Restorative Care Nursing for Older Adults
A Guide for All Care Settings
Barbara Resnick, editor
Second Edition

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RESTORATIVE CARE NURSING FOR OLDER ADULTS

Second Edition
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Marie Boltz, PhD, RN
Elizabeth Galik, PhD, CRNP
Ingrid Pretzer-Aboff, PhD, RN
This book is dedicated to all caregivers who have provided function-focused care during care interactions with older adults; to all the older adults who have taught me about resilience and ways to optimize function and physical activity despite multiple challenges; to my family, friends, and colleagues for their support; and to my deceased father for teaching me that saying “I can’t” is not an option.
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FOREWORD

This book is truly a compilation of the many years of work delineating and demonstrating outcomes associated with restorative care, or function-focused care. My own work as the CEO of the International Council on Active Aging further confirms and reinforces the critical need to change how we approach care to older adults. Function-focused care is a practical and realistic way in which to solve the problems we face with regard to insufficient time spent in physical activity, deconditioning, and functional decline that commonly occur across all care settings. For example, I am well aware that the majority of the time older adults are hospitalized is spent in bed (approximately 83%). Likewise, I wholeheartedly agree with these authors'/practitioners'/doctors' approach and philosophy and appreciate the need for all members of the interdisciplinary team to work together to decrease needless immobility and prevent functional decline. Nurses certainly provide the most direct care with patients and spend the most time in patient-provider interactions and are thus central to this process.

For nurses, regardless of level or site of practice (e.g., LPN, RN, nursing assistant, or advanced practice), this book provides a wonderful background about function-focused care and why it is necessary to change the way in which nurses most commonly provide care to patients. While never mal-intended, too much care can rob individuals of the opportunity to engage in a routine range of motion necessary for maintaining underlying capability.

The book provides a practical hands-on perspective for implementing function-focused care in all settings. The tables included in each chapter and the appendices at the end of the book provide the tools that are relevant to these different groups of individuals and sites of care. Specifically included are educational materials relevant for each setting, documentation forms for those in long-term care or acute care, and examples of goal forms that can be used. Educational materials and methods for informal and formal caregivers are included because families of patients in acute care need to understand and intervene in ways that are different from those in nursing home settings or home settings.

Woven into the chapters is the research support related to the benefits and expected outcomes associated with implementing function-focused care. Quite importantly, the authors address safety issues associated with function-focused care and provide data to support that this care approach is not only beneficial but it is safe for all older adults. Lastly, the book raises some important ethical considerations for implementation of a function-focused care perspective.
In summary, this is a unique resource that is relevant for all nurses and health care providers working with older adults. In addition to addressing functional decline, function-focused care provides a fresh and practical solution to many of the problems that tend to arise with older adults, such as infections, falls, and pressure ulcers, all known to be associated with immobility.

*Colin Milner*
CEO
International Council on Active Aging
PREFACE

Restorative care nursing, more recently referred to as function-focused care, is a philosophy of care that enables caregivers to actively help older adults achieve and maintain their highest level of function. This is the only volume written to educate caregivers and administrators about both the philosophy of restorative care and how to integrate this philosophy in all types of care settings. This updated second edition contains new content in each chapter along with two entirely new chapters on function-focused care for cognitively impaired adults, ethical issues, and patient-centered care.

This book provides an education program about function-focused care for formal and informal caregivers, suggestions for beneficial activities, and practical strategies for motivating older adults and caregivers to engage in function-focused care. Information specific to settings as well as ways to provide function-focused care to those with moderate to severe cognitive impairment are provided. Tables in each of the chapters and the appendices feature the necessary tools for effective implementation of function-focused care, and its philosophy, in any setting.

