

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

TEACHING TIPS

Pre-publication Edition I

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SUPPLEMENTAL MODULE # 9 A QUALITY ACTIVITY PROGRAM INDICATES A QUALITY OF LIFE FOR ALL RESIDENTS TEACHING TIPS

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 and an evaluation of what was 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.

You may need:

- Copies of the exercises
- Overhead projector and screen

Sample masters for transparencies are included for use in reviewing some of the module content for group discussion. These may be converted into slides.

Accountability

After the discussion, ombudsman trainees will be asked to complete the following accountability exercises:

- 1) At least five proposals the ombudsman would recommend to help improve the activity program, 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.

Exercises

Sample Observations, pp.5-9: This exercise offers examples of observations from ombudsmen's visits to facilities regarding activities. The exercise is intended to be completed by group discussion.

Another teaching tool in this document is a report from a survey of activity programs of facilities in one county. Included in this report is a list of findings from the survey. This could be used as a checklist for a group discussion on whether these same situations exist in the facilities ombudsmen visit. The body of the report can be used as a source of additional suggestions an ombudsman could use in talking to administrators about the need for a viable activity program that meets each resident's needs.

Resources

Rights of Family Councils p. 9
Activity Program Survey: A Report p. 10

ACCOUNTABILITY EXERCISE 1

Write at least five proposals the ombudsman would recommend to improve the activity program, including recommendations for starting or maintaining a family council. Consider your role as a change agent.

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ACCOUNTABILITY EXERCISE 2

Write at least five questions you have about the content of this module. You may write as many questions as you would like.

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SAMPLE OBSERVATIONS OR COMPLAINTS ABOUT ACTIVITY PRACTICES THAT MAY REQUIRE OMBUDSMAN IDENTIFICATION AND INVESTIGATION

Ombudsmen are a powerful group that can produce positive changes in long term care. The instructor needs to reinforce this concept in presenting this module because the level of activities can be a measure of the facility's health and the residents' overall well-being.

Another important point the instructor needs to stress is that the activities in a facility and the attitude about activities are only as good as the upper level management allows them to be. The ombudsman should always take lack of activities that are systemic throughout a facility to the administrator.

Individual ombudsmen must not specifically tell or advise the facility how to correct the specific activity problem, either observed directly or alleged, for two reasons: 1) the ombudsman does not have all the information about residents' care plans and, therefore, the suggestion may be only partially correct; and 2) since the ombudsman is not an activity professional, the suggestion may be viewed as incorrect or negatively.

However, for the ombudsman to observe a lack of activities, or lack of activities that meets individual interests, and then believe that things will get better without ombudsman action is neglecting the ombudsman's duty to protect residents.

When there is an observed or perceived problem, the ombudsman must act, and act in a positive manner. An alternate way of providing advice is to offer positive examples of good practices: Pioneer Network Practices or other exemplary practices that the ombudsman has read about or observed in other facilities. Additionally, the ombudsman can encourage the facility to contact its facility association, consultant or other resources to learn about current ideas for ascertaining what activities are likely to be appropriate for residents with the most difficult conditions.

Quality Activity Program Exercise

Observation #1 is an example how an ombudsman addressed an activity problem, by citing an instance of how one facility encouraged interest and ensured participation of all residents in an activity. The following observations are for a group exercise to prompt thinking about positive examples that can be used in meeting with the facility administrator to address perceived activity deficiencies. The exercise can include having individuals practice how to present positive strategies for an effective activity program to an administrator, citing instances of best practices as opposed to finding fault with the existing activity program. Your trainer may substitute other observations and examples.

Observation #1: *One complainant said that her mother who was hearing impaired never attended the birthday parties in the facility. When the resident was asked if she wanted to go to the party, she did not hear that it was a party and she did not know that ice cream, her favorite food, was being served.*

Issue: Are the birthday parties well attended by residents? Do residents get refreshments if they do not attend the birthday party?

