

Part 3: Function-Focused Care in Assisted Living Facilities

Lisa Rill, Ph.D.

An earlier version of the paper “The Ideal Assisted Living: What It Should Be and Why?” discussed the quality-of-life-oriented values that have guided the development of assisted living over the last 20 years. The main focus was to identify and describe the core values of assisted living, which include resident autonomy and choice, social engagement, privacy and dignity, and aging in place in the most homelike and least restrictive environment. In the section on social engagement and quality of life, the discussion was focused on the importance of social interaction because of the positive effects it has on AL residents’ quality of life. This paper extends the discussion of the positive impact of engagement by illustrating the effects of increased involvement in physical activity on the residents’ ability to optimize and maintain their functional skills. The implementation of the function-focused care model is used as an example of how AL residents can reach and maintain their goals.

Importance of Physical Activity on Functional Ability

As the amount of individuals entering ALFs continues to rise, so too does our need to better understand the associations between physical activity and health-related outcomes such as function and disability (Hall and McAuley 2011). There is ample evidence that physical activity among older adults is a key factor to aging successfully (Resnick, Galik, and Boltz 2013). For instance, one study illustrates that residents who participate in more physical activities have higher levels of self-efficacy, less functional impairment, enhanced perceived health, healthier cardiovascular outcomes, better mood, and a higher quality of life (Hall and McAuley 2011; Resnick and Galik 2013). There is

even evidence suggesting that participating in physical activity as little as 40 min/day, such as a small increase in walking (4 blocks/day), results in positive health and functional benefits for older adults (Resnick and Galik 2013). However, multiple studies illustrate that many ALF residents are inactive and have limited opportunities to engage in physical activity. For example, one study found that the majority of residents participate in less than 1 minute a day of moderate level physical activity, and some do not engage in any physical activity and only burn on average 54 kcals a day (Resnick, Galik, Gruber-Baldini, and Zimmerman 2011).

A major contributor to this lack of physical activity comes from the expectations of residents and families regarding the care provided by the direct support staff. They believe that monthly payments ensure that the staff will provide the service rather than encourage the resident to participate in their own care, such as walking, dressing, or bathing (Resnick, Galik, and Vigne 2014). That belief, along with multiple other barriers, has led to a culture of care that focuses on providing care *for* (bathing or dressing an individual) as opposed to *with* (providing verbal cueing) the residents (Resnick, et al. 2009, 2011). This type of protective care decreases physical activity, facilitates functional decline, increases the chance of falls, and contributes to disability (Resnick, Galik, and Boltz 2013). This, in turn, raises cost of care and the chance of relocation to a nursing home.

Barriers to Physical Activity in ALFs

Understanding barriers to physical activity in ALF settings is critical for the appropriate design of programs for residents (Benjamin, Edwards, Ploeg, and Legault 2014). There are three categories of barriers that lead to decline or absence of

participation in physical activity in ALFs: residential, organizational, and environmental (Benjamin et al. 2014). Residential barriers to physical activity include the following: poor health and physical limitations, such as stroke and limited mobility; anxiety and agitation due to cognitive impairments; and fear of falling (Resnick et al. 2009, 2010). When residents are in poor health, they often feel that participation in ADLs or activities will cause pain. If a resident is anxious or agitated, the nursing staff may only encourage sedentary activities or give sedative medications to prevent behavioral outbursts. Falls during transfers or walking can be caused by poor eyesight or balance, thus, increasing the fear of injury and decline in physical activity (Benjamin et al. 2014).

Organizational barriers include: funding limitations (staffing constraints); lack of time in daily routine due to competing demands and schedules; poor communication among staff; and lack of personalized activity programs (Benjamin et al. 2014). Inadequate staffing levels due to budget constraints increases the staff responsibilities, which leads to reduced opportunities for staff to assist residents in activities. Family visits and scheduled care routines, such as toileting or bathing, can also interfere with other activities that are planned at the same time. When residents are unaware of activities being offered, it is often due to communication gaps between the staff. Physical activity programs that are offered can sometimes be too difficult or too easy for the residents because they are not personalized (Benjamin et al. 2014).

Barriers at the environmental level include: limited space; lack of equipment; and unsafe indoor and outdoor designs (Benjamin et al. 2014). ALFs with limited space do not typically have designated activity rooms; therefore, multipurpose areas decrease the availability of activity programs for the residents. Exercise equipment can be used any

time of the day; however, many ALFs do not have the additional space for extra equipment or available staff to supervise the residents. Hazardous designs, such as dim lighting and uneven flooring can make even basic ADLs difficult for the residents (Benjamin et al. 2014).

Implementation of Function-Focused Care in ALFs

In 1987, the Omnibus Budget Reconciliation Act mandated that long-term care residents reach and maintain their highest level of function. Function-focused care (FFC) was developed for ALFs to address the common issue of functional decline among residents. FFC is a model of care that helps optimize and maintain the residents' functional abilities and increases time spent in physical activities (Resnick and Galik 2013). FFC accomplishes this by altering how staff provides care to the residents, shifting from performing the task *for* the resident, to performing the task *with* the resident (Resnick et al. 2011). Examples include using verbal cues to assist the resident in completing a task with minimal help, walking to the bathroom instead of using a bedpan or bedside commode, and getting the resident involved in exercise classes at the facility (Resnick, Galik, and Boltz 2013).¹

Implementation of FFC includes four components: assessment of the environment and policies/procedures of the facility; education of the interdisciplinary team, residents, and family; development of FFC goals for the resident; and mentoring and motivating the caregivers (Resnick et al. 2011; Resnick, Galik, and Vigne 2014). Facility assessment helps to identify interventions that are needed to improve the environment for the residents. Staff and caregiver educational sessions are provided to teach them about the

¹ More information on FFC is provided at this website <http://www.functionfocusedcare.org/home>

FFC model of care. Individualized goals for the residents are established to optimize participation in functional and physical activities. Continuous mentoring and motivation is provided to the staff and caregivers to encourage the use of FFC. Each component is applied sequentially and the process continues until all parts become a routine part of care.

Effects of Function-Focused Care

Multiple studies have tested the FFC approach in various long-term care settings. Resnick and colleagues (2013) provide a comprehensive review of these findings. The variables in the studies included ADLs, depression, quality of life, gait and balance, falls, and disruptive behaviors. Most of the studies had mixed results with some positive outcomes, some unchanged, and in a few cases the outcomes got worse.² The review provided some consensus that there are benefits to implementing FFC, particularly for maintaining functional skills, and is a must needed change in the long-term care setting.

Overall, the FFC model of care has shown benefits for residents in various settings with evidence of improving or maintaining the negative impact that sedentary behavior has on the residents in terms of contributing to de-conditioning, pressure ulcers, falls, infections, and exacerbation of underlying comorbidities (Resnick and Galik 2013). However, in order for this to occur, the focus of the nursing staff needs to shift from the idea of “getting their work done” to focusing on the promotion of physical activity (Benjamin et al. 2014). Further, environments in ALFs should facilitate physical activity as a way to reduce functional decline and enable people to achieve their highest level of function (Resnick and Galik 2013). This approach not only provides more personalized

² In the cases where the outcomes were unchanged, the authors suggested that this ability to maintain function should be considered as a success for FFC.

care, but also improves quality of life by enabling residents to remain in their ALF rather than be transferred to a nursing home or acute care setting (Resnick et al. 2011).

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