

THE LONG-TERM CARE



Restorative
Nursing
Desk
Reference

Barbara Acello, MS, RN

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HCP Pro

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Good luck with your mission to provide quality restorative care. I believe in you and admire your commitment. Please feel free to contact me through HCPro or by e-mail if you have questions or comments.

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Introduction



Surprisingly, the federal long-term care facility rules liberally refer to the need for restorative nursing, but fail to adequately define restorative care. The best explanation of restorative care comes from the book of instructions for completing the Minimum Data Set (MDS).¹ The *Resident Assessment Instrument (RAI) User's Manual* also makes intermittent reference to restorative nursing care as “nursing-based rehabilitation,” “restorative care,” “restorative therapy,” and “restorative nursing services.”

Finally, on page 191, the *RAI User's Manual* provides this definition:

Rehabilitative or restorative care refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as is possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy. A resident may also be started on a restorative program when he/she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when a restorative need arises during the course of a custodial stay. Restorative nursing does not require a physician's order.²

Restorative nursing is sometimes misunderstood, and many nurses have been forced to learn it through intensive self-study and the school of hard knocks because programs of this type are not part of basic nursing education and specialized restorative nursing educational programs are not available in many areas of the country. A one-day seminar is not enough to teach all that is necessary, but is much better than nothing at all.

Despite the shortcomings in restorative education, many restorative nurses have persisted through determination and prevailed in creating something from nothing. You are to be commended for your dedication! With this in mind, one goal of this book is to help make your job easier by providing useful clinical pearls, helpful factoids, and functional tools with which to do your job.

Restorative nursing is good, holistic nursing care. When compared with general nursing, the primary difference is that in a formal restorative program, routine activities of daily living are regarded as individual therapeutic modalities. They are not new or different procedures. Sometimes a change of perspective is needed to see them in this manner, but this should not be difficult, because you know the procedures work regardless of the label. Understanding and believing in the restorative philosophy is what we do as nurses. You have confidence in your ability to provide quality care. Placing an emphasis on restorative care is just a different way of viewing things that nurses regularly do. This restorative focus has become increasingly important in today's healthcare environment, in which residents have many needs and are often weak and fragile on admission.

This book is a reference guide of restorative nursing information and resources that will help you survive and thrive in providing restorative care in the long-term care facility environment. You already know how to be a nurse, so it is not a rehash of familiar policies and procedures. It was not written to be highly technical or theoretical or to present the results of complex research. Rather, the primary goal is to provide useful information and tools that will be both practical and functional in developing, enhancing, improving, or revamping a restorative nursing program. The book focuses on resources you need, information that will be helpful, and beneficial information for administering a successful program. It is not meant to be an exhaustive or comprehensive source of information, such as a textbook. The book includes current clinical

information that will complement more exhaustive sources of long-term care nursing reference material. Another goal is to introduce you to what is being done in facilities and what can be done in your facility. It is not to provide a primer to insult your intelligence. Some of the information is likely to be new, and some not. Take what makes sense and adapt whatever you do to your facility and your residents. Restorative care is so highly individualized that providing rigid rules is impossible.

Need, demand, and financing have a powerful impact on the care we give, and funding and reimbursement are potent drivers of the type of care we provide and the manner in which we deliver that care. The culture change movement and current regulatory environment have placed more of a focus on restorative care than ever before. The restorative nurse is a manager. To be effective in this role, you must have an understanding of the reimbursement system. If you are a good steward of your employer's money, and the restorative program is profitable, you have a strong bargaining chip when you need additional personnel, equipment, and supplies with which to expand or improve your services. This opportunity is lost without a rudimentary understanding of reimbursement. This should be a strong motivator. Most nurses are not used to having budgetary responsibilities, let alone using profit to play "Let's Make a Deal."

One chapter of the book summarizes the most common methods of reimbursement, but since the MDS is integral to the reimbursement process, you will find helpful reimbursement information throughout the book. We need experienced restorative nurses who can identify and articulate the residents' needs and formulate caring and effective ways of meeting them. This involves having a commitment to relentlessly seeking funds to support and enhance your programs. Keep this in perspective when you read the reimbursement information. Learning all you can will serve you well.

You have an awesome mission and responsibility. The essence of quality is the manner in which staff members relate to residents as individuals. Teach them to perform tasks with the residents, not for the residents. Quality of life is the result of a culture of caring. When the facility has a culture of caring, quality of care flourishes. This culture is created on the shoulders of strong nursing leaders with a vision. The residents derive many benefits. You will derive more job satisfaction than you ever thought possible. Believing in yourself and in the many positive aspects of restorative care is a good start. Restorative nursing is a calling. We hope this book provides you with useful tools with which to begin the process. Over time, many residents will benefit, and others within and outside of the facility will recognize how sacred is the work we do.

