

MOBILITY DECLINE PREVENTION

TRAINING MODULE

**Prepared by
The Anna and Harry Borun Center for
Gerontological Research,
a joint program of the
UCLA Medical Center and
the Jewish Home for the Aging
of Greater Los Angeles**

ABOUT THE BORUN CENTER

This training manual presents the work of researchers at the Anna and Harry Borun Center for Gerontological Research, a joint venture between the UCLA School of Medicine and the Jewish Home for the Aging (JHA) of Greater Los Angeles in Reseda.


Established in 1989 and housed at JHA, the Borun Center is an interdisciplinary center for applied research that focuses on creating, testing, and promoting the adoption of behavioral interventions to improve daily care and quality of life in nursing homes. The Center's mission encompasses three objectives:

- Identify factors that affect the quality of life of frail nursing home residents.
- Develop and test interventions to improve life quality for this population.
- Disseminate these interventions via a website, <http://borun.medsch.ucla.edu>, as well as through publications, conferences, and collaboration, and ensure their adoption by providing a system of training and expert support.

The Center's work, designed to help nursing homes make the most of the resources they have on hand to enhance patient care and improve clinical outcomes, is exceptional for several reasons:

- The Center's interventions address everyday nursing home routines that profoundly impact quality of life for residents, including incontinence management, weight loss prevention, pain assessment, mobility decline prevention, quality-of-life assessment, and pressure ulcer prevention.
- Center interventions in each of these areas have proven effective in research trials, and most were evaluated in randomized controlled trials, the gold standard for research studies.
- The Center's work has yielded validated, reliable protocols that serve as easy-to-follow step-by-step instructions for implementing resident assessments and daily care interventions. These self-explanatory protocols enable nursing home staff to readily implement the assessments and interventions with minimal need for outside assistance.
- The Center also has developed quality control protocols for managing interventions and ensuring quality of care over time.

To the best of our knowledge, no other research center in the nation can lay claim to a body of work of comparable breadth, depth, and quality.

Under the direction of John F. Schnelle, Ph.D., Borun Center researchers have won wide acclaim for their non-invasive, cost-conscious, and effective methods for enhancing nursing home management and improving quality of life for frail residents. Their work has been funded by 18 grants from the highly selective National Institutes of Health and reported in more than 160 publications in professional books and journals. 

-- Summer 2004

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ABOUT THIS TRAINING MODULE

This training module provides instructions for implementing two programs that help nursing home residents maintain function in Activities of Daily Living (ADL).

It starts with a list of learning objectives. Following that is a discussion of the problem—ADL decline among nursing home residents—with an overview of the solution—exercise.

The next sections constitute how-to manuals for implementing two exercise interventions:

- a *walking program*, appropriate for the minority of residents who are ambulatory, and
- an *exercise intervention* aimed at the 50-60% of long-stay residents who are incontinent, with many of them severely cognitively impaired.

LEARNING OBJECTIVES



At the end of this training module, you will be able to:

- Demonstrate knowledge of the importance of providing regular exercise for nursing home residents.
- Assess residents for their ability to safely participate in a walking program.
- List at least three modifications that can make a walking program potentially more feasible to implement.
- List at least four ways certified nurse aides (CNAs) can encourage residents to participate in a walking program and enhance their enjoyment of the program.

THE PROBLEM, THE SOLUTION

Learn what's expected of nursing homes with regard to improving residents' functional abilities.

Q & A: EXERCISE WITH RESIDENTS

Having spent the last 15 years conducting research in nursing homes, we at the *Borun Center* are nothing if not realists. So here are our pointed answers to some pertinent questions about exercise with frail nursing home residents.

- Q.** Will offering regular exercise to residents require more time than providing usual care?
- A.** Yes, without question (1,2).

- Q.** Will regular exercise help restore function so that impaired residents are more independent as a result?
- A.** Probably not; it's unlikely (1,3).
- Q.** Will regular exercise reduce the incidence of common healthcare problems in residents such as pressure ulcers, falls, cardiovascular conditions, and the like.
- A.** It's unlikely (3).
- Q.** Then why the heck should our facility strain already limited resources to offer regular exercise to residents who you say will probably not improve their health as a result?

Here's our most pointed answer of all: Because if you do nothing, then so will many of your residents. As a result, their mobility, strength,

CMS TO NURSING HOMES: “TRY TO IMPROVE FUNCTIONAL ABILITY”

These days the federal Centers for Medicare & Medicaid Services (CMS) is encouraging long-term-care consumers to use their purchasing power to hold nursing homes accountable for poor quality of care. Its Nursing Home Compare website (www.medicare.gov) exerts pressure on the industry by reporting, for each facility in the nation, the percentage of residents whose need for help with Activities of Daily Living (ADLs) has increased. A bad score signals potential problems and may steer consumers away from the facility.

Delve a few pages into this website and you find that CMS is also educating consumers to be discerning nursing home shoppers. “Nursing homes should always strive, with every resident, to try to improve functional ability as much as possible...,” it advises. “When you visit the nursing home, ask what programs are in place to maintain and improve the physical function of the residents.” (4)

The message from CMS is clear: Your facility needs to do something to help residents accomplish such basic daily activities as walking, transferring, and moving in bed. The benefits of such support programs, typically exercise programs, include enhancing self-image and increasing activity levels. The chief benefit, however, may lie not in what these programs improve but in what they prevent: further functional decline.

“If residents are to maintain their ability to walk, transfer, use the toilet, or move in bed, then they must continue to engage in these activities or something very much like them.”

AT THE VERY LEAST, PREVENT DECLINE

These days no one is expecting miracles from your facility. Those of us who work in long-term care have come to realize that the functional abilities of long-stay nursing home residents have worsened in recent years as housing options for more independent seniors have expanded. With today’s very frail nursing home population, the first goal is not so much to improve ADL function (though that would be great) as it is to prevent its decline.

Even the folks at CMS seem to recognize this new reality. Its quality measure doesn’t bother to look at long-stay residents who have improved their ADL function, just those who have gone downhill. In a statement to consumers, CMS notes: “Regardless of how much effort a nursing home program puts into improving function in their population of frail elderly residents, some residents will inevitably experience a loss in function over time. This is especially true of very sick or very frail residents... (4)” And, we might add, that’s most of them.

USE IT OR LOSE IT

The question now is not whether to offer programs that help residents maintain their ADL function but what kinds of programs to offer.

Ultimately, it boils down to that wise adage: Use it or lose it. If residents are to maintain their ability to walk, transfer, use the toilet, or move in bed, then they

must continue to engage in these activities or something very much like them.

This training module provides instructions for implementing two programs that help residents maintain ADL function. The first is a walking program, appropriate for the minority of nursing home residents who are ambulatory. The second is an exercise intervention aimed at the 50-60% of nursing home residents who are incontinent. Unlike many other exercise programs in nursing homes, this one welcomes residents who are severely cognitively impaired.

PROGRAM PREREQUISITES

Three prerequisites are recommended before you start:

- First, enlist top-level support from a managerial “champion” to facilitate acceptance of the new programs by direct care staff. One way to recruit help: Hand the likely champion a copy of this module and ask if you two can discuss it after he or she has read it. Have you considered that you yourself might be the champion?
- Second, read through all steps of the walking program and/or all steps of the exercise intervention so that, from beginning to end, you know what’s needed to achieve success.
- Finally, allow extra time at the beginning to climb the learning curve. Trust us—both programs consume less staff time the longer your facility administers them.

PREREQUISITES FOR RESIDENTS

Preliminary to participating in either program, residents should be treated if they have a current medical problem such as an infection or pain (see our Pain Screening Module available on our website, <http://boruncenter.medsch.ucla.edu>).

A pharmacist’s or physician’s review of their medications is also helpful. This review may prevent or minimize such side-effects as drowsiness and confusion, which can undermine participation in exercise programs.

YOUR ASSIGNMENT

This is often an eye-opener for medical directors and nurse supervisors: Stroll down your facility’s hallways at 10 a.m. and again at 4 p.m. on the same day. Each time, note the names or room numbers of residents whom you observe in bed. Compare the two lists to identify those residents observed in bed at both times.

Our research indicates that these residents spend an estimated 16 or more hours a day in bed (5). These residents definitely are not “using it.” There’s a good chance they’re “losing it.” It’s time to exercise.

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THE WALKING PROGRAM

Follow these four steps to implement a walking program for ambulatory residents.

- Step 1: Conduct a screening assessment, page 11
- Step 2: Find time for the program, page 15
- Step 3: Walk, page 19
- Step 4: Monitor the program, page 22

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STEP 1: CONDUCT A SCREENING ASSESSMENT

Follow this assessment procedure to identify nursing home residents who are appropriate candidates for a walking program.

SIMPLE, EFFECTIVE

The beauty of walking programs is their simplicity. A number of such programs have been tested in nursing homes (1), and while they differ in their details, they all share a basic goal: Get residents to walk more as a means of improving or maintaining their mobility, strength, and endurance.

The problem with these programs is that only ambulatory residents are appropriate candidates for them. And with the blossoming of assisted

living facilities and widely available home health care, these residents now represent a minority (and apparently shrinking) proportion of the nursing home population. Observed one veteran long-term-care researcher, “If a resident is especially ambulatory, you have to wonder why he or she is even in the nursing home.”

That said, walking programs for those who qualify are an appealing intervention that helps prevent mobility decline. How do you implement one in your facility?

CONDUCT A SCREENING ASSESSMENT

Start with resident assessment, and aim to be as inclusive as possible. Your residents may surprise you. We, for example, evaluated a walking program for frail, cognitively impaired residents and found that 19 of the 22 residents (86%) completed the 12-week program (2). We extended the program to 22 weeks and offered it to more residents for a total of 41 participants.

