide a quality of life for each resident. A few facilities across the country achieved systems that differed from any seen before. These long term care facilities went above and beyond OBRA by implementing total culture change in nursing homes. In 1997, The National Citizen's Coalition for Nursing Home Reform (NCCNHR), an organization of advocacy groups, ombudsmen, facility providers, certified nursing assistants and others interested in quality care for residents convened a meeting of facility providers in Rochester, New York. NCCNHR invited seven professionals, who had worked in nursing homes, or who were currently working in nursing homes, that were credited for changing the culture in nursing homes from a traditional medical model of care to the social model with individualized care. Sarah Greene Burger, the executive director of NCCNHR, called the professionals **Pioneers**. Thus the movement to change the culture in nursing homes is known as the **Pioneer Network**.

### **A. PIONEERS CHANGE THE EXISTING NURSING HOME CULTURE**

Building on the foundation of the Nursing Home Reform Law (OBRA 1987), the Pioneers of nursing home reform strive to transform the culture into one that erases the loneliness,

*The Pioneers of nursing home reform strive to transform the culture into one that erases the loneliness, boredom and loss of autonomy of residents.*

boredom and loss of autonomy of residents. The elements of culture that they change are core values, organization of time and space, relationships, language and rules, objects used in everyday life, contact with nature, and ways of celebrating and grieving (traditions and rituals).

The Pioneer models have a resident centered focus by joining forces with their staff, residents and families. Caregivers are empowered to facilitate that control. They move away from the medical model and begin to “[put] person before task” (Fagan, Williams, Burger 6). Figure 1 illustrates the paradigm change from traditional care to individualized care as proposed by the Pioneer Models.

**Figure 1  
The Pioneer Paradigm Shift**

TRADITIONAL CARE <b>Medical Model</b>	PIONEER CARE <b>Social Model</b>
Staff provide “treatments”	Nurture the human spirit in addition to meeting medical needs
Residents follow facility routine	Facility follows resident’s routine
Staff float	Permanent staff assignments
Staff make decisions for residents	Residents make their own decisions
Facility belongs to staff	Facility is resident’s own home
Structured activities	Spontaneous opportunities around the clock
Departmental focus	TEAM!!
Staff know you by diagnosis	Staff know you as a person

***B. THE PIONEER MODELS ARE ABOUT A CHANGE IN HOW DAILY ACTIVITIES OCCUR***

The pioneer models of culture change in long term care facilities all strive for similar goals for residents:

- a living environment,
- a chance to be part of a nurturing community, and
- the power to make choices concerning all aspects of life.

Recognizing that culture change is an ongoing process, the Pioneers hope for continued education, examination, and evaluation of nursing home practices. The more facilities begin to adopt some of the ideas in the culture change process, the more activity programs in long term care will promote a quality of life.

***C. SPONTANEOUS ACTIVITY GENERATED BY THE PIONEER MODELS***

Each Pioneer model has designed a long term care system that affects activity programs either directly or indirectly. One effect on activities most of them hold in

common is spontaneous activity. The **Eden Alternative** holds the shift towards spontaneous interaction and the de-emphasis of planned activities as major principles.

The daily meeting of the **Regenerative Community** provides a daily opportunity for spontaneous activity, which in some cases carries over throughout the day. In these daily meetings, the residents begin to find things they hold in common sparking a connected community and interpersonal relationships. In this setting, community members find their interests together and fill their days with activities that meet those interests.

The **Regenerative Community** also has a special focus on the intentional incorporation of residents with different physical and cognitive disabilities into the community. A comprehensive individualized activity program is the model's tool for incorporating all the different abilities and reaching out to the residents who normally resist participation.

The **Resident-Directed Care** model is another environment in which residents have the freedom to live spontaneously. The goal of this model is for the staff to respond to residents' needs and follow their lead in scheduling matters. Just as staff would set a routine based on the residents' care needs, so activities would be planned around the residents' needs, interests, and schedules.