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Introduction to Restorative Nursing



History of Restorative Nursing Care

Restorative nursing has been practiced for many decades. In the 1940s, years before the Salk vaccine was introduced, an Australian nurse used nursing care exclusively as a treatment for children with polio. The treatment was controversial, but effective. In the 1950s through 1970s, some states integrated restorative nursing rules into state laws, although the term “restorative nursing” was not used until the late 1960s. When a Canadian nurse coined the term in 1968, facilities focused on illness, and the medical model of care was the norm. Residents were called “patients,” and many stayed in bed, with staff members attending to their needs. Restorative care reversed this trend.

Sister Kenny

Cases of polio have existed since at least 1350 B.C., and the disease has been called by many names. The virus typically attacks the motor neurons in the spinal cord, resulting in weakness and paralysis. Before a vaccine was developed in 1955, many people died as a result of polio. Thousands of others live with its effects to this day. Nurses in the 21st century may find it difficult to envision the terror that the annual summer polio epidemics caused in the United States during the prevaccine era (the incidence of new cases declined in the winter months). The epidemic peaked in 1952 with 58,000 cases.

Sister Kenny was an Australian nurse who worked with polio patients in the Australian bush. She was not a Catholic sister or nun. The title of Sister was used only for RNs, usually those with some authority, such as the charge nurse. (The director of nursing was called “matron.”) Sister was also used to identify a military rank for nurses in the Australian medical corps.

Sister Kenny’s treatment was controversial and unorthodox. She was strong-willed, forthright, and outspoken. She used only nursing care to treat polio and shunned conventional medical treatment. Sister Kenny believed that the most significant problem in the acute phase of polio was spasticity. She called the spasticity “muscle tightness.” She described some of her methods as “muscle reeducation,” an unknown term at the time. Beginning treatment early in the disease was essential. She treated polio patients with moist heat, stretching, and range-of-motion exercises. Footboards were also an essential part of patient care, as they prevented foot drop and kept the feet in a position of function in which patients could exercise the muscular reflexes used for standing up. Sister Kenny did not believe in braces, which were commonly used. Today, we continue to position patients and residents in a functional position and use footboards to prevent deformity.

In 1940, the Australian government sent Sister Kenny and her daughter (who was also considered an expert in polio treatment) to the United States to present their treatment to the medical community and verify its effectiveness. The medical community did not accept Sister Kenny’s outspoken demeanor, terminology, or methods and did everything possible to thwart her research. Her methods of care were in direct opposition to accepted conventional medical treatments, which at the time involved immobilizing affected muscles with rigid casting and splints, Bradford frames, and strapping patients (usually children) to boards for months to prevent deformities.

In 1942, a magazine article noted that the recovery rate for patients receiving Sister Kenny's treatment was 80%.¹ In 1943, Robert Bingham, MD, wrote, "Patients receiving the Kenny treatment are more comfortable, have better general health and nutrition, are more receptive to muscle training, have a superior morale, require a shorter period of bed rest and hospital care, and seem to have less residual paralysis and deformity than patients treated by older conventional methods. The Kenny treatment is the method of choice for the acute stage of infantile paralysis."² The AMA endorsed her approach in 1941,³ but was opposed to it by 1944.⁴ Eventually, a few physicians began supporting her work because of the success of the regimen.^{5, 6}

Sister Kenny threatened to return home to Australia more than once, and she kept the press enthralled with her ongoing battle with the medical community. The debate became so heated that a senator introduced a bill proposing a Congressional investigation of the opposition to Sister Kenny.⁷

Sister Kenny was a maverick, and acceptance of her restorative nursing care did not come easily. Her persistence resulted in an approach that changed the course of a contemptible, frightful disease. A combination of early treatment and restorative nursing techniques changed the approach to the treatment of thousands of patients with polio.

Initially, Sister Kenny's theories were applied only to the treatment of polio, then later expanded to care of patients with other upper and lower motor neuron lesions. Today, the Sister Kenny Institute in Minneapolis offers rehabilitative services at five hospitals. Sister Kenny provided us with the earliest known example of restorative nursing, and although she is now viewed favorably, she fought valiantly for her patients and for acceptance of autonomous nursing practice throughout her career. She died in 1952, before the introduction of the Salk vaccine, but she left behind an incredible legacy of patient advocacy and restorative techniques that continue to be used.

McIver's trees

Vera McIver likened patients to trees that were being deprived of the nutrients necessary to function normally and maintain their identities as human beings. The physiological roots were being cared for, but psychological and sociological needs were ignored. She believed this caused a loss of identity and social and psychological demise. The freehand picture of the tree she drew had solid roots and trunk, but the tree looked sickly, with wilting leaves and branches. Mrs. McIver implemented a holistic model of care that she aptly called the Priory Method of Restorative Care. (The name of the facility was St. Mary's Priory.) She changed the name "patient" to "resident." The program was successful, and the residents improved, causing her to revise the drawing of the tree several times as nursing programs evolved.