Seventy-three percent of this group completed all 22 weeks of walking. We used no cognitive screen in this study, though we did require residents to pass a simple behavioral screen: They had to follow a one-step command.

ASSESSMENT PROCEDURE

Here, organized around questions and answers, is the procedure for conducting resident assessments for a walking program based on the one we tested:

Q. Who should conduct the screening assessment?

A. A registered nurse

Q. When should assessments be conducted?

A. At admission, when staff conduct the resident’s Minimum Data Set (MDS) assessment, and with each quarterly MDS reassessment. When starting a new program, you may want to screen all residents in the facility within a week or two to get appropriate candidates onboard as soon as possible. Thereafter, screening assessments at admission (for new residents) and quarterly (for all other residents) will be sufficient.

Q. What resident assessment criteria should be used to identify appropriate candidates?

A. Residents should meet these criteria:

- Residents should be able to walk without human assistance. Use MDS items G1c(A), “walk in room,” and G1d(A), “walk in corridor,” to identify these ambulatory residents. Residents should be rated “0”

“When should assessments be conducted? At admission when staff conduct the resident’s MDS assessment, and with each quarterly MDS reassessment.”

- (independent) or “1” (requires supervision) on *both* of these items to qualify for the walking program.
- Residents should be able to sit-to-stand.
- Some residents who can walk may nevertheless be inappropriate candidates for the program due to behavioral problems. At the very least, residents need to be able to follow a one-step command: during the assessment, hold up a pencil and a glass in opposite hands, and ask the resident to look at the pencil. Residents should be able to follow the command in one try. Any resident who fails to comply should be excluded from participation.

As a practical matter, ask any resident who meets all of the above criteria what time of day he or she prefers to exercise. The answer will help set walking schedules for qualified residents (see the next section, page 15).

Q. If the resident passes this assessment, what next?

A. Residents also need consent to participate from their physicians. Before contacting the physician, the

nurse should collect the following relevant medical history information :

- Current medications, some of which might exclude the resident from exercise
- Any cardiac conditions that might exclude the resident from exercise such as frequent angina or severe congestive heart failure
- Any other unstable medical conditions, or...
- A terminal diagnosis with life expectancy of less than six months

The physician may decide to exclude residents based on findings in the medical history.

Q. Should residents with serious cognitive impairment be excluded?


- A. Not necessarily. If a resident with even *severe* cognitive impairment passes the functional ability and behavioral screens and earns physician consent to participate, then he or she should be given the opportunity to surprise you.

“If a resident with even *severe* cognitive impairment passes the functional ability and behavioral screens and earns physician consent to participate, then he or she should be given the opportunity to surprise you.”

YOUR ASSIGNMENT

- Assess two or three residents, up to the point where you need to request physician consent. Then answer these questions: Were you able to complete this part of each assessment? On average, how long did it take to complete the assessment activities? Were any of the residents you assessed appropriate candidates for a walking program? Based on your experience, is the assessment feasible to conduct with residents throughout your facility? Please contact us via our website, <http://borun.medsch.ucla.edu>, to share your answers. We'll report your feedback in updates to the site.

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STEP 2: FIND TIME FOR THE WALKING PROGRAM

Before you can implement a walking program, you need to find staff time for it. Learn about strategies for tailoring your program so that it meets resident needs without overwhelming staff resources.

WHERE WILL CNAs FIND THE TIME?

Once you have the physician's consent for a resident to participate, that resident can join the walking program.

In this program, certified nurse assistants

(CNAs) are assigned to walk with the residents. Do they need special training? Probably not; their initial training should have prepared them. They do, however, need to be informed about the new program, either as a group when you first launch the program or as their assigned residents join it. Here it is especially important to discuss time management with CNAs.

By far, the greatest impediment to implementing and maintaining a walking program is lack of staff time. As it is, most nursing homes are understaffed to the point that they have difficulty providing the most basic care to residents (cite). Now consider that our program, similar to other walking programs, encourages residents to walk five times a day for up to 30 minutes a day. Where are CNAs going to find this kind of time in their busy schedules?

EXPERIMENT WITH THESE STRATEGIES

We pride ourselves on giving straightforward answers, but we have none for this question, nor could we find one in the literature. What works in one facility may fail in another for a myriad of complex factors: case mix, staff-to-resident ratios, organization of current services, even who is on which hallway.

What we can offer are strategies for tailoring your walking program so that it meets residents' needs without overwhelming your staff resources. Consider them all, then implement those that you believe will work best in your facility.

- **Try it, then tinker**

Pilot test the walking program with a handful of residents or on one or two hallways for up to two weeks. Then ask the staff involved to identify what worked well and what didn't. Make changes as needed to ensure that a facility-wide implementation rolls out smoothly.

- **Ask CNAs for suggestions**

CNAs can help you brainstorm realistic strategies for implementing the walking program. You might start by asking a question such as: "If you were assigned to walk with 1-3 residents for 10-30 minutes a day per resident, how would you manage this task?" (Keep in mind, and remind the CNAs, that most residents will probably *not* participate in the walking program.)

If CNAs feel they couldn't manage the task, ask them to consider variations on the program: "What if the walking program was implemented on fewer days?" "What if some residents walked in groups?" "What if walking was broken up over the course of the day and integrated with

"Pilot test the walking program with a handful of residents or on one or two hallways for up to two weeks. Then ask the staff involved to identify what worked well and what didn't."

other daily care activities such as toileting?"

Listen to their answers. Try to implement their solutions.

- **Establish a set time for walking**

Find a time for daily walks that suits both the resident and the assigned CNA, then stick with the schedule. It may take several days to determine the best schedule for all involved.

In the initial screening (see Step 1), you should ask residents when they prefer to exercise. Try first to schedule walks at or as close as possible to those times. If you can't meet a resident's preference, go with the next best alternative. If the resident objects, you have several options: work with the resident to find a new time; explain your constraints to the resident and ask for cooperation; or ask the resident again in a day or two—it's possible the resident will have changed his or her mind.

Allow up to 30 minutes per resident per day for walking, though residents may walk fewer minutes at the start of the program. Expect increases in the amount of time that residents can walk. When we tested our walking program, participating residents increased the amount of time they walked from an average of 11 minutes at the start to 20 minutes after 12 weeks (1); at that point, walking times stabilized.

- **Make walking a regular part of the day**

An alternative to setting aside a specific time for walking is to integrate walking with residents' other daily care routines, such as using the toilet or going to the dining room. Residents do not have to walk all at one time to gain benefits from the program. Several short walks will probably work just as well as one long walk.

- **Walk in groups**

This may be an especially feasible (and enjoyable) option for residents who are rated "0," or independent, on the MDS walking items. One CNA could be assigned to assist two fairly independent walkers, or two CNAs could assist 3-4 walkers. This latter option allows the CNAs to cover for each other if a resident needs special assistance during a walk.

- **Drop uncooperative residents from the program**

Don't get us wrong; we're not trying to scratch participants from the program. Residents should be encouraged to walk, and if at first they refuse, as some likely will, they should be asked again within a day or two. And then again, if necessary. But it's reasonable to impose a stopping rule. So...any resident who refuses to walk on three occasions in a row should be dropped from the program. If, however, the resident still qualifies for the walking program at the next MDS reassessment, he or she should be considered a participant, and encouraged to walk, again, and again, if necessary.

- **Graduate safe, active walkers from the program**

Any participating resident who proves able to walk for more than 30 minutes a day probably does not need CNA assistance to walk. A registered nurse should evaluate these residents' ability to walk safely on their own. If they pass this assessment, the residents can "graduate" from the walking program. They may, however, still need verbal reminders and encouragement to walk daily.

- **Cut back on the number of days the program is offered or the maximum number of minutes walked each day**

We consider this a strategy of last resort because it will compromise the effectiveness of the program and dilute its beneficial outcomes. But if none of the above strategies work for your facility, then cutting back on days or minutes may be your best option. Better some walking than none. This option also is preferable by far to excluding willing participants from the program, a strategy that we believe is ethically and clinically unjustifiable.

YOUR ASSIGNMENT

- This will be quick: From the list of strategies described above, pick the three that you believe are worth trying first in your facility. Share your picks with us via our website, <http://borun.medsch.ucla.edu>, and we'll share them with others in updates to this site. Want extra credit? Implement those three strategies in your walking program.

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STEP 3: WALK

Follow these tips to increase resident compliance with your walking program.

SUGGESTIONS FOR SUCCESS

Finding staff time for the walking program was the hard part. The next step is relatively easy: Certified nurse aides (CNAs) should take walks with the residents.

In our evaluation, we found that residents enjoyed the walking program, and their compliance rate showed this: On average, residents walked four out of five days per week over a 22-week period.

Below are suggestions for bolstering compliance rates and enhancing resident enjoyment in your program. Be sure to share these recommendations with the CNAs who will be

walking with residents.

- To the extent possible, **let residents choose the time of day** for their walk (for more on this, see the previous section).
- **Let residents set their own pace.** Speed is not the point here. It's all about the effort.
- **Let residents choose the walking route** whenever possible. Some residents may prefer to choose a destination for their walk rather than circle the halls.
- **Set goals for walking.** We recommend setting goals based on the amount of time walked as opposed to distance walked. Each week note the resident's maximum (or alternatively average) daily walk time. In the next week, encourage the resident to increase that time by a few minutes. Expect walk times to level out after 10-12 weeks (1).

- **Converse during the walk.** One study found that conversation significantly improved compliance with an assisted walking program (2). Our guess is it made for a more pleasant activity.
- **Provide reassurance,** praise, encouragement, and verbal goal reminders to get residents up and keep them walking. A little cheering can help a lot. However, end the walk if the resident complains twice of fatigue or a need to stop.
- **Walk in groups;** the extra company may motivate some residents. (For more on this, see the previous section.)
- **Forego walking if the resident feels sick or is in pain.** A registered nurse should assess these residents for possible treatment.
- **Reassess residents whose walk times decline** consistently over a period of days. These residents should be assessed by a registered nurse or their physician to determine the cause for the decline in function.