KEY FEATURES

- Teaches practical application of function-focused care with educational programs relevant for the various settings
- Designed for use in long-term care, assisted living, home-based care, and acute care settings
- Provides a philosophy of care carried throughout all care interactions
- Contains new content in each chapter and two new chapters
- Includes helpful suggestions and strategies for motivating older adults and caregivers
ACKNOWLEDGMENTS

This book could not have been revised and published without the support of Springer Publishing Company for being willing and interested in this critically important care approach, as well as the hard work and contributions of my co-authors Drs. Elizabeth Galik, Marie Boltz, and Ingrid Pretzer-Aboff. Dr. Galik shares her research and expertise in implementation of function-focused care with older adults with moderate to severe dementia, Dr. Boltz shares her work in acute care settings, and Dr. Pretzer-Aboff provides the support and tools to implement function-focused care in the home setting. Lastly, I want to thank our amazing editorial assistant Ardis O’Meara who kept us all on track through the process and completed our final editing and book delivery. May the resources within this book help you to change how you provide care to older adults and think first about what the individual can do and how to help him or her optimize underlying function, engage in physical activity, and worry less about task completion.
ONE

FOCUSING ON FUNCTION
IN ALL CARE INTERACTIONS:
A NEW PHILOSOPHY OF NURSING CARE

Barbara Resnick

In understanding our current approaches to nursing care, it is helpful to reflect on our history and where nursing has been in terms of definitions of the profession and philosophies of care. In ancient cultures, religious beliefs and myths were the basis for health care and medical practice. Nurses delivered custodial care and depended on physicians or priests for direction. We are all acutely aware of, and may have even experienced, the days of nursing when the nurse stood by the bedside and took orders from the physician for all patient care-related activities.

Under the influence of Christianity, nurses gained respect, and the practice of nursing expanded. The Sisters of Charity, founded by St. Vincent de Paul, cared for people in hospitals, asylums, and poorhouses. Then Louise de Marillac established perhaps the first educational program to be associated with a nursing order. The Sisters of Charity, following this approach, were introduced in America by Mother Elizabeth Seton in 1809. In 1847, Florence Nightingale went to Kaiserswerth to work with the deaconesses, and her career and the Civil War (1861–1865) stimulated the growth of nursing in the United States. Clara Barton (who founded the American Red Cross in 1882), Harriet Tubman, and others tended soldiers on the battlefields, cleansing their wounds, meeting their basic needs, and comforting them in death. Clearly, they provided care for these individuals throughout the acute and recovery processes.

In the 1890s, after the Civil War, nursing flourished through the efforts of Mary Agnes Snively and Isabel Hampton Robb, and the Nurses’ Associated Alumni of the United States and Canada was founded. This is now known as the American Nurses Association (ANA) and the Canadian Nurses Association. Early in the 20th century, Mary Adelaide Nutting was instrumental in establishing nursing education within universities and became the first professor of nursing at a university in 1907. From there the profession and scope of practice have likewise expanded. It has not been made clear, however, that we have altered our core philosophy and approach at the bedside in terms of how care is provided to the patient and with what intention.
THE NURSING PHILOSOPHY OF CARE

As far back as 1859, with the writings of Florence Nightingale, the philosophy of nursing care was defined as being in “charge of the personal health of somebody . . . and what nursing has to do . . . is to put the patient in the best condition for nature to act upon him.” This philosophy, although innovative when established, suggests a framework in which nurses are in control and doing for rather than providing care with the patient. Florence Nightingale’s philosophy of nursing has been revised over the years by nurse theorists but has essentially remained the same. In the words of nursing theorist Virginia Henderson, for example, nurses help people, sick or well, to do those things needed for health or a peaceful death that people would do on their own if they had the strength, will, or knowledge. This philosophy, yet again, reflects the provision of care by the nurse with no indication that the patient might be engaged in the care activity.

Rosemarie Rizzo Parse, another nurse leader, provides another reflection on nursing and philosophy and the way in which nursing care is provided. She writes:

Every physician recognizes the importance of good nursing. In the treatment of disease medicinal agents are necessary to combat the various symptoms as they arise, but it is equally important that the surroundings of the patient should be so arranged that he may be supported and tided over the critical period of his illness. It is not too much to say that in many illnesses good nursing is more than half the battle. When a man is seriously ill he is practically as helpless as a child, and can neither think nor act for himself. He is fortunate should there be some friend or relative who will take the initiative for him, but there are many people—often men in good social position—who have no one about them whom they would care to trust. The sick man sends for his doctor, and nurses are provided on whom rests the responsibility of seeing that he is properly cared for, and that no advantage is taken of his helplessness. The trust is a sacred one, and for the honour of the nursing community is rarely or never abused.1

Yet again, nurses are described as providing care to an individual with the assumption that total care is needed and will best serve the individual throughout his or her recovery process.