Mrs. McIver envisioned a healthy tree that was nourished by holistic programs, which were interdisciplinary approaches to care. The second drawing of a tree was upright and much more healthy in appearance. It had numerous roots. Each main root was labeled with the various types of human needs, such as psychological, sociological, spiritual, and physiological. Smaller branches of each root listed subcategories and methods of meeting the basic human needs, such as worship, meaningful activities, communication, sensory stimulation, love, praise, hygiene, grooming, adequate rest and sleep, and many others.

As the various approaches of care met with success, the tree was revised. Mrs. McIver believed that restorative care consisted of four fundamental elements that were necessary to nourish each person:

- Strengthening the body
- Strengthening the ego

- Humanizing the environment (which, at the time, was very clinical)
- Creating a living community (versus the model of care at the time, which was entering the nursing home to die)

The revised tree was healthy-looking and had four large roots, each labeled with one of the elements listed above. The residents were highly involved in community life, decision-making, self-care to the extent they were able, and helping others. However, Mrs. McIver continued to improve the program, implementing new approaches to care. The final tree was identical to the tree listing the elements of care noted above. When this tree was developed, a philosophy of care had been written. The tree and its roots were surrounded by a circle in which the principles that guided the nursing infrastructure were added. These were:

- Innovative roles
- Change
- Hotel service orientation
- Policymaking in a new world

This revolutionary nurse deserves much of the credit for the restorative nursing care being used today. At the same time, facilities in New York, Arizona, and Illinois were implementing restorative care programs, but the Priory seems to have had a much more complete vision and was well supported in implementing this new method of care. For a much more comprehensive explanation of the Priory Method and pictures of the trees, see Mantle and Funke-Furber's *The Forgotten Revolution: The Priory Method*, published by Trafford Publishing (www.trafford.com) in 2003.

Independence

The dictionary defines “independent” as “not subject to control by others, not requiring or relying on someone else (as for care or livelihood).”⁸ Independence is a relative term that might be better described as being “self-sufficient,” because we all depend on others for some things. Independence involves moving about and caring for oneself. It is also a state of mind. In this context, it involves being free to do what we want, when we want, within the confines of personal ethics and the law. Independence is intangible, and most people take it for granted. However, loss of independence is palpable. When this occurs, independence is tangible, and the loss is tremendous.

Loss of independence

Approximately 96% of long-term care facility residents need help with bathing. About 87% need help with dressing and grooming. Another 46% require assistance with eating, and 63% require toileting assistance. Almost 74% require help with bed-to-chair transfers, and about the same percentage have walking difficulties.⁹

People lose independence by degrees as they age, but trauma can cause a sudden, immediate loss of independence. Rebounding from a major physical loss is difficult and frustrating for the resident and caregiver. Many do not make a full recovery and must adjust activities and routines to disability. Because we live in a culture that values independence, learning new methods of doing familiar tasks is extremely difficult and frustrating. Being completely dependent is even more frustrating, but for an unfortunate few, it will be their reality for the rest of their lives. If a nurse loses independence, his or her caregiver mentality usually interferes with the ability to accept care graciously, causing feelings of grief and shame.

Loss of independence is associated with many complications, such as falls, injuries, reduced mobility, skin breakdown, and contractures. Newly disabled residents may be ashamed to call for help. Some are in denial about their abilities and continually create safety risks. Some will try using mind over matter to cause their bodies to respond the way they did previously. When they fail, the frustration is overwhelming.

The value of independence

As healthcare providers, we try to be empathetic and understand the residents' feelings. We sometimes forget the complexity of disability and the total impact on the residents' lives. At face value, we think that a resident with severely arthritic knees can shave, brush his teeth, and do his own AM care. However, his knees prevent him from standing at the sink, and if he sits, he cannot see in the mirror. As restorative nurses, our job is to find a solution to the problem and maintain his independence. Residents expect us to ease their pain, which may be physical and/or emotional. Understanding how tangible independence is, along with the dynamics of loss, pain, and grief experienced when rebounding from a major loss, will enhance your insight into the needs of the residents. You will understand why some residents take risks. Their obstacles are physical, mental, emotional, and psychosocial. Restorative nursing personnel must touch all aspects of the individual resident, including:

- Feelings
- Thoughts
- Lifestyle
- Physical condition
- Hopes, dreams, and future plans

The grieving process

All major losses trigger the grieving process. Residents and their loved ones will grieve because of disability, loss of independence, and facility admission. They are not always gracious about it. Staff members may label residents as “difficult,” “trying,” and “uncooperative” when, in fact, the residents are grieving. If you find yourself in this situation, the social worker or social service designee may be able to assist in developing a restorative plan of care. In any event, consider where your residents are in the grieving process when planning care. The stages of grieving, summarized in Figure 1.1, affect rehabilitation and safety.