YOUR ASSIGNMENT



CNAs can use our walking log on page 56 to record the outcomes of each daily session.

Most walking program descriptions end here, with the image of CNAs and residents casually strolling down the hall, enjoying each others' company. Not our description. Please read on.

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REFERENCES

1. MacRae PG, Asplund LA, Schnelle JF, Ouslander JGF, Abrahamse A, and Morris C. (1996). A walking program for nursing home residents: Effects on walk endurance, physical activity, mobility, and quality of life. *Journal of the American Geriatrics Society*; 44:175-180.
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STEP 4: MONITOR THE PROGRAM

Learn three methods for monitoring the walking program so that its beneficial results are sustained.

FAILURE TO MONITOR CAN UNDERMINE THE PROGRAM

We know from past experience that the image of residents and certified nurse assistants (CNAs) happily strolling together will likely fade unless supervisors regularly monitor the walking program. In the absence of quality control assessment, CNAs may backslide and fail to consistently implement the protocols for a new program.

Studies in other fields have shown that old habits are hard to break and new ones are hard to maintain if you don't get timely feedback about how you're doing, including reinforcement for doing things right and recommendations for improvement if you're doing things wrong. This feedback loop is a hallmark of continuous quality improvement programs. Creating such a loop is the purpose of this step.

USE BUT DON'T RELY SOLELY ON CNA REPORTS

Start by collecting program assessment data. The walking logs completed by CNAs should tell you almost at a glance whether residents are improving their mobility with the walking program.

The log (page) includes a column for recording the total minutes each resident walks in a given day. Scan the column to see whether walk times for a particular resident are gradually increasing; holding steady; or declining, which would signal the need for a reassessment.

Data from the walking logs can also be used to calculate compliance rates (what percentage of days in a given period did residents walk?) and identify reasons why residents may have refused to walk (useful for improvement purposes).

We recommend collecting and reviewing walking logs every two weeks. That's roughly how much walking activity CNAs can record on our one-page log.

As informative as they may be, DO NOT solely rely on the CNAs' written logs of walking activity to evaluate the program. In several studies, we found that CNAs consistently recorded as delivered care that they in fact never provided (1-3). In fairness to the CNAs, we believe they did this largely because they truly lack the time required to provide the multitude of services that we—employers, regulators, resident family members and friends—ask them to provide. But with performance expectations continuing to exceed most nursing homes' staff resources, it's best to use CNA reports only in conjunction with data gleaned from other assessment strategies, such as resident reports or direct observations.

CONDUCT DIRECT OBSERVATIONS

With walking programs, direct observations are a feasible evaluation strategy. If you have established a set walking schedule for residents, then a supervisor should be able to stroll through the halls at specified times and spot CNAs and residents walking.

This type of monitoring works best if it too follows a schedule. Keep in mind that more frequent "control checks" are needed at the start of the program, when new routines are being developed. If all goes well, you should be able to cut back on the number of observations needed to maintain quality of service. Start with twice-weekly control checks; after 3-4 weeks you may be able to drop to observations conducted once a week, and possibly once every two weeks.

Here is our procedural recommendation:

- Each week, a nurse supervisor should *randomly* (pull them out of a hat) select two days to conduct hallway observations.
- The supervisor then consults the walking schedule to identify which residents should be walking at what times on the selected days.
- At those times, on those days, the supervisor walks through the hallways that serve as walking routes for the participating residents. He or she notes whether the residents are indeed walking as scheduled.
- The supervisor records observation results in our observation log (see page 57).

The whole process should take only a few minutes each day.

CONDUCT RESIDENT INTERVIEWS

You can also monitor the walking program through periodic interviews with participating residents. Most residents, even those with moderate-to-severe cognitive impairments, can reliably report on their care (4,5). They can tell you whether in fact they received it, they can tell you if they liked it, and often they can tell you how to improve it. All you have to do is ask them.

Resident interviews, even short ones, are more time consuming to conduct than the direct observations described above. Consequently you'll want to complete them at longer intervals. Our recommendation? A supervisor should try to interview all participating residents individually at some point in the first month of the program. This will allow each resident to give feedback that will help you create a more responsive program. Thereafter, we recommend repeating interviews during the residents' MDS reassessments.

Keep the interview short and simple. For help with conducting resident interviews, check out our interview protocol in the *Quality-of-Life Assessment Module*., available on our website, <http://borun.medsch.ucla.edu>.

Sample interview questions include:

- Did a nurse aide ask you to walk today?
- (If yes), Did you walk with the nurse aide?
- (If no), Why not?
- (If yes), For about how many minutes did you walk?
- Was your walk too long?
- Was your walk too short?
- What would make your walk more enjoyable?

Be sure to record responses. Our interview protocol in the Quality-of-Life Assessment Module includes suggestions for interpreting and reporting responses.

CONDUCT BOTH

We strongly recommend that you conduct both direct observations and resident interviews. The first will tell you objectively whether the walking program is being implemented as planned. The second will tell you subjectively, from the residents' perspective, how well the program is being implemented.

COMPARE RESULTS TO CNA REPORTS

You can compare results from the direct observations and resident interviews with information in the CNAs' written logs to identify any reporting discrepancies. These may indicate areas for improvement or further training. A CNA's log may also explain what otherwise might appear to be a glitch in execution. For example, the log may include a note that a resident felt sick and so couldn't walk that day.

ANALYZE RESULTS

With all your program assessment data in hand, ask yourself this question: Is the program working as expected? This, of course, raises several related questions:

- Are CNAs walking with residents as scheduled?
- Are residents consistently consenting to walk?
- Are walk times increasing or at least holding steady?
- Are CNAs accurately completing the walking logs?
- Is the program meeting resident

preferences for walking?

If you identify a problem in any of these areas (look for the “no” answers) you may need to investigate further before you can resolve it. Often a meeting with the CNAs can help clarify and correct problems.

SHARE RESULTS WITH STAFF

For best results, complete the feedback loop by sharing results from the walking logs, direct observations, and resident interviews with the CNAs who perform the lion’s share of the work in this program. As we noted earlier, staff members need feedback—both good and bad—to help them establish new work routines. Simply posting the percentage of participating residents who were observed walking during control checks each week, for example, will enable nurse aides to make connections between their work and the impact it has on their residents.

If these direct care providers can see tangible evidence of the walking program’s benefits, then they are less likely to view the intervention as an additional burden and more likely to work to sustain its positive effects.

Sharing performance results also gives CNAs the opportunity to help supervisors correct any problems that arise. Often the CNAs are the first to know if a resident’s status has changed or if there’s been a break-down in the work process. Involving these staff members in improvement efforts will also help strengthen their commitment to the program.

Another way to complete the “circle of communication” is by presenting and discussing program performance results at in-service trainings and during regular staff meetings. We have discovered in our recent work that brief meetings of about five minutes once a week that are focused specifically on a new program are

effective for training and management purposes.

Also consider rewarding CNAs for consistently good results. Recognition as employee of the month, a staff pizza party for outstanding performance, a gift certificate to a local restaurant—they can’t hurt.

The next section presents an exercise intervention for incontinent residents.

YOUR ASSIGNMENT



1. Visit our website, <http://borun.medsch.ucla.edu>, and browse through our protocol for designing and conducting quality-of-life assessment interviews with nursing home residents so that you are better prepared to implement this fourth step in your walking program.



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FUNCTIONAL INCIDENTAL TRAINING

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- Step 1: Understand your choices, page 28
 - Step 2: Provide incontinence care, page 31
 - Step 3: Offer exercise, page 34
 - Step 4: Implement time-saving strategies, page 37
 - Step 5: Monitor the program, page 39 

STEP 1: UNDERSTAND YOUR CHOICES

“FIT” FOR FRAIL RESIDENTS

For ambulatory residents there’s our walking program (see page 10). For almost everyone else, there’s FIT. Stands for Functional Incidental Training, and it combines low intensity exercise with scheduled toileting as a means of improving continence as well as mobility, strength, and endurance among very frail nursing home residents.

The intervention’s special features are several:

- **Targets the very frail.** It is designed for the more than 50% of nursing home residents who are incontinent of urine, many of them with severe cognitive impairments, and all of them physically inactive and deconditioned, with a high risk for hospitalization. We know of no other exercise program that has proven effective with such an impaired population.
- **CNAs implement it.** It is designed to be implemented by certified nurse assistants (CNAs), rather than higher-cost professionals such as physical therapists.
- **Combines daily activities.** To further reduce time costs, it maximizes efficiency by integrating one daily routine—incontinence care—with another—exercise. CNAs are normally in contact with incontinent residents throughout the day to provide toileting assistance. This daily care activity offers a time-efficient opportunity for residents to practice other daily living activities such as walking, standing, and transferring at the same time.
- **Distributes exercise.** FIT spreads exercise over the course of a day, as opposed to offering it in a single session. Providing several brief opportunities to exercise reduces the risk of injury for these frail residents, many of whom would not be able to sustain increased activity during more traditional, single exercise sessions of 30-45 minutes.
- **Proven effective.** Perhaps most importantly, it has been shown to improve or maintain both physical activity and mobility endurance in extremely frail residents. These findings

come from two randomized controlled trials—the gold standard for research studies—which also found that the comparison group, which did not receive FIT, declined in function (1, 2). Did we also mention that FIT participants improved their continence?

FIT OVERVIEW

But we'll be honest with you: Notwithstanding its benefits and cost-efficient design, FIT still takes considerably more time to administer than usual care, and this can be a big barrier to its implementation.