The ANA currently defines nursing as “the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.”2 Furthermore, the ANA differentiates between nursing and medicine and suggests that nurses’ focus be on the whole person, not just the unique presenting health problem. Specifically, nurses respond to the human response to a health problem rather than the health problem in and of itself. The common thought is that physicians cure and nurses care. In so doing, the ANA delineates that nurses build on their understanding of disease and illness to promote the restoration and maintenance of health in their clients. How health is defined and achieved and who does what in the process of establishing health is not well articulated and varies by setting and by individual nurse.
Chapter One. Focusing on Function in All Care Interactions

■ TO CARE FOR OR CARE WITH: OUTCOME-BASED EVIDENCE FOR DECISIONS

There is no question that the historically based philosophy of care and theories of nursing are well substantiated in logical and well-intended approaches. They are not, however, always evidence based. Intuitively, for example, we tend to believe that rest will facilitate recovery. In fact, bed rest as a therapy can be traced back to Hippocrates and has been used to manage many types of illnesses, acute and chronic, since that period of time. Currently, bed rest persists as a nursing intervention in some situations.

For example, patients undergoing some cardiac procedures such as percutaneous coronary interventions are commonly given antiplatelet therapy before and after the procedure as well as heparin during the procedure. Thus, they are viewed as being at greater risk of developing vascular complications, such as a hematoma, pseudoaneurysm, and bleeding at the puncture site, than those patients undergoing coronary angiography without antiocoagulation. In order to prevent bleeding from a groin puncture site, patients who were treated with antiocoagulants are generally restricted to bed rest and advised to keep the affected limb straight. There is little evidence to support this approach and known evidence of risks such as physical pain, depression, pressure sores, and deconditioning.

Further research demonstrated that reducing bed rest and engaging these patients in functional and physical activity increased the comfort of the patient and did not increase the risk of vascular complications at the wound site.

It is well known that there is a gap between research and practice. Nurses working in clinical settings, for example, continue to fear that patients with a deep vein thrombosis (DVT) will be harmed by ambulating. Nurses also implement bed rest with these patients based on nursing diagnoses such as risk of falling. The Nursing Interventions Classification (NIC) defines bed-rest care as the promotion of comfort and safety and the prevention of complications for a patient unable to get out of bed. Nurses genuinely believe that bed rest will keep patients safe from harm and ensure optimal recovery.

Bed rest persists despite lack of evidence-based benefit of this intervention and even in the face of evidence to suggest harm. Multiple studies have been done, for example, to demonstrate that there is no difference in occurrence of pulmonary embolism in patients put on bed rest versus those allowed to ambulate freely post-DVT. The persistence of either medically prescribed or nursing-facilitated bed rest is evident empirically among hospitalized older adults. In a recent study by Brown et al., it was noted that older adults were spending 83% of the time while hospitalized in bed and at least 40% to 60% of these individuals demonstrated some decline in functional ability with declines occurring as early as the second day of hospitalization. Immobility and functional impairment increase the risk that older adults will develop infections, pressure sores, and fall, or require nonelective rehospitalization. Nurses conceptualize their roles as “watching over” patients to protect them from falls and other adverse events and encourage what are believed to be risk-free activities, such as staying in bed and using a urinal. This protective, custodial, task-oriented care facilitates functional decline, decreases physical activity, and contributes to deconditioning and disability.

Although complete bed rest is less common in long-term care settings, there is evidence of limited functional and physical activity and a persistent decline in function among residents in these settings. Specifically, it has been noted that the majority of individuals in nursing homes and assisted living facilities are inactive and have...
limited opportunities to engage in physical activity. Moreover, the activity that they perform is mainly in a seated position. The amount of activity engaged in by those in assisted living settings was less than that reported by community-dwelling older adults with degenerative joint disease (204,593 counts/day), those at risk of disability (113,695.6 counts/day), those living in nursing homes (55,710–103,647 counts/day), or healthy community-dwelling older adults (113,695.6–237,425 counts/day). In addition, direct care workers (DCWs) in these sites encourage participation in ambulation and other types of physical activity in only approximately 3 out of 19 common care interactions (e.g., bathing and dressing).