Figure 1.1

Grieving Associated with Loss of Independence

Stage	Resident response	Nursing response
Denial	<ul style="list-style-type: none"> • Refusing to accept inability to perform routine tasks • Poor safety judgment • Refusing to ask for help • Refusing to accept an unfavorable prognosis or permanent disability 	Reflect and paraphrase the resident's comments; avoid confirming or denying an unfavorable prognosis. Example: <i>“My daughter said she will sell my house to pay my bill, but I will improve soon and return home.” “It must be very difficult for you. You have been through a lot.”</i>
Anger	<ul style="list-style-type: none"> • Taking risks because of anger • Feelings of loss of control over body, environment, routines • Not wanting to accept help • Anxiety, fear of the unknown • Frequent use of call signal for minor requests • Refusing care • Lashing out at caregivers and family members 	Try to identify and understand the source of the anger. Provide empathy, understanding, and support. Use active listening skills. Anticipate needs, give the resident choices and as much control as possible, and try to meet reasonable needs and demands quickly. Example: <i>“This food is terrible—not fit to eat.” “Let me see if I can find something that would appeal to you more.”</i>

Figure 1.1

Grieving Associated with Loss of Independence (cont.)

Stage	Resident response	Nursing response
Bargaining	<ul style="list-style-type: none"> • Anxiety, fear of the unknown persists • Worrying about how to complete unfinished business from prior to disability • Making deals with the higher power for return of function in return for good deeds 	<p>Meet the resident's requests, if possible. Use active listening skills.</p> <p>Example: <i>"If God will spare me this, I'll go to church every week." "Would you like a visit from your pastor?"</i></p>
Depression	<ul style="list-style-type: none"> • Profound sadness over leaving home, belongings, loved ones, pets • Taking risks because of apathy • Feeling as if it is not worth it, too difficult to rebound • Feeling as if regaining independence is far too difficult; there is no point in trying • May neglect hygiene and appearance • Giving up, wanting to die, refusing restorative and rehabilitative care • Worry about bills and other responsibilities 	<p>Avoid clichés that minimize or dismiss the resident's condition or depression ("It could be worse—you could be in pain, have lost your mind, etc."). Be caring and supportive. Avoid false hope. Let the resident know that it is all right to be depressed.</p> <p>Example: <i>"There is no point in trying." "I understand you are feeling sad and depressed."</i></p>
Acceptance	<ul style="list-style-type: none"> • More cooperative • Willing to try • Realizes the disability is permanent, wishes things were different 	<p>Avoid assuming that the resident has accepted the condition and no longer needs emotional support. Acknowledge that the resident may be afraid of what the future holds. Use active listening. Be supportive and caring.</p> <p>Example: <i>"I feel so alone." "I am here with you. Would you like to talk?"</i></p>

Promoting independence

Promoting independence is part of restorative care that has physical and psychological benefits. Completing part of a task is better for the resident (although this may take a long time), even if you must finish it. Residents with physical dependence are psychologically independent when allowed to make choices and decisions that set the care routine. Encourage the resident to tell you what he or she wants. Being independent makes the resident feel useful and worthwhile and maintains his or her ability to perform the skill. The effect of personal independence on the residents' self-esteem is worth the investment of your time.

Restorative Nursing Care and the OBRA 1987 Legislation

A solid understanding of the purpose and philosophy of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) is essential to understanding restorative nursing. An OBRA legislation is enacted each year. OBRA 1987 caused many changes and reforms in long-term care facilities. The legislation was phased in gradually and was implemented in the early 1990s. It has been revised in the past two decades, but the spirit and intent of the original legislation are still intact. The law required facilities to change the way they provide care. Facilities must:

- View residents as complex individuals with many strengths and needs. All of these affect their lives to a greater or lesser degree. Strengths and needs can be physical, mental, social, financial, or spiritual.
- Identify and act on risk factors to prevent deterioration and functional declines. Some, but not all, keys to identifying risk factors are built into the Minimum Data Set (MDS), which was also introduced as a result of OBRA 1987.
- Promote independence and assist residents to be as independent as possible. Independent residents are believed to have higher self-esteem than dependent

residents. Residents who are physically dependent can demonstrate psychological independence by verbally directing their care. Cognitively impaired residents should be as independent as possible. Encourage them to be involved in care, facility life, and decision-making. Maintaining the residents' remaining abilities and preventing declines is a major focus.