Let's look briefly at how FIT works, then discuss time management.

FIT is designed to be implemented four times daily, every two hours, between 8:00 a.m. and 4:00 p.m., five days a week. The procedure is as follows:

- During each of the four daytime care episodes, CNAs prompt incontinent residents to toilet, and change those who are wet.
- Before or after this incontinence care, CNAs encourage residents to walk, or if nonambulatory, to wheel their chairs and to repeat sit-to-stands up to eight times.
- During one episode per day, each resident, usually while in bed, is given upper body resistance training (arm curls or arm raises).
- Before *and* after each care episode, residents are offered beverages to increase their daily intake of fluids.

How long does all this take? Approximately 20 minutes per episode when we count travel time

FIT VS. GROUP EXERCISE

An hour per resident per day! That's too much, you balk. And we agree, it's a lot. But we can't figure out how to reduce the time costs any further, and as we stated earlier, we know of no other exercise intervention that works as well, or just plain works at all, with such an impaired population.

On the bright side, consider that FIT offers residents not only exercise, but also incontinence care, which your CNAs need to provide in any case. As a result, it not only increases mobility and physical activity, but also keeps residents drier.

Still, it's worth considering group exercise programs as an alternative to FIT. Some of these have been shown to work with more ambulatory, less cognitively impaired residents (3). In our experience, however, "group exercise" for residents with severe cognitive impairments is a misnomer. Yes, you can gather these residents in a group, but they are unlikely to accomplish much unless you work one-on-one with each individual.

Bear in mind that, while group exercises are more time-efficient than FIT, they are still time-consuming. Figure that sessions for groups of about 10 fairly ambulatory residents should be offered 3-5 times per week, with each session lasting 30-45 minutes. This does not include

travel time, which as we've seen in the FIT breakdown, can add up quickly. Also consider that these exercise-only sessions do not include toileting assistance for incontinent residents.

AN ONGOING INDUSTRY CHALLENGE

That we and other long-term-care researchers have met with only qualified success in designing effective and feasible exercise programs for frail residents reflects two ongoing challenges within the nursing home industry.

The first is the very frailty of this client population. Even when offered FIT, many of these very impaired residents will not regain their ability to function independently and safely. Most will continue to need staff assistance and supervision. Thus, this program, and probably others similar to it, cannot be expected to pay for themselves down the line through offsets in labor costs.

Second, understaffing in many nursing homes presents an almost insurmountable barrier to translating many efficacious clinical interventions into everyday practice. We as a nation need to take into careful consideration the resources needed to meet the standards of care we expect for our rapidly growing, frail older population.


That said, we're left with doing the best we can in an imperfect long-term-care system. It's time to move on. The pages that follow present instructions for implementing FIT. Along the way, we'll identify trade-offs you can choose between to provide the best care possible given your facility's resources.

YOUR ASSIGNMENT

Consider the pros and cons of group exercise vs. the FIT intervention. Now consider your facility's case mix. Which type of exercise program seems most feasible to implement with the residents in your facility? Would it work to offer both types for different groups of residents?

Share your thoughts with us so we can share them with others. Please contact us via our website, <http://borun.medsch.ucla.edu>, and we'll post your feedback in updates to the site.

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STEP 2: PROVIDE INCONTINENCE CARE

Learn how to conduct the incontinence care component of the FIT program.

IDENTIFY INCONTINENT RESIDENTS

FIT is designed for residents who are incontinent of urine. More specifically, it's for incontinent residents who receive some type of staff toileting assistance to help them stay dry. This means, of course, that these residents already have been, or should have been, assessed and treated for any transient causes of urinary incontinence.

If any incontinent residents haven't yet been assessed by a physician, they should be, for it is possible that their incontinence can be treated.

Step 1 of our incontinence management training module (available on our website, <http://borun.medsch.ucla.edu>) outlines the assessment process. You may want to review this section to make sure your facility is covering all the bases.

From this point on, we'll assume that you've identified all incontinent residents who need some type of staff assistance to stay dry (or drier).

PROVIDE REGULAR TOILETING ASSISTANCE, PREFERABLY PROMPTED VOIDING

FIT follows best practice guidelines for incontinence care in that it calls on nursing home staff to provide incontinent residents with toileting assistance every two hours during the daytime (roughly 8:00 a.m. to 4:30 p.m.). Toileting assistance can take a number of different forms. It can mean checking and

changing diapers; habit training; scheduled toileting; or prompted voiding.

Of these various management options, only prompted voiding has been shown to significantly improve continence (1). This is one reason we strongly recommend that you provide prompted voiding as part of the FIT program.

You can review prompted voiding procedures in Step 2 of our incontinence management training module, available on our website, <http://borun.medsch.ucla.edu>.

PROMPTED VOIDING VS. OTHER OPTIONS

Yes, you can use FIT with the other toileting care routines, as long as that care is offered every two hours. But while you're at, why not take advantage of the opportunity to provide the most effective care available to your residents?

If you're concerned about how much time prompted voiding takes, we can offer some assurances. On average, it takes about 7 minutes to provide prompted voiding to a single resident. That's about 12 *seconds* longer than it takes to provide scheduled toileting (2). And it's about a minute and a half longer than it takes to check and change a resident. In other words, you won't save much time per episode of care by implementing one of the less effective toileting interventions.

PV ADVANTAGE: TARGETING PROCEDURES

And there are additional advantages to offering prompted voiding. One is that we have developed a simple, valid procedure for identifying residents who are responsive to prompted voiding. You can review it in Step 2 of our incontinence management training module, available on our website at

compromised and its positive effects diluted. As a general rule, nursing home programs that are implemented in residents' rooms at various times throughout the day are difficult to monitor through objective means. It's not feasible, for example, for supervisors to conduct regular observations of the care being provided. Prompted voiding programs, however, are the exception to this rule.

With prompted voiding programs, supervisors can conduct periodic control checks that allow them to continuously monitor the care provided. We tell you how to conduct control checks, and analyze the results, in Step 4 of our incontinence management module, which you can access on our website at <http://borun.medsch.ucla.edu>.

These control checks won't tell you whether or how well nurse aides are carrying out the exercise component of FIT. But they do allow you to assess the intervention's other key component (toileting assistance). And if this care activity is being accomplished, then that's some small assurance that the other component, exercise, also is being accomplished.

We are unaware of any valid control checks for the other incontinence management strategies.

ONE LAST TIME...

Going forward, we will assume that your facility is committed to providing FIT participants with some form of toileting assistance every two hours during the daytime on five days per week. We've said it various ways throughout this section, but it bears repeating one last time: There are distinct advantages to choosing prompted voiding as the form of toileting assistance your program provides. (Remember: most residents who are *not* responsive to prompted voiding are placed in check-and-change programs.) You can read more about this toileting strategy in our incontinence management module (go to our website,

<http://borun.medsch.ucla.edu>).

YOUR ASSIGNMENT

Visit our website at <http://borun.medsch.ucla.edu> and take a few minutes to review our incontinence management training module. Then turn to page 58 in this manual and review the prompted voiding protocol.

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STEP 3: OFFER EXERCISE

Learn how to conduct the exercise component of the FIT program.

FIT'S EXERCISE COMPONENT

Let's review. We now know that FIT targets incontinent residents, and is intended to be implemented by certified nurse aides (CNAs) every two hours, roughly between 8:00 a.m. and 4:30 p.m., on five days per week. This schedule allows for four care "episodes" each day. During each episode, CNAs provide residents with toileting assistance, preferably prompting voiding, and change those who are wet. That's the incontinence component of FIT.

The exercise component includes the following:

- Walking or wheeling
- Sit-to-stands
- Arm curls or arm raises

These exercises emphasize specific functional skills involved with toileting and other activities of daily living.

Let's discuss procedures for each exercise, starting with walking and wheeling.

WALKING OR WHEELING

- A licensed nurse should assess the walking capability of each resident during the first FIT session and share results with the appropriate CNAs, letting them know which residents can walk and which are non-ambulatory.
- Based on the nurses' assessment findings, CNAs should encourage residents to walk or, if non-ambulatory, to wheel their chairs during each of the four care episodes.

- Residents may walk or wheel their chairs either before or after receiving incontinence care. Ask the resident for his or her preference.
- To start, encourage residents to walk or wheel their chairs for one to five minutes per session. Prompt them to gradually (over several weeks) increase their mobility time until they reach a maximum of five minutes per session.
- See Step 3 of our walking program (page 19) for tips on motivating residents to stay mobile. These suggestions are geared toward encouraging residents to walk, but most apply equally well to encouraging residents to wheel their chairs. See also our tips for improving wheelchair mobility on page 45, in the “Frequently Asked Questions” section.
- Record the results of each session in our *FIT log* (page 60).

SIT-TO-STANDS

- CNAs should encourage *all* FIT participants to repeat sit-to-stands during each care episode.
- Residents may engage in this exercise either before or after receiving incontinence care, and before or after walking or wheeling. Ask the resident for his or her preference.
- The resident should start from a seated position on a chair in the room. Instruct the resident to move to the edge of the chair. If possible, the chair’s back should be supported against a wall. A resident may sit in his or her own wheelchair for this exercise, but make sure the wheelchair is locked before the resident

attempts to stand.

- Although residents may use their arms to help them stand up, they should be encouraged to use their legs more than their arms.
- To start, encourage residents to repeat 1-4 sit-to-stands. Prompt them to gradually (over several weeks) increase the number of repetitions until they reach a maximum of eight sit-to-stands per session.
- Offer residents the *minimal* physical assistance needed to complete each sit-to-stand. From minimal to maximum, the assistance levels are as follows:
 1. General command: “Please show me how you can stand and then sit.”
 2. Verbal cues or instruction
 3. Tactile guidance to initiate the action
 4. Physical assistance throughout the action
- Record results in the *FIT log* (page 60).

