16 Rehabilitation and Restorative Care

1. Discuss rehabilitation and restorative care

When a client loses some ability to function due to an illness or injury, rehabilitation may be ordered. **Rehabilitation** is care that is managed by professionals to help restore a person to her highest possible level of functioning. It involves helping clients move from illness, disability, and dependence, toward health, ability, and independence. Rehabilitation involves all parts of the person's disability, including physical needs (e.g., eating, elimination) and psychosocial needs (e.g., independence, self-esteem). Goals of a rehabilitative program include the following:

- To help a client regain function or recover from illness
- To develop and promote a client's independence
- To allow a client to feel in control of his life
- To help a client accept or adapt to the limitations of a disability

Rehabilitation will be used for many clients, particularly those who have suffered a stroke, accident, joint replacement, or trauma.

When the goals of rehabilitation have been met, **restorative care** may be ordered. The goal of restorative care is to keep the client at the level achieved by rehabilitative services. Restorative care works to maintain a client's functioning, to improve her quality of life, and to increase independence.

Both rehabilitation and restorative care use a holistic, person-centered approach. Because home health aides spend many hours with clients, they are a very important part of the team. They play a critical role in helping clients recover and regain independence.

Rehabilitation is one of the great joys of working as a caregiver. HHAs should enjoy seeing clients progress toward independence or recovery and take pride in their contributions to clients' improving health.

2. Explain the home care rehabilitation model

Home health aides who work with clients who need rehabilitation or restorative care will be working as part of a team (Fig. 16-1). Some different members of the team and their roles are listed below.

Fig. 16-1. *A team of specialists, including doctors, nurses, physical therapists, and other kinds of therapists, helps assist clients with rehabilitation.*

The physician and nurses will establish goals of care. These include promoting independence in activities of daily living (ADLs) and restoring health to optimal condition.

The physical therapist, occupational therapist, and/or speech-language pathologist will work with the client to help restore or adapt specific abilities (Fig. 16-2). Mental health professionals such as therapists, psychologists, or other counselors may see the client to help promote attitudes of independence and acceptance. The effects of the illness or injury cannot always be reversed. Mental health professionals help people adjust to trauma and loss.

Fig. 16-2. *A physical therapist will help restore specific abilities.*

The home health aide will be in the home, carrying out instructions of the other care team members. The HHA will assist in achieving the client's goals and will also observe and report the client's progress.

3. Describe guidelines for assisting with rehabilitation and restorative care

When assisting with rehabilitation and restorative care, these guidelines are critical to clients' progress:

Guidelines: Rehabilitation and Restorative Care

- Be patient. Progress may be slow, and it will seem slower to you and your clients if you are impatient. Clients must do as much as possible for themselves. Encourage independence and self-care, regardless of how long it takes or how poorly they are able to do it. The more patient you are, the easier it will be for them to regain abilities and confidence.
- Be positive and supportive. A positive attitude can set the tone for success. Family members and clients will take cues from you as to how they should behave. If you are encouraging and positive, you help create a supportive atmosphere for rehabilitation (Fig. 16-3).

Fig. 16-3. *Being optimistic and encouraging can have a positive effect on clients and their progress.*

- Focus on small tasks and small accomplishments. For example, dressing themselves may seem like an overwhelming task to some clients. Break the task down into smaller steps. Today the goal might be putting on a shirt without buttoning it. Next week the goal could be buttoning the shirt if that seems manageable. When the client is able to put the shirt on without assistance, congratulate him on reaching this goal. Take everything one step at a time.
- Recognize that setbacks occur. Progress occurs at different rates. Sometimes a client can do something one day that he cannot do the next. Reassure clients that setbacks are normal. Focus on the things that the client can do and not on what he cannot do. However, document any decline in a client's abilities.
- Be sensitive to the client's needs. Some clients may need more encouragement than others. Some may feel embarrassed by

certain kinds of encouragement. Get to know your clients and understand what motivates them. This is part of providing person-centered care. Adapt your encouragement to fit a client's personality.

- G Encourage independence. A client's independence may help his ability to be active in the process of rehabilitation. Independence improves self-image and attitude. It also helps speed recovery.
- G Provide privacy when clients are attempting to do skills or activities of daily living. Doing this promotes dignity and maintains clients' legal rights.
- G Involve clients in their care. Clients who feel involved and valued may be more motivated to work hard in rehabilitation. Fears may be eased by including family and friends in the rehabilitation program. A team approach is inspiring.