The restorative program teaches, encourages, and enables residents to practice daily living skills and improve overall function. Sometimes residents are working on skills lost due to disease or injury, but in some situations, they are learning a new way to perform the skill. The caregiver teaches the resident new ways of adapting the body to a change of function, taking the problems related to injury or illness into consideration. We consider the whole person, including psychosocial and personal problems that may affect residents' self-care abilities. Limitations and strengths are considered and used to promote the best clinical outcome. This is holistic care at its finest. The practice and repetition cement the information into the brain and body.

Restorative nursing care:

- Is a philosophy of care, not a task.
- Is affected by the residents' culture and our overall culture of independence.
- Is a nursing program, ordered by nurses. Therapists are consultants only; they do not write nursing orders.
- Restores or helps compensate for lost skills.
- Helps meet residents' psychosocial needs.
- Reduces or eliminates risk factors.
- Improves the quality of care.

- Improves the quality of life. Quality is whatever the residents perceive it to be.
- Eliminates restraints, catheters, and many negative factors of care.
- Is given in a homelike environment.
- Has tangible and intangible benefits to residents and staff members.
- Is based on the holistic nursing model of care.

Risk Factors

Risk factors are conditions that suggest potential problems may develop, causing the potential for a resident's health to worsen. Nurses are expected to identify risk factors through various methods, such as common sense, written risk assessments, considering past history, and using the MDS. Typically, the combination of physical findings and medical diagnoses alerts nursing personnel to the need for a preventive care plan. Once identified, nursing action is required.

The presence of one or more risk factors does not equal inevitability. Once the risk of complications is known, nursing personnel plan care to reduce or eliminate the risk, thus preventing the complication and promoting a positive outcome. For the most part, this is done through the written care plan. Planning, implementing, and evaluating a resident's response to preventive care is a core nursing function that is essential to positive outcomes. The care plan is a communication tool that keeps all workers on the same page. Without it, the best intentions are doomed to failure.

Declines

Under the OBRA 1987 rules, declines are not permitted unless they are medically unavoidable. If the resident has a chronic disease or degenerative condition, the

facility is expected to slow and delay the deterioration as much as possible. Documentation must support unavailability of the decline and chronicle nursing actions to prevent or slow the decline. Surveyors usually will not accept physician progress notes stating a problem is unavoidable. Additional proof and care plan changes are almost always necessary. Some conditions are so routine that staff members may not identify them or recognize them as deterioration. Examples of common declines that may not be properly identified as declines are:

- Pressure ulcers
- Hip fractures, skin tears, and other injuries
- Incontinence
- Using a wheelchair if the resident was previously ambulatory

Some declines are obvious immediately, such as skin tears and injuries. However, many are subtle, developing gradually over a long period of time. Recognizing that these problems represent declines and taking prompt, aggressive action to reverse them is essential.

Declines are avoidable when:

- Assessment or interventions are inadequate
- There is no ongoing loop of reassessment and care plan revision (unless reasonable options were previously attempted)

Declines are unavoidable when:

- They are a consequence of the natural progression of the underlying disease and appropriate (maximal) interventions have not altered the course. (This assumes interventions are documented.)

- The causes of decline (e.g., medications or acute medical conditions) cannot be identified or there is a refusal of care despite efforts to counsel and offer alternatives.

Assessing/evaluating decline

Surveyors will take these steps when evaluating declines. The restorative nurse should consider these questions:

- What was the resident's baseline status?
- What is the natural history or progression of the diagnosis, injury, or underlying medical problem?
- What risk factors are contributing to or may have contributed to decline?
- What assessments have been done?
- Are they adequate and appropriate?
- Has an appropriate care plan, including measurable objectives, been developed?
- Have the resident, responsible party, and nursing assistant staff members had input in the care plan?
- If a care plan has proven to be ineffective, has a revised plan been implemented?
- In the event of an alert resident who is refusing care, have teaching, counseling, and alternatives been offered?
- Has depression been considered?
- Have outcomes been followed and interventions revised accordingly?

What Is Restorative Care?

Remember that residents do not live in our facility, we work in their home. Perform the task with the resident, not for the resident.

The personnel in each facility work as a team to benefit the residents. The expression “*It takes a village to raise a child*” is a metaphor that also applies to long-term care. The expertise of a team of professionals and paraprofessionals representing many disciplines is needed to care for each resident. Team members must have frequent, precise communication and follow the chain of command. A care plan lists guidelines to ensure consistency. Documentation must also be concise and accurate. Each resident’s care plan and documentation should validate the steps used in the nursing process.

The *RAI User’s Manual* states, “Rehabilitative or restorative care refers to nursing interventions that promote the resident’s ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.”¹⁰

“Do no harm” is an old maxim in healthcare. Allowing residents to develop pressure ulcers, contractures, and other declines is doing significant harm. It also constitutes negligence and malpractice. Providing restorative nursing care is part of what we do, who we are, and what makes us nurses and nursing assistants.

