

Rehabilitation in Residential Aged Care Facilities: Barriers and Facilitators in a Dementia Context

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This review of the literature sought to highlight key barriers to the implementation of rehabilitation-based interventions in an aged care facility context. It then identifies how such barriers might be actively countered with a view to facilitating rehabilitation-based strategies within such contexts. Key barriers identified included staffing issues, heterogeneity of residents, and the potential complexity behind establishing appropriate forms of rehabilitation for the residents. The most successful facilitators identified included training, the provision of appropriate support, and an open communication process. Having an awareness and an appreciation of potential barriers to the use of rehabilitation interventions in aged care facilities provides the opportunity to actively plan around them, thereby increasing and improving their use.

Keywords/phrases: dementia, rehabilitation, aged care facility, aging

Introduction

Despite research highlighting a range of strategies and interventions proving useful within the dementia population at various levels of severity (e.g., Brennan, Giovannetti, Libon, Bettcher, & Duey, 2009; Clare et al., 2000; Engelman, Mathews, & Altus, 2002; Nomura et al., 2009), such programmes are often not implemented widely within residential aged care facilities (RACFs). Maintaining consistency in approach can be difficult in the RACF context due to high staff turnover and difficulty attracting new staff (Cheek, Ballantyne, Jones, Roder-Allen, & Kitto, 2003); lack of appropriate training (Charness & Holley, 2001; Woods, 1999); and agency workers being used to fill the gap (Martin & King, 2008).

This review aims to identify the key reasons why a rehabilitative approach to dementia is difficult to implement within RACFs, despite the positive impact such strategies can have on degree of independence and sense of life satisfaction in residents (e.g., Brodaty, 1996; Burns & Rabins, 2000; Rusted & Clare, 2004). It is from an understanding and appreciation of the barriers that research into the future might be more targeted and therefore able to successfully overcome such barriers to ensure best practice in dementia care. The review therefore begins by highlighting those factors that have been found to hinder a rehabilitative approach in dementia care. The focus

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then turns to highlighting how a rehabilitative approach might be facilitated, in the context of such barriers.

Barriers at the staff and facility level

The staff-to-patient ratio in RACFs often means that in order to get through the tasks of the day, the schedule of care is made up of highly structured routines (e.g., Bowers, Esmond, & Jacobson, 2000; Phillips & Van Ort, 1995) and is therefore task-oriented in nature. The basic needs of people with dementia are generally catered for, however there is limited time available to spend on psychosocial needs (Younger & Martin, 2000). Therefore, despite evidence for the efficacy of individualised, person-centred care (e.g., Zimmerman et al., 2005), research indicates that RACFs continue to adopt routinised methods of care.

At a more global level, a low level of support from facility management can also hinder the implementation process (Mentes & Tripp-Reimer, 2002). In the absence of such underlying support, adequate staff resources and time to implement any new programmes is generally not prioritised (Blackford, Strickland, & Morris, 2007). In addition, already stressed staff may have limited capacity with regards to both a desire to learn and implement new strategies (Bird, 2003).

Another factor that may determine adherence is how relevant, or applicable, staff think the intervention is to their residents. For example, Phillips and Van Ort (1995) suggest that if the staff think the residents will be unable to effectively carry out the strategies, it will be less likely that those strategies will be implemented. They also suggest that if the intervention does not fit within the overall model of care undertaken by a facility, it will similarly not be used.

There is also the difficulty around continued maintenance of established rehabilitative strategies in the longer term. For example, staff identified as part of the Janes, Sidani, Cott and Rappolt (2008) review found it difficult to plan to use particular strategies because of the perceived variability in the patients. One day the patients could have a 'good' day, and the next a 'bad' day. For the staff, this meant that they had to determine the best thing to do in each moment, based on what was best for them and the person with dementia. In that same review, staff were also less inclined to use strategies that did not result in a consistent positive outcome. Potentially this feeds back into the factor of limited time, whereby staff do not perceive that they have the time to keep trying things that are not working on a consistent basis. Consider also, that people with dementia commonly display '... significant behaviour disorders ...' (Doyle & Ward, 1998, p. 589). Such behaviours can often lead to frustration and a desire for a quick fix from nursing staff, especially those in most contact with the patients (Cohen-Mansfield, Werner, Culpepper, & Barkley, 1997). Regardless of available interventions and strategies, the more immediate, problematic behaviours are most often the issues focused on by time-poor staff.

Barriers at the resident level

The characteristics of the residents themselves may also create a barrier to implementing rehabilitation-based strategies. For example, advanced age, level of frailty, and level of cognitive and physical impairment (Mentes & Tripp-Reimer, 2002) can, in and of themselves, act as barriers. Whether these are based on stereotypical beliefs

or are qualities based in fact, the reality is that the decision to rehabilitate or not is often made before a person with dementia even enters a facility (Baltes, 1995). Additionally, the family may be disinclined to allow their relative to be involved in any form of rehabilitation over concerns of injury, whether it be physical and/or psychological risk (Resnick & Remsburg, 2004). Resnick and Remsburg (2004) also note that the patient themselves may be unwilling to participate, lacking the motivation to be involved, for example.