Investigative Action: The ombudsman investigated to see if other residents did not receive ice cream. When the investigation revealed that no residents in their rooms received ice cream and were not offered any, he/she met with the administrator's designee of facility and told of the complaint. She then described the following example, which she had observed in another facility:

"I do not know all of your systems for encouraging residents to participate in activities, but when I visited Windy Farm Manor, its staff had what I thought was a creative plan to ensure that every resident participated in birthday parties.

While I attended a large birthday party in the dining room, trays of cake and punch were brought to each unit for the residents who weren't able to attend the celebration. The residents on the unit were invited to come to the unit lounge by nursing staff and volunteers. Any residents living on the unit and celebrating birthdays were honored (again) as the residents and others enjoy the refreshments. The nursing staff made sure the residents remaining in their rooms were given the opportunity to enjoy the refreshments safely.

By bringing refreshments to the units, everyone participated in celebrating the residents' birthdays. There was cooperation from the interdisciplinary team and volunteers in involving the residents in the celebration. By honoring the residents who were celebrating a birthday, and who lived on that unit, there was a more personal interaction. Others present on the unit (including staff) were drawn into the celebration and partook of the refreshments. The nursing staff took a piece of cake and a glass of

punch to the room-bound residents and helped them eat the refreshments while discussing birthday parties.”

After relating this example to the administrator, the ombudsman then asked if some other system could be implemented, similar to the one she had observed.

Follow-up: If nothing changed in this facility in the following month, what would be the ombudsman’s next steps?

Observation #2: *Some residents are sitting in the hallway while a large group activity is occurring in the dining room. The CNA states that the residents were asked once if they wanted to go and they indicated that they did not. The CNA said that this was their choice.*

Issue: Staff who has asked the residents if they wanted to participate in an activity may not actually know these residents, does not communicate with them in a way that accommodates their individual types of disabilities, or do not know the approach to use to motivate them to attend the activity. For example, one resident with Alzheimer disease would always go to an activity if the CNA offered to get her a cup of coffee and then said “Come with me to the (type of activity).” After the resident was taken to the activity, she enjoyed it. She was not able to communicate her preference about the activity before experiencing it.

Investigative Action: Ombudsmen should ask the residents sitting in the hallway if they want to go to the activity. If they now say that they want to go, ask the staff to take them to the activity. If the ombudsman determines that the residents are incapable of responding, the ombudsman should talk to the activity director, or whomever the facility has determined as the ombudsman contact, about when these residents in the hallway have activities and what kind of activities they have.

Observation #3: Seventeen residents sitting in the main room in the morning with the weather channel on the television and no sound. All appear to be asleep.

Issue: (Discuss what may be the issue(s) for the foregoing observation.)

Investigative action: (Discuss what would be an appropriate action for the issue(s) identified.) What are some positive examples?

Observation #4: *A large room in which one or more activities are occurring with many residents and only one activity staff person.*

Issue: (Discuss what may be the issue(s) for the foregoing observation.)

Investigative Action: (Discuss what would be an appropriate action for the issue(s) identified.) What are some positive examples?

Observation #5: *“Talent” groups give performances but are unprepared to perform. For example, one resident complained that instead of residents completing a craft project of making angels for a holiday, which she considered “fun to do”, the activity was cancelled because a group came to the facility to sing. The residents then had to listen to a group of people sing Christmas songs off key and the singers did not know the words to the songs. The resident knew the words and did not appreciate hearing a group perform that was unprepared.*

Issue: (Discuss what may be the issue(s) for the foregoing observation.)

Investigative Action: (Discuss what would be an appropriate action for the issue(s) identified.) What are some positive examples?

Observation #6: *Residents in beds who never have any music or other activity.*

Issue: (Discuss what may be the issue(s) for the foregoing observation.)

Investigative Action: (Discuss what would be an appropriate action for the issue(s) identified.) What are some positive examples?