ARM CURLS AND RAISES

- During one session per day, CNAs should prompt participating residents to repeat either arm curls or arm raises.
- This upper body resistance training is usually best accomplished while the resident is in bed. Thus, CNAs should encourage residents to do these exercises either before or after incontinence care and the other exercises are completed.
- Arm curls or raises can be done during any of the day’s four sessions. We

recommend that CNAs gently prompt each resident during the first session and at each subsequent session in turn until the resident completes the exercise.

OFFER FLUIDS

Before *and* after each of the four care episodes, CNAs should offer residents beverages such as water or juices. This twice-per-session fluid prompting is necessary to significantly increase fluid intake in this frail population.

For best results, offer residents a choice from a variety of beverages, ideally beverages not typically served during meals. This strategy results in fewer refusals to drink and increases intake.

Studies show that, while the majority of nursing home residents are at high risk for dehydration, few facilities offer fluids between meals. In one study, we found that staff offered residents between-meal beverages less than once per day on average.

Many workers erroneously believe that residents will request fluids, if thirsty, or retrieve a glass of water for themselves from their bedside pitcher. But few residents do this. One reason they don't is that the thirst sensation declines with age, so many older adults may not recognize that they are thirsty even when they are. In addition, cognitive impairment and depression can impair a resident's ability and motivation to seek out fluids. As a result, it is critical that staff not only offer fluids but also provide encouragement to residents to drink.

For more information about increasing residents' fluid and food intake, see our weight loss prevention training module on our website, <http://borun.medsch.ucla.edu>.

CAUSES FOR CONCERN

Special circumstances warrant special attention:

- **Forego exercise if the resident feels sick or is in pain.** When this happens, CNAs should report their findings to a registered nurse so he or she can assess the resident for possible treatment. CNAs should still provide the resident with toileting assistance.
- **Report to the nurse any resident whose performance declines consistently over a period of days.** CNAs should report a consistent decline in any of the exercises: walking, wheeling, sit-to-stands, arm raises, or arm curls. The nurse or a physician should assess the resident to determine possible causes for the decline in function.

YOUR ASSIGNMENT

Assess the walking capabilities of a handful of incontinent residents. How many of the residents are ambulatory enough to walk in the FIT program? How many should be encouraged to propel their wheelchairs?

Use our sit-to-stand protocol (on the previous page) to prompt a few residents to repeat this exercise. Were residents able to complete the exercise? How many repetitions were they able to complete?

Share results of these assessments with us. Please contact us via our website, <http://borun.medsch.ucla.edu>, and we'll report your feedback in updates to the site. Ω

STEP 4: IMPLEMENT TIME-SAVING STRATEGIES

Implement these time-saving strategies to help your facility maintain the FIT program and maximize benefits for frail nursing home residents.

LACK OF STAFF CAN HAMPER IMPLEMENTATION

Having reviewed Step 1 (*Identify the problem, the solution*), Step 2 (*Provide incontinence care*), and Step 3 (*Offer exercise*), you are now in a position to make informed decisions about how to deploy the one resource that can make or break the FIT program: your staff.

Lack of staff time is THE biggest barrier to implementing the FIT program. How big? We

estimate that in a nursing home with a staffing ratio of 10 residents to one certified nurse aide (CNA), the CNAs will need 60 minutes of every daytime hour to provide FIT to all eligible incontinent residents (1). In other words, they wouldn't have time for any other duties. Given that this resident-to-CNA ratio is typical of the industry, FIT clearly is not going to work in the majority of facilities without modification.

Below, we offer two suggestions. The first will make the biggest difference in nursing homes with staffing levels that approach an ideal: five residents to one CNA. This first suggestion will also help in lower-staffed facilities, where the daytime ratio reaches seven or more residents to one CNA, but is unlikely to be sufficient. In these facilities, consider also the more drastic change outlined in our second suggestion.

REDUCE NURSE AIDE WORKLOADS IN OTHER AREAS

Assign time-consuming tasks that are typically the responsibility of CNAs to non-traditional care providers such as volunteers, social service staff, even administrative personnel, so that CNAs have more time to implement FIT. For example, some mealtime chores and between-meal snack deliveries can be handled by non-traditional staff. See our weight loss prevention module, available on our website, <http://borun.medsch.ucla.edu>, for tips on redeploying staff at mealtimes.

stand to lose the most functionality if denied regular exercise. In our clinical judgment, these are residents who are on the verge of losing their ability to walk. “They’re wobbly,” one of our researchers observed. “They can still bear weight, but they can’t walk safely without assistance.” They’re not the most impaired residents, nor the least impaired; they’re between these two extremes.

For these residents, their FIT-ness goal should be to maintain their walking ability.

YOUR ASSIGNMENT

Find out your facility’s resident-to-CNA ratio during daytime hours. Then estimate the percentage of residents in your facility who are incontinent.

If both the staffing ratio and percentage of incontinent residents are at or above industry standards (that is, about eight residents to one CNA and an incontinence incidence of 50%), then your facility should pare down the number of FIT participants. With a better staffing ratio and/or a lower percentage of incontinent residents, a cutback in the number of FIT participants is less necessary.

Let us know how your facility fares. Would you have to reduce the number of FIT participants or not? Please contact us via our website, <http://borun.medsch.ucla.edu>, and we’ll report your feedback in updates to this site.

REFERENCES

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STEP 5: MONITOR THE PROGRAMS

Learn three methods for monitoring the FIT program so that its beneficial results are sustained.

Studies in other fields have shown that old habits are hard to break and new ones are hard to maintain if you don't get timely feedback about how you're doing, including reinforcement for doing things right and recommendations for improvement if you're doing things wrong. This feedback loop is a hallmark of continuous quality improvement programs. Creating such a loop is the purpose of this step.

USE BUT DON'T RELY SOLELY ON CNA REPORTS

Start by collecting program assessment data.

The *FIT daily logs* (page 60) completed by CNAs should tell you almost at a glance whether residents are improving their mobility, strength, and endurance with the FIT program. Our log includes columns for tracking each day's

performance: the total minutes each resident walks or wheels, the number of sit-to-stands, and the number of arm curls or raises completed.

We recommend collecting and reviewing FIT logs every two weeks. A nurse should scan the logs to see whether the numbers for each resident are gradually increasing; holding steady; or declining, which would signal the need for a reassessment.

The control checks (they take about 15 minutes a week to complete) allow you to compare the percentage of incontinent residents found wet at any given point in time to the percentage who *should be* wet if the prompted voiding program is working as expected. If the “actual” percentage exceeds the “expected” percentage, there’s a problem, and it needs further analysis if you intend to resolve it. Typical problems stem from changes in a resident’s status or breakdowns in the prompted voiding work process.

You can access procedures for conducting control checks from the incontinence management training module on our website, <http://borun.medsch.ucla.edu>.

If your facility offers prompted voiding to FIT participants, then a staff nurse should take the time to conduct weekly control checks. They’re the best method for ensuring the integrity of this service.

CONDUCT RESIDENT INTERVIEWS

You can also monitor the FIT program through periodic interviews with participating residents. Most residents, even those with moderate-to-severe cognitive impairments, can reliably report on their care (4, 5). They can tell you whether in fact they received it, they can tell you if they liked it, and often they can tell you how to improve it. All you have to do is ask them.

Resident interviews, even short ones, are time consuming to conduct. Consequently you’ll want to complete them at fairly long intervals. Our recommendation? A supervisor should try to interview all participating residents individually at some point in the first month of the FIT program. This will allow each resident to give feedback that will help you create a more responsive program. Thereafter, we recommend repeating interviews during the residents’ MDS

reassessments.

Keep the interview short and simple. Follow our protocol for conducting resident interviews, presented in the Quality-of-Life Assessment Module available on our website at <http://borun.medsch.ucla.edu>.

Sample interview questions include:

- Did a nurse aide ask you to walk today?
- How many times did you walk today?
- Did a nurse aide help you to the toilet today?
- How many times were you helped to the toilet today?
- Did a nurse aide help you with arm exercises today?
- Did you get enough exercise today? Too much? Too little?

Be sure to record responses. Our resident interview protocol (available in the Quality-of-Life Assessment Module on our website, <http://borun.medsch.ucla.edu>) includes suggestions for interpreting and reporting results.

COMPARE RESULTS TO CNA REPORTS

You can compare results from the resident interviews with information in the CNAs' written FIT logs to identify any reporting discrepancies. These may indicate areas for improvement or further training. A CNA's log may also explain what otherwise might appear to be a glitch in execution. For example, the log may include a note that a resident felt sick and so couldn't exercise that day.

ANALYZE RESULTS

With all your program assessment data in hand, ask yourself this question: Is the FIT program working as expected? This, of course, raises several related questions:

- Are CNAs consistently offering to FIT participants incontinence care and exercise every two hours?
- Are the residents consistently consenting to exercise?
- Is resident performance improving or at least holding steady?
- Are CNAs accurately completing the FIT logs?

If you identify a problem in any of these areas (look for the “no” answers) you may need to investigate further before you can resolve it. Often a meeting with the CNAs can help clarify and correct problems.

SHARE RESULTS WITH STAFF

For best results, complete the feedback loop by sharing results from the FIT logs, wetness control checks, and resident interviews with the CNAs who perform the lion's share of the work in this program. As we noted earlier, staff members need feedback—both good and bad—to help them establish new work routines. Simply posting the wetness control checks each week, for example, will enable nurse aides to make connections between their work and the impact it has on their residents.

If these direct care providers can see tangible evidence of the FIT program's benefits, then they are less likely to view the intervention as an extra burden and more likely to work to sustain its positive effects.