**Resident-Directed Care** is unique in its design to allow and encourage daily service activities within the neighborhood. Residents can retain a sense of usefulness by helping with the upkeep of the facility such as meal preparation and cleanup, folding and passing laundry, etc. Residents can also choose not to participate in these activities. The staff is there to fulfill those duties if residents either cannot or do not want to contribute to those tasks.

Finally, the **Individualized Care** model influences activities indirectly. The interdisciplinary team of **Individualized Care** is much like the cross-trained staff of the **Resident-Directed Care** Model. All care team members need to be both educated about activities and aware of individual interests in order to use activities as a tool in approaching behavioral symptoms creatively.

As staff begins to understand dementia, they can also begin incorporating techniques to turn all daily tasks into engaging activities. The treatment of residents who have dementia should be no different from the treatment of other residents in that care is focused on all parts on the person—the physical, mental, and psychosocial well-being.

All of these models have boldly made environmental, structural, and organizational changes in order to shift the focus of long term care from institutional care to resident-based care. Part of that shift is the recognition of the importance of activities on the mental and psychosocial health of residents.

The Pioneers realize that activities can stimulate and engage residents leading to an increase in the well-being of the whole person.

## VI. IMPORTANT COMPONENTS OF AN ACTIVITY PROGRAM

### **A. ACTIVITIES MUST BE INDIVIDUAL AND VARIED TO MEET ALL RESIDENTS' NEEDS**

Large group activities are out; small group and individual activities are in—if the facility is meeting most of the residents' activity needs. The activities should be based on what the resident wants to do, and if that is uncertain, what the resident used to like to do.

### **B. RESIDENTS' ACTIVITIES ALIGN WITH PSYCHOSOCIAL NEEDS**

Performing activities of choice can be therapeutic for certain residents. Before a care plan meeting, the activity director must know the psychosocial assessment of the resident and have the following types of information concerning the person:

- psychosocial issues (this term does not imply a medical condition or mental illness, but rather how a person copes with her social environment, e.g., temporary depression)
- kinds of hobbies
- work experiences
- leisure and entertainment interests
- family and other relationships

If the family or resident has not provided this information prior, the first care plan meeting is an opportunity to have the family assist in providing this type of information.

In order to know each resident's individual preferences and lifestyles, the activity director interviews the resident and works with the person in charge of psychosocial services (social services director).

*Activities should complement social service interventions*

The social services director provides information to the activity director about what may be troubling a resident and what is keeping the resident from fully participating in life. Although there may be social service interventions to address problems such as behavioral symptoms and depression, it is critical that the social service director and the activity director work together so that the activities planned for the resident dovetail with the social services interventions.

### **C. ACTIVITIES FOR RESIDENTS UPON ENTERING A FACILITY**

When a resident first enters a facility, it most often is a traumatic time. Many families and residents cannot recall what happened during the admission process because it is so fraught with emotion.

Upon admission, residents often go through the same stages of loss as are in the grief process, from disbelief, to anger and, perhaps, to acceptance. Most residents do

experience real losses--their home, their car, and their independence. They feel cut off from their friends and family.

During the first few weeks after the resident enters a facility, the activity director has to be in touch with the resident through the shock and grief period. He/she should be ready to introduce involvement with activities to these new residents when they are ready—or to promote their readiness with activities.

The activity director has to plan the activities for residents so that residents are not overwhelmed, but there is some structure to their lives. It is important that the residents do not fall into a “learned helplessness syndrome” and not do anything.

#### **D. LIFE AS AN ACTIVITY**

An important part of maintaining one’s independence and identity after entering a long term care facility is to continue to do those things one did while living in the community.

Well-trained direct care staff can make every daily living activity (grooming, dressing, eating, etc.) into an individual activity that complements the planned activity calendar. Giving residents chances to maintain and re-acquire daily living skills promotes the maintenance and enhancement of physical and mental health.

*Well-trained direct care staff can make every daily living activity into an individual activity that complements the planned activity calendar.*

Another component of activities that promote resident independence is the opportunity for service activities. Residents can help serve residents and staff in the facility as well as participate in service activities in the community.