Observing and Reporting: Restorative Care

- O/R Any increase or decrease in abilities (for example, "Yesterday Mr. Schiff used the bedside commode without assistance. Today he asked for the bedpan.")
- O/R Any change in attitude or motivation, positive or negative
- O/R Any change in general health, such as changes in skin condition, appetite, energy level, or general appearance
- O/R Signs of depression or mood changes

4. Describe how to assist with range of motion exercises

Exercise is important for improving and maintaining physical and mental health. Inactivity and immobility can result in loss of self-esteem, depression, pneumonia, urinary tract infection, constipation, blood clots, and dulling of the senses. People who are in bed for long periods of time are more likely to develop contractures (*kon-TRAK-churs*) or muscle atrophy. A **contracture** is the permanent and often painful shortening of a muscle, tendon, or ligament. It is generally caused by immobility. Contractures can result in the loss of ability. When **atrophy** occurs, the muscle wastes away, decreases in size, and becomes weak.

Range of motion (**ROM**) exercises put a particular joint through its full arc of motion. The goals of range of motion exercises are to decrease or prevent contractures or atrophy, improve strength, and increase circulation. **Active range of motion** (**AROM**) exercises are performed by a client himself, without help. The HHA's role in AROM exercises is to encourage the client. **Active assisted range of motion** (**AAROM**) exercises are performed by the client with some assistance and support from the home health aide or other caregiver. **Passive range of motion** (**PROM**) exercises are used when clients are not able to move on their own. PROM exercises are performed by caregivers, without the client's help. When assisting with PROM exercises, the HHA should support the client's joints while moving them through the range of motion.

Range of motion exercises are specific for each body area. They include the following movements (Fig. 16-4):

- **Abduction**: moving a body part away from the midline of the body
- **Adduction**: moving a body part toward the midline of the body
- **Extension**: straightening a body part
- **Flexion**: bending a body part
- **Dorsiflexion**: bending backward
- **Rotation**: turning a joint
- **Pronation**: turning downward
- **Supination**: turning upward
- **Opposition**: touching the thumb to any other finger

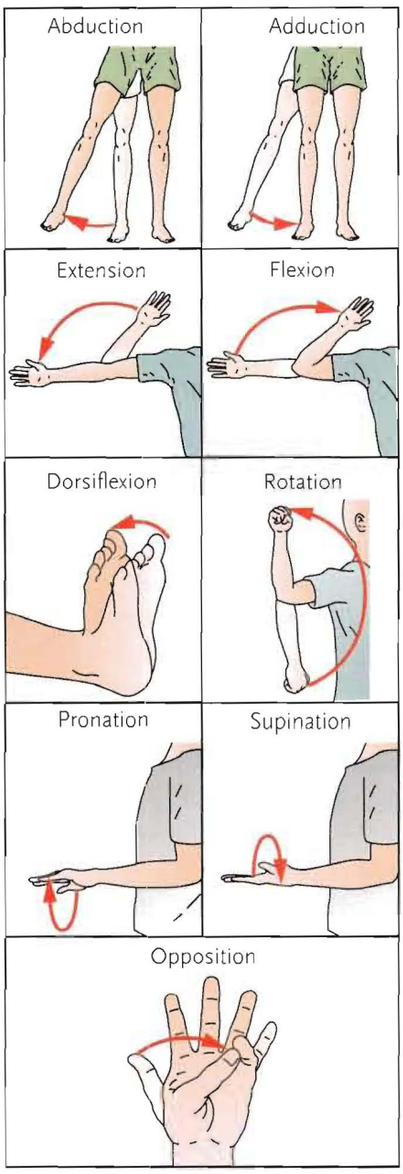

Fig. 16-4. *The different range of motion body movements.*

Range of motion exercises are not performed without a specific order from a doctor, nurse, or physical therapist. The HHA will repeat each exercise three to five times, once or twice a day, working on both sides of the body. When performing ROM exercises, the HHA should begin at the client's shoulders and work down the body. The upper extremities (arms) should be exercised before the lower extremities (legs). The HHA should give support above and below the joint. The joints should be moved gently, slowly, and smoothly through the range of motion to the point of resistance. The HHA should ask the client to let her know if the client experiences pain and should watch for nonverbal signs that the client is in pain. The HHA should also ask if the exercises are causing pain during the procedure. The HHA should stop the exercises if the client complains of pain and report the pain to the supervisor.