Sharing performance results also gives CNAs the opportunity to help supervisors correct any problems that arise. Often the CNAs are the first to know if a resident's functional status has changed or if there's been a break-down in the work process. Involving these staff members in improvement efforts will also help strengthen their commitment to the program.

Another way to complete the "circle of communication" is by presenting and discussing program performance results at in-service trainings and during regular staff meetings. We've found in our recent work that brief meetings of about five minutes once a week that are focused specifically on a new program are effective for training and management purposes.

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MOBILITY DECLINE PREVENTION QUIZ

Instructions: Check the best answer.

1. Frail nursing home residents who do not engage in regular exercise tend to:

- a. Lose functional ability over time
- b. Maintain functional ability over time
- c. Increase functional ability over time
- d. Maintain or increase functional ability over time

2. Ambulatory residents should be encouraged to walk even if:

- a. Their physician refuses consent
- b. They report pain
- c. They refuse the first offer to walk
- d. They report feeling sick

3. To encourage residents to walk, nurse aides should:

- a. Converse with the residents
- b. Let residents set the pace
- c. Let residents choose the walking route
- d. All of the above

4. When setting walking goals for ambulatory residents, the Borun Center recommends that nursing home staff:

- a. Encourage residents to walk faster over time
- b. Encourage residents to increase the distance they walk
- c. Encourage residents to increase the amount of time they walk
- d. Any one of the above

5. Which of these program evaluation strategies is recommended for walking programs?

- a. Resident interviews
- b. Supervisor observations of walking
- c. Walking logs
- d. All of the above

6. FIT differs from most exercise programs in nursing homes in that it:

- a. Distributes exercise over the course of a day
- c. Is designed for residents with severe functional and cognitive impairments

8. Compared to scheduled toileting, prompted voiding:


- a. Takes considerably more time to implement
- b. Is more effective at reducing incontinence
- c. Is less appropriate for residents with cognitive impairments
- d. Is more commonly used in nursing homes

9. Which of these program evaluation strategies is not recommended for the FIT program because it is impractical to implement?

- a. Resident interviews
- b. Supervisor observations of care delivery
- c. Daily logs
- d. Weekly wet checks

10. The most practical strategy for modifying FIT so that it is feasible to implement in more nursing homes is to:

- a. Reduce the number of FIT participants
- b. Increase the number of staff available to implement FIT
- c. Offer fewer daily episodes of incontinence care and exercise
- d. All of the above

Answers: 1. a; 2. c; 3. d; 4. c; 5. d; 6. d; 7. d; 8. b; 9. b; 10. a 

FREQUENTLY ASKED QUESTIONS

Q: Many of our residents cannot walk but could get around in their wheelchairs more than they do. How can we encourage residents to propel their wheelchairs more?

A: Of the estimated 1.8 million nursing home residents in the United States, more than half are incapable of independent ambulation. For these residents, wheelchair propulsion is their only means of mobility. Wheelchair use also increases feelings of independence and fosters a sense of physical and emotional well-being, say residents (1). But for all these advantages, few nursing homes formally assess or evaluate residents for a wheelchair, and too often the staff assumes that wheelchairs are meant to be pushed, not self-propelled (2). The upshot is that most residents in wheelchairs rarely take those chairs for a spin (2). But you can help increase their mobility with a few easy-to-implement strategies:

- Residents who need or want to use a wheelchair should be assessed by a physical therapist or occupational therapist for the most appropriate type of wheelchair.
- Customize the wheelchair so that it fits the resident. Consider seat width, back cushions, ankle positioning aides, leg-rest panels, foot supports, headrests, and head supports.
- Make sure the resident can reach and release the chair's brakes. A PVC pipe can be fitted to a chair's brake as an extender so that the brake is easier to reach and release.

- Show residents how to use their wheelchairs. Demonstrate how to operate the brakes and foot pedals, where to place their hands and legs, how to use their hands and/or legs to propel the chair, and how to get up from and sit back down in the wheelchair.
- Pay attention to residents' safety behaviors. For example, does the resident lock the wheelchair and move the foot pedals before standing?
- Regularly check wheelchairs for defects and, if found, promptly repair them.
- Label each wheelchair so that it stays with the right resident.

Q: How can we tell if residents are spending too much time in bed?

A: Try this: Stroll down your facility's hallways at 10 a.m. and again at 4 p.m. on the same day. Each time, note the names or room numbers of residents whom you observe in bed. Compare the two lists to identify those residents observed in bed at both times.

Our research indicates that these residents spend an estimated 16 or more hours a day in bed (3). And that's too much, even for very frail residents.

Our research indicates that the more time residents spend in bed during the day, the more they sleep during the day, the more socially isolated they are, and the less they eat (4). These findings are in keeping with other studies showing that excessive time in bed is associated with detrimental outcomes, including under-nutrition, pressure ulcer development, pneumonia, and urinary incontinence.

A: We thought it might, but upon examination, it didn't.

For this study, we enrolled 89 incontinent residents in two nursing homes (5). Half the residents participated in the FIT program, receiving regular incontinence care and exercise. The other residents, the control group, received usual care.

At the end of 32 weeks, the FIT group showed significant improvements or maintenance across all measures of daily physical activity, functional performance, and strength compared to the control group. But there were no differences between the two groups in the amount of food and fluids consumed. Both groups consumed an average of 55% of all meals, with no change over time.

There was also no change in the frequency of bowel movements in either group.

Based on these findings, we believe a feeding assistance intervention aimed specifically at increasing mealtime consumption may be more effective than physical exercise in helping residents maintain and increase weight. Our Weight Loss Prevention Module available on our website, <http://borun.medsch.ucla.edu>, presents protocols for a feeding assistance intervention that has proven effective for nursing home residents.

"Our research indicates that the more time residents spend in bed during the day, the more they sleep during the day, the more socially isolated they are, and the less they eat."

Q: If residents exercise more during the day, will they sleep better at night?

A: Our research suggests that increased physical activity alone will not improve residents' nighttime sleep, but exercise combined with a nighttime noise and light abatement program will (6).

The noise and light abatement program centered on common sense procedures such as closing doors to residents' rooms, fixing squeaky equipment, turning off unattended TVs and radios, and using table lamps instead of overhead lights when providing incontinence care.

In one study, daytime exercisers who received the nighttime noise and light abatement program were in bed less during the day and showed less agitation than residents who received only the nighttime program (6). A second study showed that an exercise program alone did not improve nighttime sleep for residents (7).

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6. Alessi Ca, Yoon EJ, Schnelle JF, Al-Samarrai NR, and Cruise PC. (1999). A randomized trial of a combined physical activity and environmental intervention in nursing home residents: Do sleep and agitation improve? *Journal of the American Geriatrics Society*; 47:784-791.
7. Alessi CA, Schnelle JF, MacRae PG, et al. (1995). Does physical activity improve sleep in impaired nursing home residents? *Journal of the American Geriatrics Society*; 43: 1098-1102. [Ω](#)

"...increased physical activity alone will not improve residents' nighttime sleep, but exercise combined with a nighttime noise and light abatement program will."

RELATED STUDIES

- **Functional Incidental Training, Mobility Performance, and Incontinence Care with Nursing Home Residents**

John F. Schnelle, Priscilla G. MacRae, Joseph G. Ouslander, Sandra Simmons, and Misty Nitta, 1995, in *Journal of the American Geriatrics Society*; 43:1356-1362.

Severely demented, inactive, and physically frail nursing home residents can significantly increase their mobility endurance and physical activity when regularly offered the opportunity to exercise, according to the study reported in this article. The study evaluated an intervention called Functional Incidental Training or FIT, which integrates prompted voiding for incontinent residents with low-intensity exercises such as walking, wheelchair propulsion, and sit-to-stands. Findings showed that the highly deconditioned, cognitively impaired residents who enrolled in the study not only complied with the exercise protocol, completing 75% of all

exercise sessions offered four times per day, but also achieved 100% of their individualized exercise goals on 80% of these sessions. In contrast to more traditional, once-a-day exercise programs, this intervention distributed exercise over the course of the day, with brief sessions offered by nurse aides once every two hours in conjunction with incontinence care for the individual. This strategy reduced injury risks from over-exertion and deployed staff more efficiently. Nevertheless, the intervention requires significantly more time to provide than usual care—an estimated 18 additional minutes per resident per day. The authors conclude, “The increased cost of this intervention must be evaluated both in terms of clinical outcomes and by the reality that the target group for this intervention is very frail and will continue to require nursing home care, even assuming an excellent response to the intervention.”

- **Translating Clinical Research into Practice: A Randomized Controlled Trial of Exercise and Incontinence Care with Nursing Home Residents.**
John F. Schnelle, Cathy A. Alessi, Sandra F. Simmons, Nahla R. Al-Samarrai, John C. Beck, Joseph G. Ouslander, 2002, in *Journal of the American Geriatrics Society*, 50:1476-1483.

An incontinence care and exercise intervention called FIT, for Functional Incidental Training, resulted in significant improvements in physical mobility and continence for most residents who received the intervention. The staffing requirements needed to implement the intervention, however, are high and exceed the resources available in most nursing homes.

In this randomized, controlled trial, research staff prompted each of 94 intervention residents to toilet every two hours during the daytime, five days a week. Before or after providing incontinence care, staff also encouraged the residents to walk or, if nonambulatory, to wheel their chairs and to repeat sit-to-stands up to eight times. Once a day, each resident was given upper body resistance training (arm curls or arm raises). After 32 weeks of FIT, intervention residents maintained or improved performance on 14 of 15 outcome measures, whereas the performance of the 96 residents in the control group declined.

The mean time required to implement the intervention each time care was provided was 20.7 minutes. Consequently, one nurse aide for every five residents would be needed to implement the intervention. Less than 10% of the nation's nursing homes are staffed at this level. The researchers conclude, "Fundamental changes in the staffing of most nursing homes will be necessary to translate efficacious clinical interventions into everyday practice."