The residents can be offered choices in a manner that they will learn how to contribute to the functioning of the facility, each in his or her own way. For example, a resident could put the silverware on the table. In one facility, one resident who is 90 years old, peels nearly all of the potatoes. Although the facility has to have adequate staff to complete resident-related activities, residents can choose to work in a facility if they are informed that they will not receive pay, and still choose to work. The facility is required to ensure infection control measures for these resident service activities. A resident’s service activity must be part of her individual care plan.

An activity director, with help from volunteers and service organizations from the community, can regularly schedule service projects outside of the facility in which residents can participate. The opportunity for service projects helps residents maintain a connection to the community that can easily be lost when entering a facility.

#### **E. RESIDENT AND FAMILY GROUPS**

Perhaps the single most important action an ombudsman can take to promote the well-being of residents is to assist in the establishment and support of resident and family councils.

Each long term care facility is required to establish and maintain a resident council in order to give residents a chance to voice grievances, be informed about the facility and their care, and to plan social events. As more of the long term care resident population is affected by dementia, resident councils are challenged to maintain productive meetings. Even with their right to hold private, independent meetings, it is often necessary for a staff member to lead and support the meetings.

With or without a productive resident council, there is still a need for all consumers to be given a voice of advocacy. Families, as consumers, also have the right to hold independent council meetings.

A family council is an independent (self-led and self-determining) group of families and friends of residents that together protect and improve the quality of life for residents and provide families with a voice in decisions that affect their loved ones. Family councils can offer support and empowerment, education and information, discussion and action on concerns for families, as well as services and activities to supplement the activity program for residents. A family council can offer families a united voice for legislative action and be the catalyst for systemic change.

A well-organized family council can be one of the most important resources the activity director has. In its efforts to improve the conditions in a facility, a family council can

*The ombudsman can be instrumental in empowering the family and resident councils to see the opportunities for increased quality care.*

supplement the activity programming and be a vital connection to the community. The family council can network within a community to find more volunteers for the facility, bring in volunteer entertainment, or oversee drives and fundraising efforts in the community.

The ombudsman can be instrumental in empowering the family and resident councils to see the opportunities for increased quality care that can result from support of activities in facilities.

With full support from the facility administration and staff, as well as the support of the ombudsman program, families and residents can take great strides towards increasing the quality of care residents receive. For more information on supporting family councils, visit [www.tlcinltc.org](http://www.tlcinltc.org).

#### **F. PLANNING FOR MEN'S ACTIVITIES IN LONG TERM CARE**

For the present, most residents are women: this may change in the future as men are living longer. Because a nursing home ordinarily has a predominately female population, men may be overlooked. The ombudsman should observe to see there are activities for men that differ from those for women. Men often require a different type of activity and a different approach in getting them interested in the activity. Men of the generation presently in long term care know most about the work they did. Some of these men often choose work-related activities over leisure activities. To provide activities for this type of adult who had jobs and raised families, the activities need to pattern some type of work or adult responsibility. Two examples are:

- An accountant, who now has dementia, has a box of invoices and bills to sort.
- Residents talk to a car dealer who comes to the facility with a car that may need repair. The dealer discusses how to fix the car or shows a film on car repair.

### **G. ACTIVITIES FOR RESIDENTS WITH ALZHEIMER'S DISEASE OR OTHER TYPES OF DEMENTIA**

The key to appropriate programming for residents with dementia is to link them with their former lives. The activity director should identify these residents' interests and types of activities they participated in before they developed the disabling condition, then adapt the interests to the activity. For example, a resident liked to bake apple pies. When the resident entered the facility, she had the apple pie recipe and could help other residents make the apple pie. Later on, as the dementia progressed, she could hold the recipe, and give some instructions as other residents made the apple pie. Still later, she could smell the cinnamon and apples as she watched the pie being made.