Assisting with passive range of motion exercises

1. Wash your hands.
2. Explain the procedure to the client, speaking clearly, slowly, and directly. Maintain face-to-face contact whenever possible.
3. Provide privacy if the client desires it.
4. If the bed is adjustable, adjust the bed to a safe level, usually waist high. If the bed is movable, lock the bed wheels.
5. Position the client lying supine—flat on her back—on the bed. Use proper alignment. Ask the client to let you know if she has any pain during the procedure.
6. While supporting the limbs, move all joints gently, slowly, and smoothly through the range of motion to the point of resistance. Repeat each exercise at least three times. Ask the client if an exercise is causing pain. Watch for signs of pain and stop performing the exercises if the client appears to be in pain or reports pain. Report to your supervisor.
7. **Shoulder**. Support the client's arm at the elbow and wrist while performing ROM for the shoulder. Place one hand under the elbow and the other hand under the wrist. Raise the straightened arm from the side position upward toward the head to ear level and return the arm down to side of the body (extension/flexion) (Fig. 16-5).

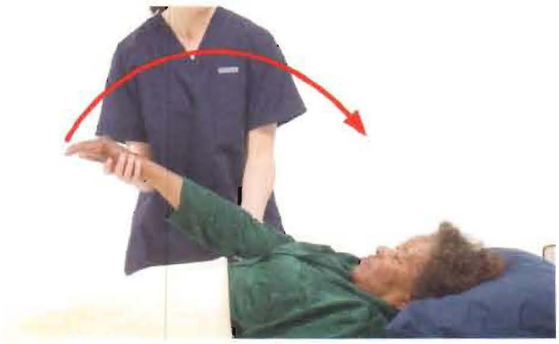

Fig. 16-5. Raise the straightened arm upward toward the head to ear level, and return it to the side of the body.

Keep one hand under the elbow and one under the wrist. Move the straightened arm away from the side of the body to the shoulder level and return the arm to the side of the body (abduction/adduction) (Fig. 16-6).

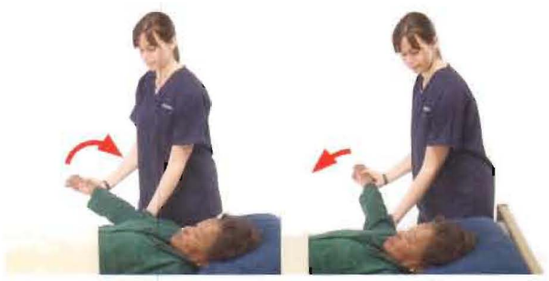

Fig. 16-6. Move the straightened arm away from the side of the body to the shoulder level and return the arm to the side.

8. **Elbow**. Hold the client's wrist with one hand and the elbow with the other hand. Bend the elbow so that the hand touches the shoulder on that same side (flexion). Straighten the arm (extension) (Fig. 16-7).

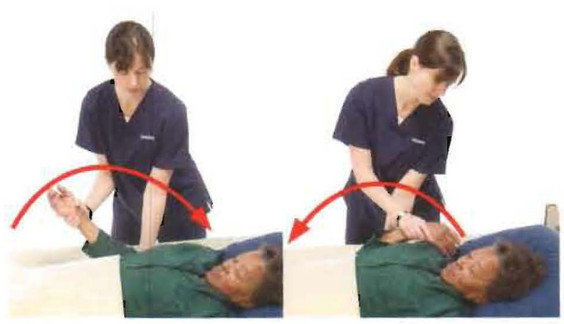

Fig. 16-7. Bend the elbow so that the hand touches the shoulder on the same side, and then straighten the arm.

Exercise the forearm by moving it so the palm is facing downward (pronation) and then the palm is facing upward (supination) (Fig. 16-8).

Fig. 16-8. Exercise the forearm so that the palm is facing downward and then upward.

9. **Wrist**. Hold the wrist with one hand and use the fingers of your other hand to move the joint through the motions. Bend the hand down (flexion). Bend the hand backward (dorsiflexion) (Fig. 16-9).

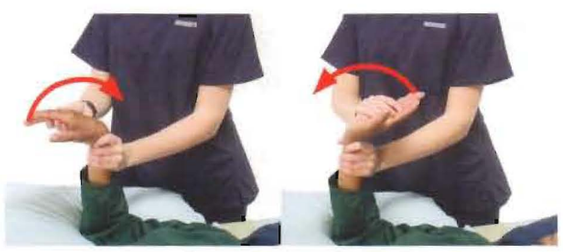

Fig. 16-9. While supporting the wrist, gently bend the hand down and then backward.

Turn the hand in the direction of the thumb (radial flexion). Then turn the hand in the direction of the little finger (ulnar flexion) (Fig. 16-10).

Fig. 16-10. Turn the hand in the direction of the thumb, then turn it in the direction of the little finger.

10. **Thumb**. Move the thumb away from the index finger (abduction). Move the thumb

back next to the index finger (adduction) (Fig. 16-11).