- **Does an Exercise and Incontinence Intervention Save Healthcare Costs in a Nursing Home Population?**
John F. Schnelle, Kanika Kapur, Cathy Alessi, Dan Osterweil, John C. Beck, Nahla R. Al-Samarrai, and Joseph G. Ouslander, 2003, in *Journal of the American Geriatrics Society*; 51:161-168.

The short answer to the question posed in this randomized, controlled trial is no. Although the intervention, which combines low-intensity exercise with frequent incontinence care, improved functional outcomes for the 98 intervention subjects, it did not reduce the incidence and costs of selected acute health conditions. Thus, the authors conclude, the costs of implementing this labor-intensive intervention would not be off-set by reduced medical care costs. A previous paper reported that a ratio of five residents to one nurse aide would be necessary to implement the intervention and that more than 90% of the nation's nursing homes would have to significantly increase staffing to do so. For the study, intervention subjects received low-intensity, functionally oriented exercises and incontinence care every two hours during the day, five days a week for eight months. A control group of 92 residents received usual care.

- **Effects of an Exercise and Scheduled-Toileting Intervention on Appetite and Constipation in Nursing Home Residents**
Sandra F. Simmons and John F. Schnelle, 2004, in *Journal of Nutrition, Health, and Aging*; 8(2):116-121.

If nursing homes offer incontinent residents daily exercise and frequent toileting assistance will the residents increase their consumption of food and fluids? Findings from this controlled, clinical intervention trial suggest they will not. The study enrolled 89 incontinent residents in two nursing homes. For half the residents, research

staff provided exercise and toileting assistance every two hours, four times per day, five days a week for 32 weeks. The other residents, the control group, received usual care. At the end of 32 weeks, the intervention group showed significant improvements or maintenance across all measures of daily physical activity, functional performance, and strength compared to the control group. But there were no differences between the two groups in the amount of food and fluids consumed. Both groups consumed an average of 55% of all meals, with no change over time. There was also no change in the frequency of bowel movements in either group. The authors suggest that a feeding assistance intervention aimed specifically at increasing mealtime consumption may be more effective than physical exercise in helping residents maintain and increase weight.

- **A Randomized Trial of a Combined Physical Activity and Environmental Intervention in Nursing Home Residents: Do Sleep and Agitation Improve?**

Cathy Alessi, Eun J. Yoon, John F. Schnelle, Nahla R. Al-Samarrai, and Patrice A. Cruise, 1999, in *Journal of the American Geriatrics Society*; 47:784-791.

This study provides preliminary evidence that an intervention combining increased physical activity with improvement in the nighttime nursing home environment improves sleep and decreases agitation in nursing home residents. For the study, participating residents received either an intervention that combines daytime exercise with a nighttime noise and light abatement program or the nighttime program alone. Compared to the second group (n=14), the first group of residents (n=15) slept more at night, were in bed less during the day, and showed less agitation. A previous study showed that the physical activity program alone did not improve nighttime sleep. The authors conclude, “We believe both the daytime and nighttime

aspects of the intervention, rather than a single component, produced the observed changes.”

- **Exercise with Physically Restrained Nursing Home Residents: Maximizing Benefits of Restraint Reduction**

John F. Schnelle, Priscilla G. Macrae, Karen Giacobassi, Holden S.H. MacRae, Sandra F. Simmons, and Joseph G. Ouslander, 1996, in *Journal of the American Geriatrics Society*; 44:507-512.

This randomized, controlled trial evaluated an intervention that was designed to improve mobility in physically restrained residents. The intervention, provided to 35 residents, consisted of walking or wheelchair propulsion, supplemented by rowing exercise three times per week for nine weeks. Intervention residents also practiced behaviors related to safe movement. Compared to the control group (N=37 residents), the exercise group members significantly improved their upper body rowing performance, handgrip strength, and wheelchair endurance, and decreased injury risk factors. There was no evidence that the exercise was associated with negative side effects. Unfortunately, many physically restrained residents were not candidates for the intervention, either because of unresponsiveness or because they were too physically debilitated to participate. In addition, about 30% of the residents who initially consented to participate in the program had to drop out due to death, hospitalization, or transfer from the facility. This attrition rate reflects the extreme frailty of this population.

- **A Walking Program for Nursing Home Residents: Effects on Walk Endurance, Physical Activity, Mobility, and Quality of Life**

Priscilla G. MacRae, Leslie A. Asplund, John F. Schnelle, Joseph G. Ouslander, Allan Abrahamse, and Celee Morris, 1996, in *Journal of the American Geriatrics Society*; 44:175-180.

Can a walking program help deconditioned, cognitively impaired but ambulatory residents increase their mobility, endurance, and physical activity levels? The delayed intervention trial reported in this article found mixed results. The study compared 19 residents in one nursing home who participated in a 12-week walking program to 15 residents in a second nursing home who received social visits as a control measure. Afterwards, all study subjects were offered the opportunity to complete a 22-week walking program. The 12-week program of daily walking at a self-selected pace produced significant improvements in walk endurance capacity, but no changes in physical activity levels throughout the day, mobility, or quality of life. At the same time, there were no negative side effects such as increases in falls or cardiovascular complications attributed to the walking program. Lengthening the program to 22 weeks produced no further significant changes in any outcome measures.

- **Wheelchairs as Mobility Restraints: Predicators of Wheelchair Activity in Nonambulatory Nursing Home Residents**

Sandra F. Simmons, John F. Schnelle, Priscilla G. MacRae, and Joseph G. Ouslander, 1995, in *Journal of the American Geriatrics Society*; 43:384-388.

Nursing homes could encourage very frail, nonambulatory residents to be more mobile by making their wheelchairs more user-friendly and

offering them organized practice in wheelchair propulsion. The 65 nonambulatory residents in this study rarely propelled their wheelchairs, although 70% were physically capable of doing so. Wheelchairs that were either dysfunctional or inappropriately fitted to the residents' size were a major barrier to wheelchair use, affecting 46% of the residents. Additionally, none of the residents could unlock their chairs, either due to difficulty locating the lock or lack of sufficient strength to move the lock. Simple wheelchair modifications can overcome some of these problems, and wheelchair exercise programs, similar to walking programs for ambulatory residents, may lead to increases in endurance, strength, and mobility.

- **The Effects of Staffing on In-Bed Times of Nursing Home Residents**

Barbara M. Bates-Jensen, John F. Schnelle, Cathy A. Alessi, Nahla R. Al-Samarrai, and Lené Levy-Storms, 2004, in *Journal of the American Geriatrics Society*; 52:931-938.

Many nursing home residents spend a potentially unhealthful amount of time in bed, between 15 and 18 hours a day, sometimes more. Why? A low staffing level is the strongest predictor of excessive in-bed times, followed by impairments in residents' functional ability, according to this study. The study also found that the more time residents spent in bed during the day, the more they slept during the day, the more socially isolated they were, and the less they ate.

The study compared nursing homes with low staffing levels—less than 3.4 staff hours per resident per day—to facilities with some of the industry's highest staffing levels—more than 3.7 staff hours per resident per day. Residents in lower-staffed homes were observed in bed an estimated average of 5 hours a day, between 7 a.m. and 7 p.m., versus an estimated average of 3 daytime hours for residents in the high-staffed homes. Given that many residents are put to bed

by 7 p.m.—a finding from previous Borun Center research (see the next study)—residents in low-staffed homes could be spending as much as an average of 17 hours a day in bed.

Eight hundred and eighty-two long-stay residents in 34 nursing homes throughout southern California participated. The authors interviewed residents; observed them at hourly intervals on one day to estimate in-bed time and measure social engagement; monitored mealtimes; and conducted physical performance evaluations to assess residents' ability to stand and bear weight.

The authors point out that letting residents with physical impairments linger in bed could accelerate their decline. And the fact that residents with similar physical disabilities were observed out of bed more frequently in the high-staffed homes suggests in-bed times can be improved.

- **The Minimum Data Set Prevalence of Restraint Quality Indicator: Does it Reflect Differences in Care?**

John F. Schnelle, Barbara M. Bates-Jensen, Lené Levy-Storms, Valena Grbic, June Yoshii, Mary Cadogan, and Sandra F. Simmons, 2004, in *The Gerontologist*; 44(2):245-255.

Nursing homes with a high rate of physical restraint use employ more restrictive care processes, which limit their residents' movements, than facilities that use restraints less often. But findings from the first study to independently evaluate the validity of a nursing home "prevalence of restraint" quality measure also suggest that most long-stay residents spend a potentially unhealthy amount of time in bed. The authors contend that an assessment of residents' physical activity might be a more meaningful measure of care quality than restraint use.

The study examines whether minimal restraint use in a nursing home reflects better care practices. The researchers compared two groups of nursing homes: eight with scores among the lowest (0-5%) on a quality indicator that measures prevalence of restraint use and six with scores among the highest on this measure (28-48%). Residents were observed in bed more often in the high-restraint homes, yet there was no obvious clinical difference between these residents and those in the low-restraint homes. On all other care process measures, including those related to the management of restraints, exercise, and gait and mobility problems, the study found no differences between the two nursing home groups. In general, all facilities provided care to residents, restrained or unrestrained, less than once every two hours.

The researchers estimate that the typical resident in a high-restraint home spends between 19 and 20 hours in bed each day. That estimate drops in low-restraint homes, but by only an hour a day. These findings suggest that all residents are spending too much time in bed and not enough time engaged in activities that enhance mobility, gait, and balance.

- **Strategies to Measure Nursing Home Residents' Satisfaction and Preferences Related to Incontinence and Mobility Care: Implications for Evaluating Intervention Effects**

Sandra F. Simmons and John F. Schnelle, 1999, in *The Gerontologist*, 39(3):1-11.