Activities that have proven successful in nursing homes include:

- Begin investment clubs for men and keep track of a portfolio. Do this until they do not have the skills to participate at the lowest level.
- For businessmen, get a desk and have piles of paper.
- For laborers, have objects that can be pulled apart, put together.
- Use fishing lures to sort or talk about.
- Hold elections from times past, such as when Roosevelt or Reagan ran for office.
- For people who love cars, get videos of cars, brochures from car dealers.
- Go to the parking lot and look at cars.
- Have antique auto clubs come to the facility to talk about cars.
- Hold a golf club meeting.
- Talk about the kinds of quilts and have quilt books.

*For residents with dementia, activities should provide a link to their former lives.*

### **H. BEGINNING IDEAS FOR ACTIVITIES IN SPECIAL CARE UNITS**

Residents in special care units require the activity director to be especially creative when developing an activity plan that will stimulate them on a daily basis as much as possible. For example, residents who are bed-bound need activities that stress small and large motor skills, if the resident has some capability to move his limbs.

For residents who are uncommunicative, cannot move, or are bed-bound, the care plan should never read that the resident will attend three activities a week; instead, the plan needs to be more specific. The activity must be something that will stimulate the resident's senses also. One successful strategy that has been known to work for persons with late stage dementia is to put birds in the dining area. The residents became interested in watching the birds eat, which stimulated some residents to feed themselves.

An activity for an agitated resident may be piano music or other recordings of sounds and types of calming music.

For persons who are semi-comatose, they need an activity they can see or hear, such as birds to watch, music or some type of light stimulation. As much as possible, the CNA's should talk to them about what interested them prior to being semi-comatose, such as mentioning a resident's son or daughter by name.

### ***I. ASSISTIVE TECHNOLOGY AND COMPUTERS FOR THE NURSING HOME IN THE NEW MILLENIUM***

In accord with a doctor's prescription, the occupational therapist, or occupational therapy aide, under the supervision of an occupational therapist, provides exercises and activities that improve or maintain a resident's fine motor skills. Fine motor skills are critical in carrying out activities for daily living (ADLs) such as buttoning, tying shoes, eating, and recreational activities such as playing cards, needlework, etc. To meet the fine motor skill goals for a resident, the occupational therapist may recommend assistive devices that help residents in using their hands to maintain their independence in dressing, eating, etc.

Prescribing and developing assistive devices is a field of knowledge known as assistive technology. Assistive devices are designed to assist people with all types of disabilities ranging from visual impairment to partial paralysis.

All goals to increase a resident's fine motor skills should be included in the care plan. After it has been determined that a person does not need the services of an occupational therapist, that person may still need certain activities and assistance to maintain their skills.

The occupational therapist may conduct the assessment of the resident's fine motor skills, provide consultant services to the fine motor skills program, and train the CNAs and activity program personnel to provide the exercises, activities, and assistance. For example, a CNA may use a "hand over hand" approach to help a resident eat while the resident holds a specially designed fork with a wide handle.

Activity programs are of primary importance in the maintenance of fine motor skills. The activity programs are required to provide various types of assistive devices that can aid residents. Types of assistive devices provided by facilities include magnifying glasses and remote controls in rooms. Such devices help residents participate in activities to which they were accustomed before needing long term care and increase their capabilities to enjoy an active life.

If there is a nursing home or family that needs to know about available assistive devices, they should be referred to the Illinois Assistive Technology Project, which is a state resource for information on the latest developments in assistive devices. This

program can be reached at One West Old State Capitol Plaza, Suite 100, Springfield, Illinois 60631. The telephone number is (217) 522-7985.

Ombudsmen may work with the family councils to provide computers for residents in nursing homes. Residents benefit from access to computers in a group setting and individual computers on carts for the bed-bound, so residents are connected by e-mail with their families, their community and the world. Computers are tools by which the activity director can motivate residents.