The American Nurses’ Association states, “Nursing encompasses the prevention of illness, the alleviation of suffering, and the protection, promotion, and restoration of health. Nurses act to change aspects that detract from health and well-being. Individuals who become nurses are expected not only to adhere to the ideals and moral norms of the profession, but also to embrace them as a part of what it means to be a nurse.”¹¹

In long-term care, this also applies to our nursing assistant staff. We depend on our skilled, paraprofessional nursing assistants to provide the bulk of the restorative care to the residents. For additional information on the restorative philosophy of care, refer to Chapter 4.

Difference Between Restorative Nursing and Therapy

Restorative nursing and rehabilitation therapy are distinct services. They complement each other and do not compete. Restorative programs ensure that the residents retain the skills they worked on in therapy. For residents in active therapy, a companion restorative program cements their learning and enables them to practice the skills on the nursing unit. Restorative nursing programs call on other disciplines to consult, advise, and cooperate, but the nursing department is responsible for planning, implementing, managing, directing, overseeing, and evaluating the total program of restorative nursing care. A comparison of nursing and therapy programs is listed in Figure 1.2. A list of similarities between the two are listed in Figure 1.3.

Figure 1.2

Comparison of Rehabilitative and Restorative Nursing

Rehabilitative	Restorative
<ul style="list-style-type: none"> • Skilled service provided by licensed therapists and their assistants 	<ul style="list-style-type: none"> • Planned, implemented, and supervised by nursing personnel with assistants from other departments, if relevant to the nature of the program • May use services of others outside the nursing department
<ul style="list-style-type: none"> • Based on the medical model 	<ul style="list-style-type: none"> • Based on the nursing model • Frequently based on risk factor identification • Licensed and unlicensed personnel provide services; unlicensed personnel primary caregivers
<ul style="list-style-type: none"> • Planned and implemented by therapists and approved (ordered) by the physician 	<ul style="list-style-type: none"> • Does not require a physician order, unless required by state law or payer of service • Orders are written by a nurse; therapists are consultants who should not write nursing orders
<ul style="list-style-type: none"> • Assessed weekly, monthly, or whenever there is improvement or decline 	<ul style="list-style-type: none"> • Assessed monthly, quarterly, or whenever there is improvement or decline
<ul style="list-style-type: none"> • Progress reviewed and summarized at least weekly 	<ul style="list-style-type: none"> • Progress reviewed and summarized at least monthly
<ul style="list-style-type: none"> • Aggressive and intensive service • Scheduled 1–4 hours a day, 5–7 days a week 	<ul style="list-style-type: none"> • Slow pace • Not scheduled unless working on a time-specific skill; given 24 hours a day, whenever needed • Must be given for at least 15 minutes daily
<ul style="list-style-type: none"> • Resident should have a rehabilitation potential of fair or better, depending on service 	<ul style="list-style-type: none"> • Rehabilitation potential not a consideration
<ul style="list-style-type: none"> • Resident must make rapid, significant progress to remain in the skilled program 	<ul style="list-style-type: none"> • Goal is to maintain; improvement is desirable, but not necessary • Progress not required; maintaining current level of function is an acceptable goal • Can be an ongoing or continuing process • Goals are to maximize and prolong abilities

Figure 1.2

Comparison of Rehabilitative and Restorative Nursing (cont.)

Rehabilitative	Restorative
<ul style="list-style-type: none"> • A separate and distinct service 	<ul style="list-style-type: none"> • Approaches integrated into regular nursing care and used whenever service is used or needed
<ul style="list-style-type: none"> • One goal is to improve and/or to teach safety 	<ul style="list-style-type: none"> • Safety is integrated into the larger goal
<ul style="list-style-type: none"> • Improves resident condition 	<ul style="list-style-type: none"> • Maintains the residents and prevents further deterioration
<ul style="list-style-type: none"> • Flows from acute illness or injury 	<ul style="list-style-type: none"> • Emphasizes restoring or compensating for skills lost through disuse or changes in physiology; acute changes not a requirement. Diagnosis is less of a consideration than functional needs. Residents with chronic conditions will also derive benefit.
<ul style="list-style-type: none"> • Largely task-oriented 	<ul style="list-style-type: none"> • Integrated into routine activities of daily living
<ul style="list-style-type: none"> • Emphasizes retraining, education, and learning (or relearning) of skills 	<ul style="list-style-type: none"> • Eliminates or minimizes aspects of care that may be considered degrading, such as restraints, incontinence, and feeding
<ul style="list-style-type: none"> • Must have some potential for improvement • Person may or may not progress, but does not decline • May participate even if no potential for improvement 	<ul style="list-style-type: none"> • Small steps used to attain larger goals over a prolonged period • Goals must be achieved within a finite period of time
<ul style="list-style-type: none"> • Provided in any setting, but not required 	<ul style="list-style-type: none"> • Required in long-term care; also desirable to provide in home health care, subacute care, and long-term acute care hospitals
<ul style="list-style-type: none"> • Paid by Medicare, Medicaid, private insurance 	<ul style="list-style-type: none"> • Inconsistently paid by Medicaid in some situations; usually not paid by private insurance. Qualifies for Medicare reimbursement in some situations.
<ul style="list-style-type: none"> • Provides home study, home care evaluation, and evaluates for environmental modifications if discharge to a private home is planned 	<ul style="list-style-type: none"> • Provided in the facility, but can provide programs for homemaking and self-care skills in preparation for discharge