The assumption can sometimes be made that residents are not interested in particular activities within an RACF, when in fact it may be that the person with dementia does not know how to participate in the activity. In some instances, independence can be fostered simply by prompting or educating the person with dementia on the use of a particular item (e.g., Rogers et al., 2000; Simmons & Schnelle, 2004).

Rehabilitation goals as barriers

A further barrier to the implementation of rehabilitation interventions comes from the need to balance levels of independence and dependence in the person with dementia. It can be the case that carers assume that deficits in functioning in one area indicate the existence of deficits in other areas, and so carers tend to carry out more activities for the person with dementia than is necessary (Resnick & Remsburg, 2004). This unfortunately removes the opportunity for the person with dementia to continue being involved in those activities of daily living (ADLs) that they can in fact perform. This not only reduces the opportunity for the person with dementia to participate in the completion of ADLs but contributes further to deficits in functioning via lack of practice (Resnick & Remsburg, 2004).

In addition, both Fisk (1986) and Bytheway (1995) have pointed out that there is a tendency to see older adults, in general, as being dependent on others. They suggest that when older adults demonstrate independent behaviours, it is more likely that they will be encouraged to behave in a more dependent way, rather than encouraging the demonstrated independent qualities. Likewise, nursing staff have been noted to have a tendency to ignore independent behaviour (Edwards & Burnard, 2003), rather than reinforce such efforts of self-sufficiency. The same authors suggest that when dependent behaviour is displayed, the result is support and care, thereby reinforcing dependency and subsequently increasing the likelihood of the person becoming more dependent into the future. Given RACFs are in the business of caring for their residents, it is not entirely surprising that there would be a greater focus on dependence as opposed to independence. However, it is worth highlighting that research supports fostering a suitable degree of independence, which has been shown to contribute to the achievement of optimal functioning, even in more severely demented patients (Resnick & Remsburg, 2004).

As a rule, there is a fine balance between the appropriate care of the person with dementia and the maintenance of successful functioning of the RACF itself (Secker, Hill, Villeneuve, & Parkman, 2003). However, there also needs to be a balance between promoting independence, while avoiding placing the person with dementia at risk of injury, for example (Bland, 1999). Generally speaking though, such focus on a dependency-based framework is not conducive to a rehabilitative model. Consideration should therefore be given to the idea that working with the person

with dementia at their own level of functioning can contribute towards preserving independence and their sense of self-worth can therefore be maintained (Tilly & Reed, 2008).

Facilitators of Rehabilitation Practice

Given the potential barriers at the staffing and facility level, it is apparent that one of the key components to facilitating rehabilitation in RACFs is the provision of adequate training, not only with regards to the use of such interventions and strategies, but also in working with and understanding people with dementia. This would provide staff with a higher degree of confidence in the use of such non-pharmacological interventions, increasing the likelihood that they will be successful, and therefore continue the use of such interventions longer term. Providing carers with the knowledge and tools necessary to implement rehabilitative practices in and of itself leads to greater adherence (Kolanowski, Buettner, & Moeller, 2006).

Effective communication between staff and researchers, as well as the general support of management and staff, have also been identified as two key factors with regards to successfully implementing new interventions within the RACF environment (Maas, Kelley, Park, & Specht, 2002; Mentis & Tripp-Reimer, 2002). A qualitative study by Train, Nurock, Manella, Kitchen, and Livingston (2005) found that improved communication was highlighted by staff, relatives and patients, with the need to have a voice and to be heard being conducive to developing individually relevant rehabilitation and to promoting an effective rehabilitative framework.

With regards to the more specific issue of fostering independence in an all too often dependent environment, Baltes, Neumann, and Zank (1994) looked at the impact of educational training in nursing staff. They found that after training, staff were more inclined to encourage independence and less inclined to foster dependence. A willingness to change on the part of the staff highlights not only the importance of training, but also the impact that improved knowledge can have on the daily functioning of RACFs. For instance, staff training in the use of the simple act of verbal prompts and opportunities to practice skills, as opposed to taking over for the patient, can promote skill maintenance (e.g., Coyne & Hoskins, 1997; Engelman et al., 2002; Rogers et al., 2000).

Limitations of the review and suggestions for further research

While this review has highlighted a number of potential limitations to successfully implementing a rehabilitative approach in RACFs, it should be remembered that each facility is different and that such barriers should not be assumed to exist in every facility. In addition, there is limited research in the context of Australia, in particular, and so the generalisability of the literature reviewed must also be considered.

Future research in this area should consider not only what rehabilitative strategies might be implemented in RACFs, but also consider how barriers such as the ones mentioned in this review might be overcome. Such a research strategy will increase the potential for rehabilitative strategies to be implemented within RACFs, ensuring the clinical and practical utility of such methods.

Conclusion

An individualised, person-centred approach allows for the inclusion of rehabilitative-based strategies, and while the literature regarding such methods of rehabilitation in RACFs is increasing, there are also a number of factors to consider if such methods are to be successfully implemented long-term and to maximum benefit. The key factors of appropriate training and support, as well as communication, clearly play an important role in whether or not rehabilitative strategies are consistently and effectively implemented within an RACF. Factors such as staffing, the overall functional ability of residents, and the overall ease of use of the intervention, are necessary considerations when developing rehabilitative strategies for use with people with dementia.

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