■ EVIDENCE OF THE BENEFIT OF PHYSICAL ACTIVITY

There is substantial evidence documenting the many health benefits associated with physical activity for adults of all ages, even for chronically ill or frail older adults for whom it is often falsely believed that physical activity will exacerbate rather than ameliorate underlying health problems. Meta-analytic reviews have provided strong evidence that participation in either nonspecific physical activity or specific aerobic or resistive exercise is associated with a variety of health improvements, such as decreased risk of coronary heart disease and stroke, decreased progression of degenerative joint disease, prevention of osteoporosis of the lumbar spine, and increased gait speed if the activity is of sufficient intensity and dosage, and is positively associated with successful aging. While there is some evidence for a dose–response relationship between physical activity and health outcomes, substantial benefits can be achieved at even relatively low levels of exercise intensity, and previously sedentary older adults are the most likely to benefit from physical activity.

In long-term care facilities, specifically nursing homes and assisted living communities, we have repeatedly shown that increasing participation in functional and physical activity among residents results in improved gait and balance and improved mood and fewer disruptive behaviors. In addition, residents who are encouraged to optimize their functional and physical activity are less likely to be transferred to the emergency room for episodes of care associated with non-fall-related problems, such as infections. Thus, there is sufficient support for encouraging more time engaged in physical activity and less time in bed and sitting for older adults across multiple settings.

■ FUNCTION-FOCUSED CARE

Function-focused care, previously commonly referred to as restorative care, is a philosophy of care that focuses on evaluating the older adult’s underlying capability with regard to functional and physical activity and helping him or her to optimize and maintain abilities and continually increase time spent in physical activity. Transitioning restorative care to a function-focused care philosophy was done deliberately to provide a more positive perspective as well as to move this work from a conceptualization of a program (e.g., restorative care program) to a broader philosophy of care that is needed regardless of setting. Examples of function-focused care interactions are shown in Table 1.1 and include such things as using verbal cues during bathing so...
that the older individual performs the tasks rather than the direct care worker bathing the individual, walking to the bathroom rather than using a portable urinal, or going to an exercise class.

### Table 1.1
Examples of Function-Focused Care Activities

<table>
<thead>
<tr>
<th>Function</th>
<th>Example of Function-Focused Care Performed</th>
<th>Example of When Function-Focused Care Is Not Performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed mobility</td>
<td>Asks or encourages older adult to move in bed and gives him or her time to move</td>
<td>Asks or encourages older adult to move in bed but does not allow time for older adult to respond</td>
</tr>
<tr>
<td></td>
<td>Gives step-by-step cues on how to move in bed—for example, put your right hand on the rail and pull yourself over on your left side</td>
<td>Moves older adult without asking older adult to help; pulls older adult up fully on bed without asking older adult to help</td>
</tr>
<tr>
<td></td>
<td>Places older adult’s hands to facilitate independent movement, for example, on guard rail</td>
<td>Discourages or stops older adult from performing activity</td>
</tr>
<tr>
<td>Transfer from one surface to another</td>
<td>Asks or encourages older adult to transfer and waits for older adult to move</td>
<td>Older adult performed activity but with no involvement or encouragement from direct care worker (DCW)</td>
</tr>
<tr>
<td></td>
<td>Gives step-by-step cues on how to transfer, for example, “slide to the edge of the chair”</td>
<td>Asks or encourages older adult to transfer but does not wait for older adult to initiate the transfer; just starts to pull him or her up</td>
</tr>
<tr>
<td></td>
<td>Places hands to facilitate independent movement, for example, places hands on walker</td>
<td>Transfers/lifts older adult fully with no encouragement by DCW to have older adult perform any of the transfer</td>
</tr>
<tr>
<td>Mobility (ambulation/wheelchair)</td>
<td>Asks or encourages older adult to walk or independently propel wheelchair and gives him or her time to perform activity</td>
<td>Discourages or stops older adult from performing activity</td>
</tr>
<tr>
<td></td>
<td>Gives step-by-step cues to get older adult to walk, for example, “move your left foot forward, now move your right foot”</td>
<td>Older adult performed activity but with no involvement or encouragement from DCW</td>
</tr>
<tr>
<td></td>
<td>Assists in, asks about, or encourages use of assistive devices (e.g., Merry Walker, rolling walker, standing table)</td>
<td>Utilizes wheelchair instead of encouraging ambulation and does not encourage older adult to self-propel (even short distance/even with one hand)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discourages or stops older adult from performing activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Older adult performed activity but with no involvement or encouragement from DCW</td>
</tr>
</tbody>
</table>
THEORETICAL MODEL TO GUIDE INTEGRATION OF THE FUNCTION-FOCUSED CARE APPROACH

