Positioning the Nursing Home Resident: An Issue of Quality of Life

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This case report focuses on one instance of seating and positioning with a geriatric client in a nursing home setting. The methods used to resolve the seating difficulties were not remarkable; the noteworthy aspects of this case are the setting and the dramatic and immediate effects the intervention had on the client.

Relevance of Positioning to Occupational Therapy

An issue that requires examination before discussion of the case itself is the role that seating and positioning play in occupational therapy. At first glance, this area might appear to be outside the realm of the profession. Seating and positioning do not fall within the historical hypothesis upon which occupational therapy, as defined by Reilly (1952), is based. Reilly's definition includes the understanding "that man, through the use of his hands as they are energized by his mind and will, can influence the state of his own health" (p. 2). This statement appears to limit the realm of occupational therapy to only those activities in which the client actively participates, thereby ruling out seating and positioning. However, current understanding of occupational therapy places seating and positioning within the intent of the profession, that is, "the health and function of each individual within his or her own environment" (Hopkins & Smith, 1983, p. 28).

Seating and positioning can play a major role in increasing function. "Proper positioning and adapted equipment provide a necessary adjunct to therapy, carrying over goals into all areas of daily living (home, school, work, etc.), normalizing tone and facilitating more normal movement" (Bergen & Colangelo, 1985, p. 3).

Background Information

The client was a 93-year-old woman with multiple diagnoses, including chronic brain syndrome, status post right cerebrovascular accident, and diabetes. At 5 ft 2 in., she weighed approximately 125 lb. Her original seating system included a water cushion topped with an incontinence pad and a waist restraint tied around the wheelchair. As there were no footrests on the wheelchair and as her trunk control was poor, there was little to prevent the client from sliding down in the chair. Sliding was a cause of concern for many reasons. Skin breakdown can result...
from both the shear forces and the uneven pressure. In addition, when sliding is seen in conjunction with the use of a waist restraint, the restraint can end up around the chest, where it constricts breathing and increases discomfort. The person in the wheelchair may also slide underneath the restraint and onto the floor. This scenario occurred with the client several times, including the day on which she was evaluated for occupational therapy.

This client typically needed to be repositioned by two staff members several times during the day and was unable to maintain an upright position. Because her poor positioning made it difficult for her to reach her plate during mealtimes, she often spilled large amounts of food. She was also noted to cough several times during the course of a meal, indicating possible aspiration of the food into the lungs, perhaps due to poor head position.

Nursing notes from the 2-month period before the client received occupational therapy indicated that her behavior was identified as problematic, with frequent periods of agitation and calling out. Her noisy behavior made it difficult for her to be a part of the nursing home activities. At the time of this study there was a standing order for .5 mg of Ativan, as needed, to decrease the client's agitated behavior.

The client was never specifically referred to either occupational therapy or physical therapy. A physician's order for an occupational therapy evaluation was requested after observation by the consulting occupational therapist of the client's positioning and behavior on the unit and during mealtimes. The client's speech was difficult to understand because of her stroke and because her first language was Portuguese. It was therefore not possible to determine through questioning whether she was physically uncomfortable or to otherwise determine the cause of her agitation. However, the theory that her agitation was related to discomfort in the wheelchair was reinforced by the observation that she was usually quiet for a short time immediately after being repositioned by the nursing staff.

Management Program

When the client was evaluated by the occupational therapist for seating and positioning, she exhibited poor trunk control, minimal forward flexion of the spine, and a marked tendency to slide down in the wheelchair. Repositioning began with a 1-in.-thick plywood board placed directly on the seat of the wheelchair to provide a solid base. A wedge cushion was placed on top of the board with a piece of nonskid material between the board and the cushion. The wedge cushion helped maintain the hips at a 90° angle and thereby decreased the risk of sliding. A front-closure seatbelt was attached to the wheelchair at a 45° angle to the hips to reinforce their position and as a safety measure to decrease the risk of falls.