Figure 1.3

How Rehabilitative and Restorative Nursing Are Alike

Similarities in rehabilitative and restorative nursing

- Assessment based
- Has specific objectives
- Medicare is the primary payer if certain conditions are met
- Decreases dependence, improves independence
- Assists person to attain optimum level of physical, mental, and psychosocial function in light of condition
- Holistic; considers how one weak area of function can affect the whole person
- Resident does not have to be alert, but must cooperate and have the ability to follow instructions
- Helps person adapt to limitations imposed by illness or injury
- Helps person regain lost skills or helps the person master a new way of doing skills lost due to illness or injury
- Requires initial evaluation and periodic reevaluation
- Must be verified by documentation
- Documentation must be measurable
- Safety an important factor
- Resident teaching is part of program; staff and family teaching may also be done
- Makes referrals to other departments or services
- Furnishes and teaches the use of adaptive devices and equipment, when needed
- Assists with activities of daily living
- Goal-oriented
- Person benefits from service
- Provides a necessary service, not given as an activity or to keep the person occupied
- Prevents complications
- Maintains current abilities
- Requires special documentation to enhance reimbursement and justify continuing need
- Improves self-esteem
- Improves quality of life

Long-Term Care Regulations

Long-term care facilities serve many masters. An old maxim is that “long-term care is more heavily regulated than nuclear power.” State and federal regulations represent the minimum required standards of long-term care. (Refer to Chapter 2 to review the importance of adhering to minimum standards of care.) In addition, nurses must abide by the State Nurse Practice act and rules of the state board of nursing.

Some nurses are not aware that facilities are operating under state and federal laws, and the distinctions are important. Different types of facilities meet different levels of inspection standards:

- The long-term care facility must have a state license, permitting the facility to conduct business. Because of the state license, facilities must follow the state long-term care licensing rules. These laws vary with the type of facility.
- Certification is necessary to collect money from Medicare and Medicaid programs. Although some facilities are 100% private pay, the vast majority accept residents whose care is paid for by the Medicaid and/or Medicare programs. Medicare and Medicaid are funded in whole or in part by the federal government, so the facility is also subject to federal laws. Certified facilities are required to follow the state licensure rules and federal certification rules. The rules are similar, but not identical. The subtle distinctions may cause survey deficiencies, depending on whose rules you follow and which agency is surveying the facility. When there is a difference between state and federal rules, always follow the most stringent rules.

Dignity and quality of life

Review the definitions of rehabilitation and restoration. They are almost identical. Rehabilitation services are delivered by licensed therapists to assist the residents to attain and maintain their highest potential. Restorative nursing care describes services

given by nursing staff members based on a belief in the dignity and worth of each resident as a unique individual. Care is designed to assist residents to attain and maintain the highest level of function possible in their individual situation. Restorative nursing programs value functional gain; task completion is less important. Most nurses want the best for their residents. Providing restorative nursing care is a way of giving the best.

Restorative programs represent quality nursing care practices. Think about the OBRA 1987 requirements. The surveyors are not trying to trap you. They are doing a job just like you are. They are instructed to write deficiencies for noncompliance with the law. They have certain criteria to follow when identifying deficiencies. Unfortunately, this is an area of the law that nurses might not understand. Surveyors are not consultants; they are instructed to avoid answering questions about how to comply with regulations. Understanding and implementing the principles of restorative nursing care will benefit your residents and facility. You will feel personally rewarded for your efforts when you see the improvements in your residents. Your surveys will show the difference, as well.

Immobility

Immobility causes serious complications rapidly in elderly persons. Bed rest is often the norm in an acute care facility, because it may be essential to treating medical problems. However, even in acute care hospitals, early activity and ambulation are provided whenever possible. See the CD-ROM that accompanies this book for a detailed listing of immobility complications.

Thanks to McIver and her trees, long-term care standards promote resident activity and involvement in community life. Residents are dressed in street clothes each day. Bed rest must be medically prescribed and requires a physician order. If bed rest is necessary, it is used for a limited period of time. Restorative nursing and rehabilitative care mobilize the residents as early as possible to prevent complications related to immobility.