### **J. THE ACTIVITY DIRECTOR, “A JACK OF ALL TRADES” AND A MASTER OF EVERYTHING**

The activity director has a superhuman job, as he/she has to be resourceful to efficiently and effectively plan for a quality of life for residents with differing health conditions, skills, family situations, cultures and ethnic backgrounds. The activity director needs to:

- Know how to promote intergenerational involvement.
- Know how to get young children and older students in the facility to interact with the residents.
- Be responsible for the plan when there are different kinds of animals that are kept in the facility such as dogs, cats and birds, --pets that residents had in their homes.
- Plan for activities that require assistive devices, given the person’s physical or mental disability, including the inability to communicate.
- Understand different ethnic traditions and lifestyles.
- Consider the spiritual needs of residents.
- Work with volunteers.
- Respond to the family council’s concerns.
- Attend care plan conferences.
- Keep records on the program and on individual resident’s response to the program.
- Coordinate with other staff for individual, spontaneous activities.
- Connect with the community to secure its involvement on a continuing basis.
- Secure the materials and resources for the activities.
- Supervise the activity program, including the activity assistants.
- Cooperate with the social services director on planning appropriate activities to decrease problem behaviors.
- Know what assistive devices and adapted materials are available.
- Maintain a positive attitude.

## **VII. ACTIVITY PROGRAM SURVEY**

In 1999, the I CARE Long Term Care Ombudsman Program surveyed all the nursing homes in one county concerning their activity programs. The problems found in the facilities surveyed may be indicative of many activity programs. The following are some examples of problems observed, along with some generalizations.

Though all the facilities had regular volunteer programs, the volunteer manpower may not have been utilized in the best way. Many times it seemed that the volunteers were there to help the facility and staff rather than to help the residents. Instead of spending time with the residents in planned activities, excursions, or one-to-one visits, volunteers helped with staff oriented tasks such as folding laundry and cleaning the dining room after meals. The opportunity to build relationships with the volunteers may be more meaningful to residents than having volunteers help with facility upkeep.

Some facilities failed to make thorough rounds through the facility directly before an activity to invite all those who wanted to come. The staff may have taken for granted that the usual attendees were the only ones interested, but a reminder directly before an event could have helped spark the interest of others. Better interdepartmental communication and cooperation can help in this instance. If nurses, CNAs, and other staff are aware of the activity schedule, they can be the ones gathering people for the event and encouraging the residents to attend.

Unlike the Pioneers, who stress cross-trained staff and interdepartmental care teams, facility staff was often at odds with each other and focused on the completion of tasks instead of the residents. Planning for a resident should be an interdisciplinary activity and this should be reflected in the individual care plans. Increased understanding of the importance of activities may lead to departments that are aware of the schedule, give feedback to improve the program, encourage residents to participate, and apply activity techniques to problem behavioral symptoms.

*The resident council is one forum for planning and critiquing activity programs.*

The opportunity for residents to plan, conduct, and critique activities is outlined in the state regulations. Taking part in the development of an activity program can give residents a sense of ownership and will facilitate the meeting of individual needs. In some of the facilities surveyed, that opportunity was not offered to residents. The resident council is one forum for planning and critiquing activity programs. However, if members of the resident council are not interested in planning, conducting, etc. it is their choice. For those who are interested, activity staff should be sure to publicize opportunities to take part in the organization of activities.

A general lack of activities on the weekends was apparent in most facilities. This can be attributed to the need for increased activity staffing, as discussed earlier. It could also be a problem easily solved with a cross-trained staff to fill-in for activity staff when the activity director and activity assistants are not scheduled. Though most residents interviewed were in understanding of this issue, considering that weekends are a time to relax and have visitors, many residents would have been involved in an activity if some kind of activity had been offered.

One-to-one visitation between the residents and activity staff is one area that deserves some attention. One-to-one visitation is a system of social interaction for residents who

cannot or do not want to participate in the small or large group activities. One-to-one activities are used for a variety of reasons: for residents who have just entered the home and have adjustment issues, residents with cognitive disabilities, residents with physical disabilities who are bedridden, and residents who are opposed to any involvement. Because the state law requires activity staff to spend a staffing ratio of 45 minutes planning, documenting, and executing activities for every resident each week, staff can no longer dismiss those residents who resist involvement. An effort must be made to engage them mentally and psychosocially to avoid deterioration of health. One-to-one activities must cater to an individual's needs and have specific goals. This is a large task for a small activity staff, but it is a necessary one.