Observation #7: *Only large group activities scheduled and provided for residents, not small group activities.*

Issue: (Discuss what may be the issue(s) for the foregoing observation.)

Investigative Action: (Discuss what would be an appropriate action for the issue(s) identified.) What are some positive examples?

Observation #8: *Activities, which require participation, are scheduled for an hour or more. (Most residents tire easily after 20 minutes)*

Issue: (Discuss what may be the issue(s) for the foregoing observation.)

Investigative Action: (Discuss what would be an appropriate action for the issue(s) identified.) What are some positive examples?

THE RIGHTS OF FAMILY COUNCILS IN NURSING HOMES

The 1987 Nursing Home Reform Act guarantees the families of residents a number of important rights to enhance a loved one's facility experience and improve facility-wide services and conditions. Key among these rights is the right to form and hold regular private meetings of an organized group called a family council.

Facilities certified for Medicare and Medicaid must provide a meeting space, cooperate with the council's activities, and respond to the group's concerns. Nursing facilities must appoint a staff advisor or liaison to the family council, but staff and administrators have access to council meetings only by invitation. While the federal law specifically references "families" of residents, close friends of residents can and should be encouraged to play an active role in family councils, too.

Specifically, the federal law includes the following requirements on family councils:

- *A resident's family has the right to meet in the facility with the families of other residents in the facility.*
- *The facility must provide a family group, if one exists, with private space.*
- *Staff or visitors may attend meetings at the group's invitation.*
- *The facility must provide a designated staff person responsible for providing assistance and responding to write requests that result from group meetings.*
- *When a family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.*

Guidelines:

- *"Voice grievances" is not limited to a formal, written grievance process but may include a resident's verbalized complaints to facility staff. "Prompt effort to resolve" include facility acknowledgment of complaint/grievances and actively working toward resolution of that complaint/grievance.*
- *If residents' responses indicate problems in voicing grievances and getting grievances resolved, determine how the facility deals with and makes prompt efforts to resolve resident complaints and grievances.*

The facility is required to listen to resident and family group recommendations and grievances. Acting upon these issues does not mean that the facility must accede to all group recommendations, but the facility must seriously consider the group's recommendations and must attempt to accommodate those recommendations, to the extent practicable, in developing and changing facility policies affecting resident care and life in the facility. The facility should communicate its decisions to the resident and/or family group and why the decision was made.

Activity Program Survey of Facilities in One Illinois County: A Report

In 1999, a survey was conducted by Erin Strotheide for the I CARE Regional Long Term Care Ombudsman Program to research the present state of activity departments in long term care facilities. The following is a report from that survey with additional information about what the law requires.

Five nursing homes in one county were selected as the representative group. Interviews were conducted with activity directors, residents of varying capabilities and involvement in the activity programs, and family members of incapable residents. A variety of activities were observed in order to understand how activity programs are currently designed and implemented.

The following are a list of findings from the survey:

- Residents felt they had the power to choose regarding activities.
- Facilities offered a variety of activities. Residents' favorite activities were offered 1 to 3 times a week with special events and other schedule variations offered 1 to 2 times a month.
- Evening activities were offered 2 to 5 times a week.
- All facilities incorporated volunteers into the activity program.
- All facilities surveyed used a variety of media for publicity of the activity schedule, including personal calendars, bulletin board calendars, daily schedule boards, announcements, etc.
- The personal calendars often used small print, and were jumbled.
- Some facility staff did not go room to room before activities to gather residents who were interested in attending.
- All but one of the activity directors had no education beyond high school in a discipline such as social services, therapeutic recreation, or occupational therapy. (A high school education is all that is required; however, these activity directors must have a consultant from one of these specialties.)
- Many activity directors were not meeting the state standard of 10 hours of continuing education each year pertaining to activity programming.
- Facilities had a poor system of interdepartmental communication and cooperation.
- Residents often did not have the opportunity to plan, prepare, conduct, cleanup, or critique activities.
- Some facilities had full activity calendars but failed to follow through with the activities scheduled.
- There was a lack of activities on weekends.
- The majority of facilities offered service activities for both the facility and surrounding community once a month, but did not offer service activities on a daily basis.
- There were few programs designed for men and male participation was low.