Remember this when considering whether to leave residents in bed for prolonged periods for conditions such as pressure ulcer healing or large residents who are difficult to move. Consider all other alternatives to bed rest and endeavor to keep the resident active. Develop a care plan that provides mobility alternatives.

Because of the interdependent relationship between the systems of the human body, one weak system will eventually affect the entire organism. Avoid isolating the care of one system from the total care of the resident (e.g., leaving a resident in bed to promote integumentary system/pressure ulcer healing).

Principles of Rehabilitation and Restoration

The principles of restorative nursing care apply to all residents, regardless of whether they are in a formal restorative nursing program. They are:

- Start treatment early. Beginning restorative nursing on admission or early in the disease will improve the outcome.
- Activity strengthens and inactivity weakens. Keep residents up, active, and involved in community life. Promote and encourage independence for all residents, including those who are cognitively impaired.
- Prevent further disability and a worsening in condition. This is done by identifying risk factors and preparing a preventive care plan for high-risk conditions, such as falls, pressure ulcers, contractures, and deformities. Practice safety.
- Focus on the ability and not the disability. Stress what the resident can do. Avoid negative phrases such as, “You can’t use your right arm.” Instead, say, “You can use your left arm.” Always assess the resident before assuming the resident

cannot complete a task. This applies equally to residents who are alert and those who are cognitively impaired.

- Consider and attend to the whole person. Avoid isolating a problem from the rest of the person. Identify the resident's strengths and needs, then develop and use strengths to overcome the needs.

Goals and Objectives of Restorative Nursing

Restorative nursing care is given by nursing personnel, who may be licensed or unlicensed. It may be formal or informal. All residents will benefit from some type of restorative care, and their rehabilitation potential is not considered. Restorative nursing is given to:

- Improve the residents' conditions
- Maintain the residents and prevent further deterioration
- Complement a concurrent therapy program
- Teach and reinforce safety
- Address risk factors and reduce the risk that they will cause complications
- Prevent new or additional complications
- Help a resident adjust to new problems or limitations and/or teach the resident a new way of performing activities of daily living (ADL)
- Enhance dignity
- Improve well-being
- Improve quality of life

How it works

Consistency is essential. Using the care plan when making assignments is the best means of ensuring that staff members are aware of the restorative program and use the same approaches each time the service is needed. Some skills are specific to a certain time of day, such as men shaving in the morning. Schedule tasks for appropriate times.

Consider each resident's maximum level of function in light of his or her abilities and needs. Some residents will be independent, whereas others are dependent on staff members for most ADLs. Establish goals to assist them to their highest level, even if the task seems like a minor one, such as washing the face or hands.

Some nurses incorrectly consider restorative care a “make work” activity that increases reimbursement. Proper restorative care has proven beneficial to the residents in facilities, and many studies have validated its advantages. Restorative care is a philosophy of plain, holistic nursing care that may be provided at long-term care facilities, subacute, long-term acute care facilities, home health care, and acute care hospitals. However, to be successful, nursing administration must believe in, support, and promote restorative care. They must expect the best and make their expectations clear, then monitor to ensure restorative approaches are implemented. Nurses teach restorative nursing by example.

The Restorative Environment

Having a restorative environment is essential to the long-term care facility. The environment in long-term care facilities has been modified to care for persons with disabilities. The culture change movement of the past decade has brought additional change. However, further environmental modifications may be necessary, based on

your individual assessment of the resident. Consider safety, environmental factors that support independence, and barriers that prevent maximal function, and make modifications accordingly.

For example, will the resident be more secure and have more space if you move the bed next to the wall? If a grab bar is installed next to the bed, can the resident use it to transfer independently? Would the resident benefit from a side rail for support? As part of your evaluation of the resident, take a close look at his or her room. Ask the resident what would make his or her life easier. Many simple changes that will make the resident's life easier can be made at little or no cost to the facility.

Quality Assurance

Each facility has some type of quality improvement program. Provide audit criteria for your restorative program to the quality assurance committee and request that the program be included in the reviews. Include restorative personnel on your committee, including nursing assistants.

Use the quality assurance program to:

- Establish a system for measuring outcomes
- Determine whether residents are improving because of the program
- Determine whether staff members are accurately identifying residents who will benefit from the program
- Determine whether documentation supports and validates the care given

Keys to Success

Keys to success of restorative nursing are:

- Managerial commitment and support.
- Consistency.
- Education—direct-care staff members understand and implement the restorative philosophy for all residents.
- Continuity of care, based on an accurate, individualized care plan that is used by staff members daily. The plan is regularly evaluated and modified whenever changes occur, even if they are minor.
- A firm commitment and belief that it works.
- Motivation—maintaining your own motivation and being a cheerleader for staff members until they see results for themselves.
- Good communication.
- Teamwork.
- Ensuring that restorative nursing has a functional purpose. For example, the resident is walked to and from the dining room instead of up and down the hallway.

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