Fig. 16-11. *Move the thumb away from the index finger and then back to the index finger.*

Touch each fingertip with the thumb (opposition) (Fig. 16-12).

Fig. 16-12. *Touch each fingertip with the thumb.*

Bend thumb into the palm (flexion) and out to the side (extension) (Fig. 16-13).

Fig. 16-13. *Bend the thumb into the palm and then out to the side.*

11. **Fingers**. Make the fingers into a fist (flexion). Gently straighten out the fist (extension) (Fig. 16-14).

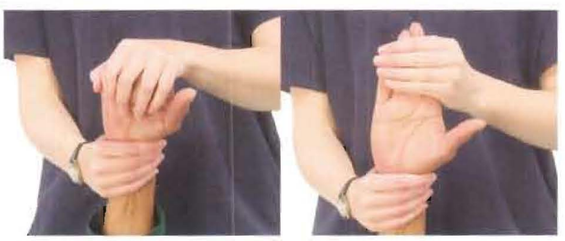

Fig. 16-14. *Make the fingers into a fist and then gently straighten out the fist.*

Spread the fingers and the thumb far apart from each other (abduction). Bring the fingers back next to each other (adduction) (Fig. 16-15).

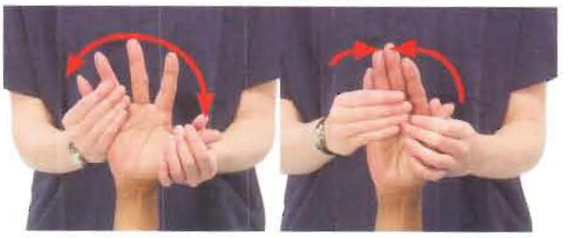

Fig. 16-15. *Spread the fingers and thumb far apart from each other and then bring them back next to each other.*

12. **Hip**. Support the leg by placing one hand under the knee and one under the ankle. Straighten the leg and gently raise it upward. Move the leg away from the other leg (abduction). Move the leg toward the other leg (adduction) (Fig. 16-16).

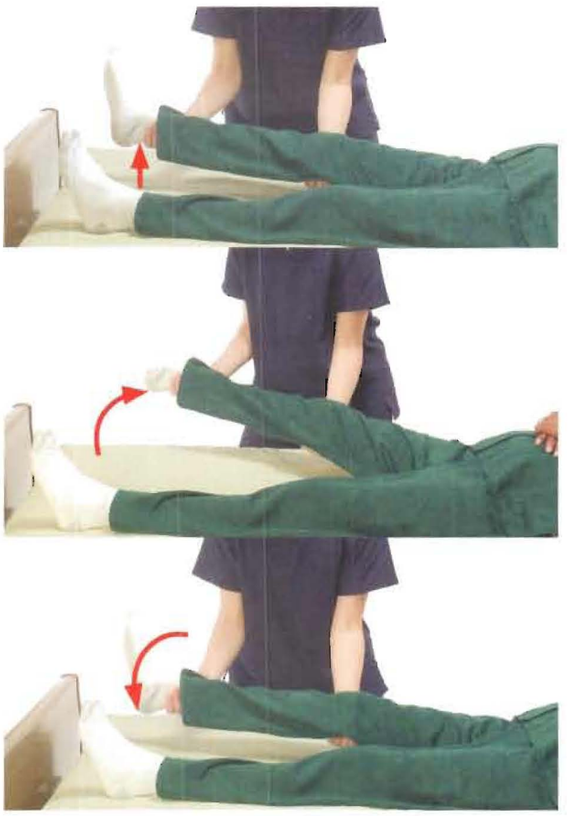

Fig. 16-16. *Straighten the leg and gently raise it. Move the leg away from the other leg and then back toward the other leg.*

Gently turn the leg inward (internal rotation), then turn the leg outward (external rotation) (Fig. 16-17).

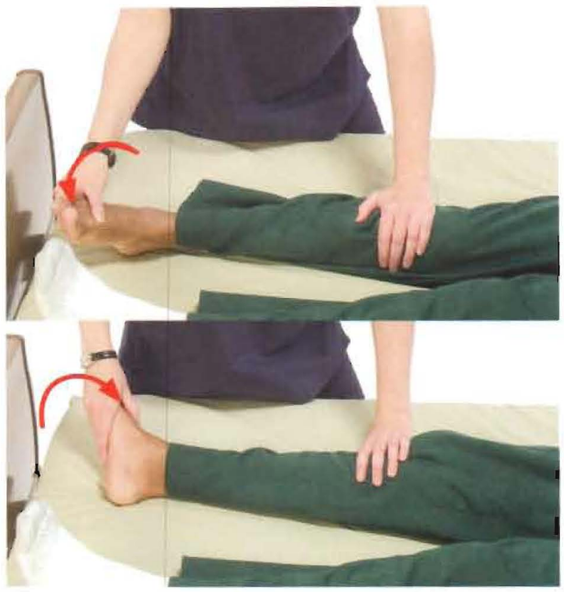

Fig. 16-17. *Gently turn the leg inward and then outward.*

13. **Knee**. Support the leg under the knee and under the ankle while performing ROM for the knee. Bend the knee to the point of resistance (flexion). Return the leg to the client's normal position (extension) (Fig. 16-18).