After she was repositioned, the client's feet tended to slide and get caught between the legs of the wheelchair instead of resting on the footrests. Shortening the legrests did not solve the problem. The maintenance department, which is in charge of the facility's wheelchairs, suggested attaching additional calf pads at right angles to the existing calf pads to block the legs from sliding. The nursing staff objected to his idea, claiming that this arrangement would make it more difficult for the nursing assistants to transfer the client. Although recognizing that the legrests could be swung out of the way, the charge nurse on duty at that time stated, "You can't expect them to take the time to do that." Ultimately, two straps of foam padding were attached between the calf pads; they were partially successful in keeping the legs from falling between the legrests.

The client currently maintains an upright position in her wheelchair for approximately 5 hr at a time without requiring repositioning. Her spilling during mealtimes has decreased greatly, enabling her to remain cleaner throughout the day and to maintain her nutritional intake. The frequency of her episodes of coughing has also decreased. Because the client is positioned on a stable base, her upper extremities are free to be used functionally in activities that she appears to enjoy, such as looking through catalogs and magazines.

The most important change, however, has been the substantial decrease in agitated behavior and the subsequent decrease in the administration of Ativan. For example, in the 2 months before the occupational therapy intervention, while still using the old seating system, the client received Ativan for agitation on 14 different days; on 1 day she received it twice. After the repositioning, the client received Ativan only twice during a 1-month period. Two months after the intervention, she had received no Ativan for 30 days. The monitoring of her Ativan intake was stopped at that time because of staffing changes in the rehabilitation department.

Although this case was not a controlled study, the correlation between the repositioning and the decrease in agitation and subsequent administration of Ativan is striking. If appropriate positioning can indeed reduce discomfort, agitation, and the administration of chemical restraints, then all nursing home residents, regardless of level of function, must be evaluated for the most appropriate seating system. To ensure reimbursement for treatment in this area, research to determine the effectiveness of correct positioning is vital.

Institutional Factors

The nursing home setting itself must be examined for the particular problems it poses for occupational therapy intervention. The rehabilitation department at this particular nursing facility had one physical therapy and one occupational therapy consultant, neither was on staff. Direct treatment for occupational therapy was also an innova-
tion at this facility. Before June 1990, occupational therapy services consisted entirely of 8 hr per month of indirect treatment, such as chart reviews and general recommendations. A team approach to repositioning this client would have been the preferred means of operation. However, the lack of a consistent presence of registered therapists and the newness of the role of direct treatment for occupational therapy made the team approach impossible.

Two restorative therapy aides were employed by the facility and were responsible for running the restorative dining group and the wheelchair exercise groups, carrying out range of motion programs, placing hotpacks, and ambulating with residents, under the direction of the two registered therapists. However, maintenance of a seating and positioning system did not fall into the realm of the restorative therapy aides, nor was it realistic to expect these aides to be available every time a resident was transferred into a wheelchair. It was the nursing assistants' responsibility to transfer the residents and to employ whatever restraint was ordered. Herein lay the problem in maintaining an intervention in the area of seating and positioning.

Nursing assistants in this facility were typically rushed, with an agenda of bathing, feeding, and cleaning up after five to eight residents in a short time. Asking the staff to perform a full occupational therapy intervention was frequently unrealistic. Therefore, to ensure the greatest amount of success with any intervention requiring long-term implementation, the intervention had to be largely self-sustaining.

Another difficulty in this particular nursing home was that no positioning equipment was kept in stock. Equipment was ordered only after the need for it had been determined on a resident-specific basis. To comply with OBRA 1987 regulations, the facility was beginning to stock seatbelts with front closure and was considering ordering large quantities of other devices, such as lateral supports and lap trays. In the meantime, the repositioning of the nursing home residents will take place, but slowly.

Summary

Occupational therapy intervention in the area of seating and positioning may play a vital role in improving the quality of life for nursing home residents. This case report indicates that appropriately positioning a client may increase comfort, decrease agitation, and decrease the administration of mood-altering drugs. Research would help to delineate the effects of appropriate seating systems, both to ensure reimbursement and to ensure that all who might benefit from positioning intervention receive the appropriate services.

OBRA 1987 regulations are forcing nursing homes to assess residents for the least restrictive restraints. These assessments offer a golden opportunity for occupational therapists to become involved in determining the most appropriate seating systems and to conduct research on their benefits.

References


Omnibus Budget Reconciliation Act of 1987, Subtitle C, Nursing Home Reform Act, Public Law 100-203.