This study compared four different interview strategies to measure 111 incontinent nursing home residents' "met needs" related to incontinence and mobility care. In one method—perhaps the most commonly used strategy in nursing homes—residents were asked direct satisfaction questions (e.g., "Overall, are you satisfied with how often someone helps you to walk?"). A second method asked residents about their preferences for care (e.g., "Would

you like for someone to help you walk more often?” “How many times during the day would you like someone to help you to walk?”). The last two methods compared resident reports about how often they preferred to receive care to how often they actually did receive care based first on research staff observations (Method 3) and then on their own reports (Method 4). Incontinent residents who passed a simple responsiveness screen (residents were asked to state their name or identify two common items) were interviewed. Each resident was interviewed on two occasions to evaluate the stability of their responses. Results showed that 75% of the residents provided logically consistent responses, a finding that dispels the widespread assumption that only a small subset of cognitively intact residents can provide meaningful information about the care they receive.

Of the four methods tested, the third method proved superior with respect to response stability. Method 1 yielded the most unstable responses. The third method also revealed comparatively higher levels of “unmet need,” but by doing so, is considered more useful for guiding improvement efforts. The authors acknowledge that Method 3 is the most time-consuming to implement because it requires objective, direct observations of the care actually provided to residents. They argue, however, that this type of monitoring should be conducted at least annually in any case. [Ω](#)

RELATED LINKS AND RESOURCES

American Geriatrics Society

Guideline for the Prevention of Falls in Older Persons

<http://www.americangeriatrics.org/products/positionpapers/Falls.pdf>

American Medical Directors Association

Scroll down to the *Clinical Practice Guideline on Falls and Fall Risk*

<http://www.amda.com/info/>

American Occupational Therapy Association

<http://www.aota.org>

American Physical Therapy Association

<http://www.apta.org/>

Archstone Foundation

Fall Prevention Conference White Paper

http://www.archstone.org/publications2292/publications_show.htm?doc_id=143885

MedQIC, an online resource from the Center for Medicare & Medicaid Services

Clinical Resources: Physical Restraints

<http://www.medqic.org/content/nationalpriorities/nursinghome/nhTopics.jsp?topicID=413&nhID=1028717&pageFrom=resources>

MedQIC, an online resource from the Centers for Medicare & Medicaid Services

Clinical Resources: Walking Improvement

<http://www.medqic.org/content/nationalpriorities/nursinghome/nhTopics.jsp?topicID=413&nhID=1028721>

National Center for Injury Prevention and Control

A Tool Kit to Prevent Senior Falls

<http://www.cdc.gov/ncipc/public-res/toolkit/toolkit.htm>

National Citizens Coalition for Nursing Home Reform

Restraint Use Fact Sheet

http://www.nccnhr.org/public/50_156_451.cfm

National Institute on Aging

Exercise for Older People: Guides and Videos

<http://www.niapublications.org/shopdisplayproducts.asp?id=5&cat=Exercise+for+Older+People>

National Resource Center for Safe Aging

<http://www.safeaging.org/resources/resources.asp>

Penn Nursing Hartford Center of Geriatric Nursing Excellence

Restraint-free Care in Nursing Homes: Training Module

http://www.nursing.upenn.edu/centers/hcgne/gero_tips/RFC/default.asp

University of Iowa, College of Nursing

Publishes nursing practice protocols on such topics as exercise, falls prevention, restraint management, and more.

<http://www.nursing.uiowa.edu/centers/gnirc/protocols.htm> Ω

FORMS

WALKING PROGRAM

- Walking Log, page 56
- Observation Log, page 57

FIT INTERVENTION

- Prompted Voiding Protocol, page 59
- FIT Log, page 60

WALKING LOG

Resident's Name: _____

Instructions to CNA:

- Ask resident to walk with you (e.g., “Good morning, Mrs. Anderson, would you like to walk today?” “It’s time for our walk today, Mr. Jones.” “Please join me in a walk, Mrs. Sanchez.”).
- If the resident refuses, politely ask why or for an explanation (e.g., “Is there a reason you don’t want to walk today, Mrs. Anderson?”).
- If there is no physical reason for the refusal (e.g., resident is not ill or in pain), then again, ask him or her to walk with you (e.g., “Please, I’d enjoy it if you’d walk with me, Mrs. Anderson”).

Record results here:

Date	Resident agreed to walk? (circle one)	If no, why not? I=illness; P=pain; N=not in the mood; O=other reason (write the reason)	If yes, time started?	Time Ended?	Total Minutes Walked*	CNA initials and comments (e.g., had to stop twice; complained of pain; walked to dining room and back, etc.)
	Yes No					
	Yes No					
	Yes No					
	Yes No					
	Yes No					
	Yes No					
	Yes No					
	Yes No					
	Yes No					
	Yes No					

* If the “total minutes walked” declines 2 days in a row, ask a nurse to assess the resident.

WALKING PROGRAM: DIRECT OBSERVATION FORM

Name of observer: _____

Date: _____

Residents' Names	Scheduled Walk Times	Time of Observation in Vicinity of Resident's Room	Resident Observed Walking? (Circle one.)	Comments
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	
			Yes No	

Prompted Voiding Protocol

1. Contact each resident every two hours from 8 a.m. to 4 pm (i.e., four times per day).
2. Focus the resident's attention on voiding by asking whether he or she is wet or dry.
3. Check resident for wetness and give feedback on whether the resident's self-report was correct or incorrect (e.g., "Yes, Mrs. Jones, you are dry.")
4. Whether wet or dry, ask the resident if he or she would like to use the toilet (or urinal).
 - a. If yes:
 1. Assist him/her with toileting.
 2. Record the results on the bladder record.
 3. Give the resident positive reinforcement by spending an extra minute or two conversing with him or her.
 - b. If no:
 1. In the event they have not attempted to void in the last four hours, repeat the request to use the toilet once or twice before leaving, and follow step 4(a) if an affirmative response is received.
 2. If the resident is wet and declines to use the toilet, change him or her.
 3. Inform the resident that you will be back in two hours and request that the resident try to delay voiding until then.
5. Record results of each wet check and toileting attempt on either the following form or the FIT Daily Log, page 60.

PROMPTED VOIDING FORM

Instructions: Use this form to record results of wet checks and prompted voiding attempts with *one* resident. The resident should receive prompted voiding every two hours between 8 am and 4 pm, for a total of 4 times on each day. There is space below to record results for 4 wet checks and prompted voiding attempts.

Resident Name: _____ **Employee Name:** _____

Date: _____

Time: _____ at 1st check _____ at 2nd check _____ at 3rd check _____ at 4th check

1. Resident's condition at check (circle one for each check):

1st check:	2nd check:	3rd check:	4th check:
Dry	Dry	Dry	Dry
Wet	Wet	Wet	Wet
Bowel	Bowel	Bowel	Bowel
Wet and bowel	Wet and bowel	Wet and bowel	Wet and bowel

2. Toileting outcome (circle one for each check):

1st check:	2nd check:	3rd check:	4th check:
Refused	Refused	Refused	Refused
Dry run*	Dry run	Dry run	Dry run
Urine	Urine	Urine	Urine
Bowel	Bowel	Bowel	Bowel
Urine and bowel	Urine and bowel	Urine and bowel	Urine and bowel

* A "dry run" means that the resident attempted to toilet but failed to void.

3. Resident's reaction to checks and prompts (circle one for each check):

1st check:	2nd check:	3rd check:	4th check:
Self-initiates	Self-initiates	Self-initiates	Self-initiates
Cooperates-neutral	Cooperates-neutral	Cooperates-neutral	Cooperates-neutral
Cooperates-reluctant	Cooperates-reluctant	Cooperates-reluctant	Cooperates-reluctant
Uncooperative	Uncooperative	Uncooperative	Uncooperative

4. Level of assistance resident needed to toilet (circle one for each check):

1st check:	2nd check:	3rd check:	4th check:
Independent	Independent	Independent	Independent
Stand-by asst.	Stand-by asst.	Stand-by asst.	Stand-by asst.
Needs help of 1 person	Needs help of 1 person	Needs help of 1 person	Needs help of 1 person
Needs help of 2 persons	Needs help of 2 persons	Needs help of 2 persons	Needs help of 2 persons

FIT DAILY LOG

Resident Name: _____ **Employee Name:** _____

Date: _____

Time: _____ at 1st session _____ at 2nd _____ at 3rd _____ at 4th

Resident's condition at the start of the session (circle one for each session):

1st:	2nd:	3rd:	4th:
Dry	Dry	Dry	Dry
Wet	Wet	Wet	Wet
Bowel	Bowel	Bowel	Bowel
Wet and bowel	Wet and bowel	Wet and bowel	Wet and bowel

2a. FOR RESIDENTS IN CHECK-AND-CHANGE PROGRAM: Change wet or soiled diapers.

2b. FOR RESIDENTS RECEIVING PROMPTED VOIDING: Toileting outcome (circle one for each session):

1st:	2nd:	3rd:	4th:
Refused	Refused	Refused	Refused
Dry run*	Dry run	Dry run	Dry run
Urine	Urine	Urine	Urine
Bowel	Bowel	Bowel	Bowel
Urine and bowel	Urine and bowel	Urine and bowel	Urine and bowel

- A “dry run” means that the resident attempted to toilet but failed to void.

3. Record the following. Check here if resident cannot exercise due to sickness or pain: _____

Total number of:	1 st session	2 nd session	3 rd session	4 th session
Minutes walked				
Sit-to-Stands				
Arm curls/raises (1 time each day; indicate session)				

4. Fluids offered. Record consumption.

No. of ounces:	1 st session	2 nd session	3 rd session	4 th session
Before exercise				
After exercise				