At least one of the homes visited had no one-to-one plan of action, and others had plans that were not implemented regularly. For the facilities that did attempt one-to-one activities, the visits were nothing more than a quick stop by to say, "Hello." Nothing can be achieved with this type of visit. The residents with cognitive disabilities caused the most frustration for the staff. Their lack of training left them at a loss for ways to make one-to-one visits meaningful and helpful to residents with dementia or other cognitive disorders.

Residents interviewed often listed past interests that were not being met in the planned activity program of the facility. Dementia residents and their families especially felt the staff did not even know past interests. If there were a higher priority on the activity section of care plans, perhaps staff would be more able to meet all residents' interests. Both residents who were regularly involved in activities and those who were not involved expressed a need for activities to be more individualized.

Residents who preferred individual activities offered a few common reasons for not getting involved in social activities. One common reason was their past life styles. Some people have never been overly social and did not like big groups. Others felt that after working hard all their lives, they were ready for a little rest and relaxation. Sleeping extra hours and doing relaxing individual activities is what met their needs. Both of these categories of people expressed their appreciation to staff that did not pressure them to get involved.

Declining any participation in activities is a resident's right and should be respected, but there are other common excuses that deserve more investigation. Some women, in particular, avoided group activities because of their "nerves." Any wanderers or overly verbal residents frightened and caused some residents stress. If this is a resident's reason for avoiding activities, the staff need to be aware and make accommodations. Perhaps he/she should only go to activities geared towards the higher functioning individuals. The activity staff need to make every effort to meet the resident's needs by providing a quiet, soothing, non-aggressive environment.

One reason for not being involved that was shared by several residents was a rather unhealthy attitude about the aging process. The men and women who shared this view all expressed the feeling of being too old to do anything anymore. Instead of learning to

make adaptations, they were too frustrated or embarrassed to try at all. Residents in this situation do not have to be forced to join in activities, but should periodically be gently encouraged to do so. Most importantly, a care team that includes the social services should evaluate the possibility of counseling or group therapy. A resident may be dealing with depression or other issues associated with growing older and entering a facility. Though facility staff must respect a resident's right to not participate in activities, they can care for a resident's emotional and psychological needs through alternative interventions.

After observing activities and interviewing both staff and residents, a clearer picture emerges of the status of activities in long term care. If ombudsmen can understand what the law requires and what residents expect, they can begin advocating for the necessary changes. Residents deserve a chance to pursue life-long interests, explore new interests, develop social relationships, and attain the highest level of psychosocial health possible.

## **VIII. OMBUDSMEN: CHANGE AGENTS**

As ombudsmen, we must act as change agents in the long term care system and promote culture change. To promote this change, ombudsmen can:

- Empower residents and families through resident and family councils.
- Inform the administrator or the owners of the facility how an activity program can be more effective.
- Inform residents and families of the importance of activities for the maintenance and enhancement of mental, physical and psychosocial health.
- Inform residents and families of residents' rights to an activity program that meets their schedules, needs, and interests.
- Inform families of the importance of speaking with staff, inside and outside care plan meetings, about their loved one's life before entering the facility.
- When you attend a resident or family council, urge the members to take any suggestions to the staff. Assess how the facility responds to the council's suggestions.
- Observe activities and note which residents and the number of residents that attend, as well as their enjoyment level.
- Speak with residents during and after an activity and ask if they enjoyed it, etc.
- Be a resource for activity directors. Obtain materials from the state ombudsman office on activity programming, how to build a volunteer-based program, dementia specific programs, and assistive technology.
- Be a resource for how the facility can increase its community involvement, but, do not assume the activity director's responsibility to arrange and coordinate community related/volunteer programs.
- Hold consultations and brainstorming sessions with activity directors and residents.
- Provide in-service sessions to facility staff on aforementioned issues.