- Not meeting the standard of 45 minutes of staff time with each resident per week. The 45 minutes per resident is a staffing ratio. This does not mean meeting with each resident for 45 minutes in an individual or group activity. The time includes planning, executing, and documenting activities.
- There was an overall lack of programs for the residents with cognitive disabilities.
- Residents' past interests were not known or incorporated into the planned activities.
- Residents who did not participate offered two general explanations for their lack of participation:
 1. Past life style. They had always pursued individual activities and preferred to not be part of big groups.
 2. Rest and relaxation. Some residents felt they deserved relaxation after years of hard work and had no desire to be involved in the activities offered.

Discussion of the findings (other than those included in the body of the training module):

All facilities visited had successfully used a variety of media to notify residents of the activity schedule. One problem was in regard to the personal calendars of activities. Often too much information was crammed into small spaces and written with small print. These two factors did not accommodate residents with vision loss. A better format may be a day-by-day listing of events stapled together as a packet.

The staff issues identified in the findings led to an interesting discussion of the regulations now in place regarding activity staff. The lack of training in fields related to activities and/or the elderly contributed to many of the problems observed during the study. State and federal regulations allow activity directors to practice without a degree in occupational therapy, therapeutic recreation, or social work as long as they have consultation, but the lack of formal education put activity staff at a disadvantage. Stricter regulations on activity director qualifications would benefit facilities by requiring directors to be trained in resident assessment and the therapeutic techniques of activities.

Also related to training was the lack of continued education among activity directors and activity staff. The state regulations require activity directors and assistants to receive 10 hours of continuing education each year pertaining to activity programming. The activity directors require Continuing Education Hours (CEHs). Activity assistants require 10 hours of in-service training related to activities. A consultant may provide the in-service training. How to transfer residents and infection control are important topics for in-service training. A few facilities do provide quarterly in-services on activity issues, but some had little to no continuing education programs for their activity staff and were not meeting the state standard.

The federal regulations are broad; however, Illinois regulations require a staffing ratio of 45 minutes per resident per week that includes assessment, planning and documentation. State regulations required that activity directors must be in a facility four days per week. Still it appeared that staffing did not increase to meet the demands of the expanded workload. As facilities continue to understand the importance of an activity program, perhaps the trend will shift beyond the 45 FTE minute rule, but now, each facility decides for itself the employment standards of activities. One director did express her desire to see a stricter regulation on this issue so that her department could be more equipped to provide for everyone's individual needs.

The education and training of activity employees also lacks regulation. All orientation or training for activity assistants is left up to the individual facility.

Cross-trained staff can learn how to make each part of the day an activity that furthers residents' self-esteem and independence. During the morning routine of dressing and grooming, care staff provides chances for the resident to do as much as they can for themselves. By offering "guided choices" for each task such as, "Would you like to wear the blue sweater or the white one?" autonomy is returned to the resident. Breaking down large tasks into smaller, more manageable tasks helps alleviate frustration and confusion. Allowing residents to participate in their own daily living tasks restores dignity and creates a routine that more closely resembles their lives before entering the nursing home.

Federal law mandates that activities should occur as planned. It can be a temptation for facilities to have a full calendar of activities but not follow through with providing them. A poorly organized program can look great on paper but does not provide appropriate programs. Not only does such a program not meet standards, but also an unreliable calendar can be confusing and frustrating to residents. Unorganized programs do not encourage participation and do not enhance residents' well being. Activity directors must be sure to make arrangements for days when staff members call off from their shift. Volunteers could be utilized, or the interdisciplinary staff teams could fill in when necessary.