Evidence and knowledge of the benefit of a care philosophy such as function-focused care is not sufficient to ensure that this will occur in real-world clinical settings. Using a social ecological model (SEM; Figure 1.1) to guide the implementation of the function-focused care philosophy provides an overarching framework for understanding the interrelations among diverse personal and environmental factors in human health and illness and addresses intrapersonal, interpersonal, environmental, and policy factors that can be used to ensure successful implementation. There is increasing recognition that this type of multilevel perspective is needed to address health behavior change and facilitate changes in current care philosophies and care practices as has been done with regard to use of physical restraints, promoting health behaviors and achieving the guidelines as noted in Healthy People 2010, and understanding caregivers’ expectations and care receivers’ competence.

Impact of Intrapersonal Factors on Function and Physical Activity

A number of intrapersonal factors can lead to functional limitation, disability, and low physical activity in older adults. These factors include comorbidities, acute medical problems, and psychological factors (e.g., mood and motivation). There are also nonmodifiable factors including demographic variables such as age, gender, and race. While it is useful to acknowledge the presence of these factors, it is challenging to relate them directly to

FIGURE 1.1
FFC social ecological model.
function as individuals vary so much. Moreover, it is impossible to separate out the multiple comorbidities common in older individuals. Appreciating the potential impact of these variables can help guide interventions; for example, knowing that someone has Parkinson’s disease would impact the type of interventions used to optimize function.

**Cognitive and Behavioral Intrapersonal Challenges**

As many as 90% of older adults in long-term care facilities have some cognitive impairment and have associated symptoms such as aphasia, motor apraxia, perceptual impairments, and apathy. This makes it particularly challenging to encourage older adults in these settings to engage in functional activities and exercise. In addition to functional and motivational challenges, problematic behavioral symptoms, such as verbal and physical aggression, insomnia, depression, and resistance to care occur in 50% to 80% of individuals diagnosed with dementia at some time during the course of their illness. Caregivers are frequently challenged by the agitated and uncooperative behaviors of cognitively impaired residents and tend to focus on maintaining behavioral stability rather than trying to engage them in functional and physical activities. Unfortunately, this reinforces sedentary activity and a “just getting it done” approach to personal care in which the caregiver completes the functional task rather than supporting the resident in doing so. Individualized approaches, altering the environment, providing verbal encouragement, cueing, role modeling, and following a simple routine are all techniques we will describe in subsequent chapters that successfully engage these individuals in functional and physical activity.

**Physical and Physiological Factors**

There are numerous physical and physiological factors that can influence participation in functional and physical activities among older adults. Quite simply, the individual’s underlying physical capability, which we will evaluate using a brief assessment tool, can limit what the individual is actually able to perform and must be used to guide the development of goals. In addition, physiological contributors such as serum albumin, endocrine immune dysregulation associated with sarcopenia, osteoporosis, D-dimer and inflammatory markers, testosterone levels, mitochondrial dysfunction, anemia, vitamin D levels, and muscle mass changes, for example, are all associated with function in older adults. Some of these factors can be evaluated and treated at the individual level, but others must just be recognized and function optimized in light of these changes.