- When meeting with a resident, activities can become a part of your conversation. Include some questions about his/her participation in the facility's activity program.
  - Do you participate in activities here?  
If yes, what are your favorite activities? How often are those offered?  
If no, why not?
  - How do you find out when and where activities are offered?
  - Do you prefer group activities or activities you can do alone?  
If prefers individual activities, does someone from activities stop by and see you regularly?
  - What time of day do you prefer to be active? Are activities available at those times?
  - Are activities available on weekends and at night?
  - What were some of your interests and hobbies before you came to the nursing home? Do the activities offered help you continue to pursue your interests?
  - Have you developed new interests since coming here?
  - Are the activity staff members aware of your interests?
  - Are you involved in resident council?  
If yes, does the council help plan and evaluate the activity program?
  - Are you satisfied with your current level of activity?
  - Are there any programs you would like to see offered?

Men and residents with cognitive disabilities (or their families) in particular may be good candidates for a discussion about past interests and whether those past interests are incorporated into the activity program.

Questions should be adapted for those residents who are less capable. For incapable residents, speak with family members. Ask the family to assess if their loved one's needs are being met, if the facility offers activities specifically for dementia residents, and if the staff is aware of the loved one's past interests. Inform them of their loved one's right to be provided activities that meet their needs and interests. Encourage residents and family members to approach activity directors with suggestions for group and one-to-one activities. Residents and family members should also be encouraged to attend resident/family councils and discuss activities in care plan conferences.

*Talk to residents about the activities in which they would like to participate.*

For residents who have resigned themselves to an inability to join activities, ask if the staff visits one-to-one regularly and accommodates any activities they pursue on their own. Inquire if the staff offers alternatives to the planned activities. As an encouragement to join group activities, inform residents of the benefits of an active lifestyle and of opportunities to adapt almost any activity to fit their ability.

☞ Tips: Other things to keep in mind while visiting a facility

- Notice if residents sit for long periods of time with nothing to do. Is it due to residents' choice or lack of planned activity opportunities?
- If the posted calendars of activities show an activity to be in progress, check to see it is occurring.
- Visit during evenings and weekends and observe what activities are offered during those times.
- Observe the variety of activities scheduled on posted calendars. Do they meet the categories of activities required by state regulations?
- Look for interdepartmental cooperation. Notice how the nurses and CNAs interact with the residents. Do they make every daily task (e.g. meals) into an activity? Are they involved in the scheduled activities including taking people to and from activities?

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*The push for change should not stop with the upholding of the laws and regulations. We should be advocating for activity programs that fit the Pioneer principles of reaching beyond the minimum standards and boldly establishing systemic change. We must remember that culture change is an ongoing, complicated process. Facilities exist for residents, not residents for facilities. Advocating for this principle, the ombudsman can take the necessary steps towards culture change and improvements in activities are bound to follow.*

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## IX. SUMMARY

Before ombudsmen can examine a facility's activity program, it is imperative to have an understanding of not only the minimum expectations, as specified by law and regulations, but also, the possibility of an exemplary activity program through Pioneer Network Practices. With a change in total facility culture, the environment, care, staffing structures and sense of community are all affected. Culture change can increase the quality of life.

Upon acquiring an understanding of the possibility for improvements in long term care facilities, ombudsmen are then challenged to examine activity programs and work with residents and staff to make needed improvements.

Because an activity program, as with all aspects of care, is based on meeting individual needs, the ombudsman's work is not complete if residents are not asked if the activity program meets their needs.

Important areas needing improvement in many activity programs include:

- a variety of planned activities offered at a variety of times to meet resident needs, especially at night and on weekends,

- physical space and use of time conducive to spontaneous activity,
- direct care staff trained to adapt daily living skills into activities (e.g., grooming, dressing, etc.),
- an understanding of past interests and hobbies,
- independent resident and family councils that are supported by the facility in advocating for improvements in facility life,
- staff that are trained in dementia-specific activities, and
- a sense of community among all residents, families and facility staff.

Change begins with education. Ombudsmen can inform all residents, families and staff they meet about Pioneer Practices and what an activity program can achieve when exemplary practices are implemented.

Establishing and/or working with an already established family council is a critical step to seeing activity program improvements implemented. Families know the needs and wishes of their loved ones and a family council can be a united voice for all residents to advocate for improvements.

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