Service activities are listed in the state regulations as a category of activity that must be offered by facilities. Service activities allow residents to retain a meaningful role in society and foster a sense of self-worth. All but one of the homes surveyed did offer service activities for charities and the outside community. The majority of facilities offered those opportunities once a month. What was missing in many places was the opportunity to do service for others on a daily basis. Many men and women were busy and determined workers in the past, and currently had no outlet for that interest. The Illinois Activity Professionals Association encourages facilities to register the "eager to help" residents with the local Retired Senior Volunteer Program for work releases. There are opportunities in most facilities for the kind of meaningful work that would cater to these residents including: folding laundry, filling water pitchers, passing mail/newspapers, etc. One facility visited offered a service program for residents to help

prepare food items like snapping beans, shucking corn, and cutting vegetables, usually in a cooking activity group.

Residents willing to work cannot take the place of paid staff and must understand that they will not be paid for this work. The facility has to assure that anyone assisting in a facility observes all infection control measures. Resident volunteers should have a signed contract with the facility. Their volunteer duties should be part of their care plan.

Programs designed for men were lacking across the board. One disadvantage of most activity departments is the lack of male input in the planning process. The majority of activity staff are female and do not have the male perspective necessary to provide the appropriate programs.

Dementia residents get overlooked in respect to most activities. Both the disruptive behavioral symptoms of dementia residents and the lack of any reaction from the lowest-functioning residents frustrate many staff. Activity staff are at a loss for programs that engage these residents and hold their attention. Sensory stimulation, such as smelling different kinds of spices is a method of involving a low-functioning dementia resident because it can stimulate a sense that normal activities do not target. Activity staff may feel awkward using a sensory stimulation kit. Feelings of awkwardness towards sensory stimulation are only normal for people who have had no training. In many ways, staff from all departments lacks education about the needs of dementia residents. If staff learned how to “speak the language of dementia,” activities could be much more accommodating to cognitive disabilities.

After observing and interviewing both staff and residents, a clearer picture emerged of the status of activities in long term care. If we can understand what the law requires and know what residents expect, we 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, no matter what the cognitive or physical level.

Quality of Life

Can be measured by our daily life activities

- Daily life habits (grooming, bathing, eating, etc.)
- Individual activities
- Large group activities
- Small group activities
- Spontaneous activities—Pioneer Practices

Pioneer Practices

A continual process of change.

There's not just one way to improve the nursing home culture.

- Regenerative Community
- Individualized Dementia Care
- Eden Alternative
- Resident-Directed Care
- Others

MODELS OF CULTURE CHANGE

	Individualized Care	Regenerative Community	Resident-Directed Care	Eden Alternative
Resident Quality of Life	Restores choice and autonomy to residents with dementia	Empowers residents to initiate culture change	Restores the power of choice to residents.	Creates a living and diverse environment that sustains life
Defining Characteristics	Staff learns to speak the language of dementia No physical or chemical restraints	Emphasis on wellness instead of illness Interconnected community that incorporates residents of all abilities	Home-like environment—Neighborhoods Incorporates residents with different abilities	Smaller communities within the larger facility Home-like environment that incorporates plants, animals, children, and personal items
Staff	Permanently assigned interdisciplinary staff	Staff is part of interconnected community	Permanently assigned, cross-trained staff teams Staff follow residents' schedules	Interdisciplinary staff teams
Authority Structure			Inverted organization of authority—Decision making power is in the hands of residents and the direct care staff	Inverted organization of authority—Decision making power is in the hands of residents and the direct care staff
Activities	Creative and individualized activities to cope with behavioral symptoms	Daily meeting Comprehensive individualized activity program Spontaneous activities	Opportunity for daily service activities Spontaneous activities	Residents have opportunities to give and receive care De-emphasizes planned activities, emphasizes spontaneous activities

Residents with Dementia and Alzheimer Disease

How can they participate in activities?

Community Participation in Activities

- Activity Director's Role
- Resident Council's Role
- Family Council's Role
- Ombudsman's Role