**Psychosocial Factors**

The most commonly noted psychosocial factors influencing function are fear of falling and depressive symptoms. Interestingly, depression can decrease the individual’s willingness to engage in exercise, although participating in exercise decreases depression and improves mood. Resilience is another psychosocial factor that influences function and participation in exercise or in any physical activity. Resilience is an individual’s capacity to make a “psychosocial comeback in adversity,” and is defined as the ability to achieve, retain, or regain a level of physical or emotional health after illness or loss.
Resilient individuals tend to manifest adaptive behavior, especially with regard to social functioning, morale, and somatic health, and are less likely to succumb to illness.\textsuperscript{44,45} For example, older women who have successfully recovered from orthopedic or other stressful events describe themselves as resilient and determined and tend to have better function, mood, and quality of life than those who are less resilient.\textsuperscript{46}

### Interpersonal Factors: Motivation and the Theory of Self-Efficacy

Motivation is a component of personality but is also influenced by variables extrinsic to the individual. Bandura\textsuperscript{47} conceptualized motivation within the broader spectrum of the theory of self-efficacy. The theory of self-efficacy suggests that the stronger the individual’s self-efficacy (SE) and outcome expectations (OE), the more likely it is that he or she will initiate and persist with a given activity. SE expectations are the individuals’ beliefs in their capabilities to perform a course of action to attain a desired outcome, and OE are the beliefs that a certain consequence will be produced by personal action. Efficacy expectations are dynamic and are both appraised and enhanced by four mechanisms: (a) enactive mastery experience, or successful performance of the activity of interest; (b) verbal persuasion, or verbal encouragement given by a credible source that the individual is capable of performing the activity of interest; (c) vicarious experience, or seeing like individuals perform a specific activity; and (d) physiological and affective states such as pain, fatigue, or anxiety associated with a given activity.

At the interpersonal level, the theory of SE can be used to guide interventions that will strengthen SE and OE among older adults and their caregivers and thereby increase the likelihood that caregivers will implement function-focused care and older adults will engage in functional tasks and physical activity. Specifically, interventions such as the use of verbal encouragement and goal setting, role modeling, mastery experiences, and decreasing unpleasant sensations are all ways in which caregivers and older adults have been motivated to successfully change behavior so that function and physical activity are optimized.\textsuperscript{17,23,48}

### Social Support

At the interpersonal level, social support networks including family, friends, peers, and health care providers are important determinants of behavior.\textsuperscript{49,50} Repeatedly, motivation to perform physical activity and exercise has been found to be influenced by the social milieu of the care setting. These social interactions can influence SE and OE and can alter the progression of functional limitations to disability. Degenerative joint disease, for example, may have less impact on dressing for individuals who are encouraged by a family member to independently dress versus a family member who dresses or insists that the caregiver dress the individual. The influence of any member of the older adults’ social network can be positive or negative depending on his or her philosophy and beliefs related to function-focused care. For example, in assisted living settings, some families advocate for maximal care to be provided to their loved one, regardless of the individual’s ability to perform the activity alone. This propagates sedentary behavior, decreases SE related to function, and can reduce participation in physical activity.

Unfortunately, the demonstration of dependent self-care behavior by long-term care residents is usually followed by positive reinforcement and support from care providers,
whereas the demonstration of independent self-care activities does not result in positive reinforcement, and is generally unnoticed by care providers.\textsuperscript{51,52} This is coupled with the tendency of care providers, in an attempt to be more efficient and caring, to complete functional tasks for the residents. Establishing a culture and philosophy of care in which older adults are consistently motivated to engage in functional tasks and physical activity and achieve realistic goals given underlying disease is greatly needed.

The success of any intervention designed to improve care to older adults depends heavily on the receptiveness of caregivers to learn new skills and their motivation to use these skills regularly. SE related to employment activities has repeatedly been associated with and can improve job satisfaction and job performance.\textsuperscript{53,54} Specifically, SE-based interventions such as verbal persuasion and education about care-related activities resulted in improved job satisfaction and decreased turnover among direct care workers.\textsuperscript{23,55,56}

Environment

Environments that facilitate physical activity can reduce functional decline and enable people to achieve their highest level of function and well-being.\textsuperscript{57–59} Unfortunately, designated exercise space is generally limited in health care settings, and the hallways, common areas, and outdoor walkways are seldom used to promote physical activity. When environments are evaluated, it is generally only for safety rather than optimizing functional usefulness. Recommendations from case studies and direct observations of residential communities for older adults indicate that visibility of exercise-related areas, walkable spaces, safety, and having interesting walking destinations can improve physical activity among residents.\textsuperscript{16} Simple and cost-efficient modifications can be made to improve the space, such as improving lighting, displaying signs that specifically promote active living, and providing physical activity stations throughout the facility. Outdoor improvements include ensuring that sidewalks and stairs are safe and accessible, providing greenery and interesting destinations, and ensuring that there is adequate shade and seating so that residents will feel comfortable outdoors. Interventions that educate and engage all members of the community to utilize environmental resources to promote physical activity are underused and needed.

In addition to consideration of the objective physical environment, the degree of person-environment fit (P-E fit) is critical to evaluate, especially as function declines.\textsuperscript{60} The environment includes the physical, personal, small group, suprapersonal, and the social environment. Adaptation, or P-E fit, occurs when there is a match between the person and the environment. There is evidence to suggest that individuals with lower competence are particularly influenced by the P-E fit as they have to spend a great deal of energy overcoming and adapting to environments and consequently are unable to optimally engage in functional or physical activity. In these instances, physical activity can be improved by lowering environmental demands through interventions such as altering the height of a bed or a chair to facilitate transfers.

Policy

Policy initiatives have been successful in changing behaviors in areas such as wearing seat belts and smoking cessation. There are, however, no national policies related to physical activity. Nursing home settings are federally mandated by the Omnibus Budget
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Reconciliation Act (OBRA) of 1987 to provide care that ensures that residents attain and maintain their highest level of function. There are no such national guidelines for assisted living, acute care, or the home setting. General public health guidelines do, however, recommend 30 minutes daily of low- to moderate-intensity physical activity for all adults. Dissemination of these guidelines can be used as a way in which to encourage caregivers and older adults to engage in all types of physical activity.

In addition, the policies, procedures, and philosophy of care within organizations are critical to establishing a function-focused philosophy of care. Policies related to use of shared-space areas, provision of care, and availability of services in long-term care or acute care facilities can influence participation in physical activity and function among older adults within those settings. If outdoor space for walking is locked and made inaccessible, or if the underlying philosophy or culture within the facility is to provide care rather than optimize function, perceptions and expectations among older adults, staff, and families can be affected, which can lead to functional dependency. Understanding the policies and informal structures in care facilities is a necessary first step to identifying barriers to implementing a function-focused care philosophy and interventions relevant to function-focused care.

FROM THEORY TO IMPLEMENTATION OF FUNCTION-FOCUSED CARE

In summary, despite our long nursing history of providing care for individuals, there is a great need, given what is known about physical activity and the impact of limited mobility on future outcomes, to transition our philosophy of care in nursing to one focused on optimizing function and physical activity. Use of a social ecological model is needed to guide the implementation of this philosophy of care and ensure that outcomes are achieved. At the intrapersonal level, the social ecological model serves as a reminder to consider the many intrapersonal factors in residents and in caregivers that might influence their perceptions about function-focused care and their ability to engage in these activities. The interpersonal factors associated with implementation of function-focused care are particularly critical to successful implementation. Self-efficacy-based interventions are very effective and include such things as ongoing education of caregivers and older individuals, ongoing verbal encouragement, role modeling, cueing, and removal of unpleasant sensations associated with function-focused care activities. These are described in greater detail in subsequent chapters.

Environment interventions are useful to ensure that the resources are present so as to optimize outcomes. If, for example, there is no place to walk safely, it may be difficult to achieve a goal of walking for 20 minutes a day. Furthermore, the environment needs to be arranged so as to ensure optimal completion of functional tasks. Bed and chair heights are simple examples of how environmental interventions can facilitate transfers. Lastly, at the policy level, it may be necessary to alter institutional policies and philosophy so that there is a focus on optimizing function and increasing physical activity among older adults within those settings. Acute care settings in which patients are unable to walk to tests and procedures, for example, limit activity and can contribute to deconditioning. Changes in such policies are needed to truly integrate a function-focused philosophy of care and achieve optimal outcomes.
There is sufficient evidence to support the benefits of helping older adults remain physically active through performance of functional activities and general physical activity as per the guidelines set by the American College of Sports Medicine and the American Heart Association. Likewise, the implementation of a function-focused care approach across multiple care settings has been shown to be safe and beneficial for older adults and may even prevent the need for acute medical interventions due to such things as infections. The remaining chapters of this book will delineate how to implement a function-focused care philosophy and provide older adults with this level of care across all types of care settings and situations.

**REFERENCES**

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Chapter One. Focusing on Function in All Care Interactions