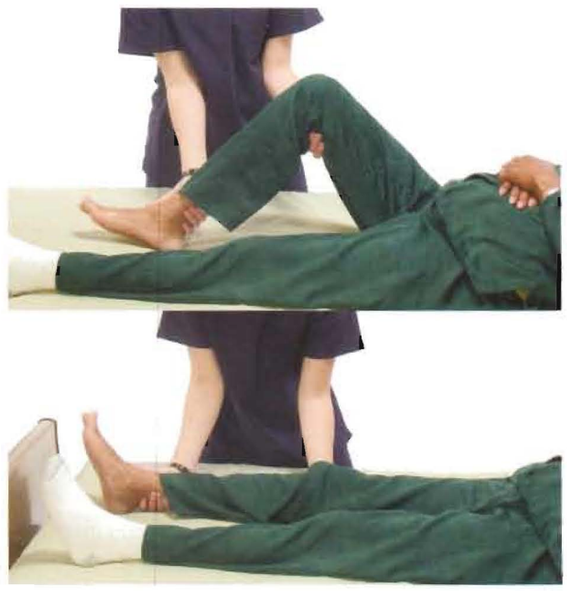

Fig. 16-18. *Gently bend the knee to the point of resistance and return the leg to its normal position.*

14. **Ankle**. Support the foot and under the ankle close to the bed while performing ROM for the ankle. Push/pull the foot up toward the head (dorsiflexion). Push/pull the foot down, with the toes pointed down (plantar flexion) (Fig. 16-19).

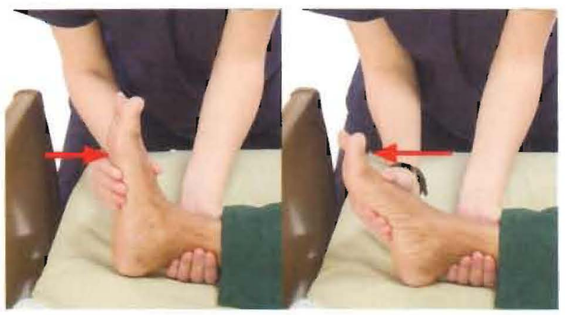

Fig. 16-19. *Push the foot up toward the head and then push it back down.*

Turn the inside of the foot inward toward the body (supination). Bend the sole of the foot so that it faces away from the body (pronation) (Fig. 16-20).

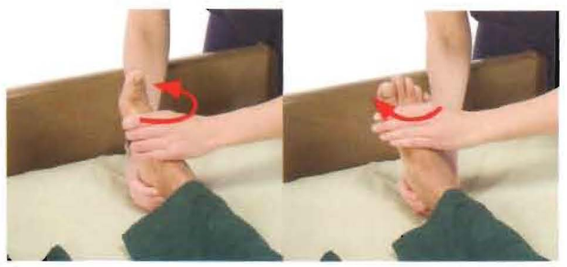

Fig. 16-20. *Turn the inside of the foot inward, toward the body, and then bend it to face away from the body.*

15. **Toes**. Curl and straighten the toes (flexion and extension) (Fig. 16-21).

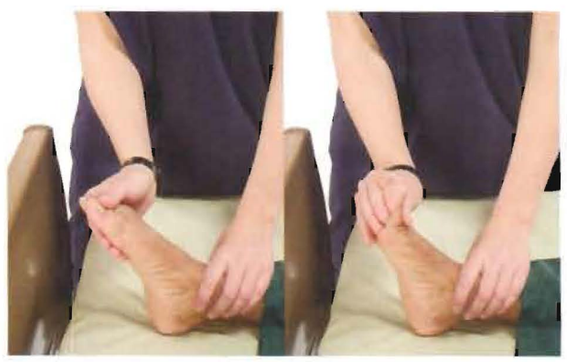

Fig. 16-21. *Curl and straighten the toes.*

Gently spread the toes apart (abduction) (Fig. 16-22).

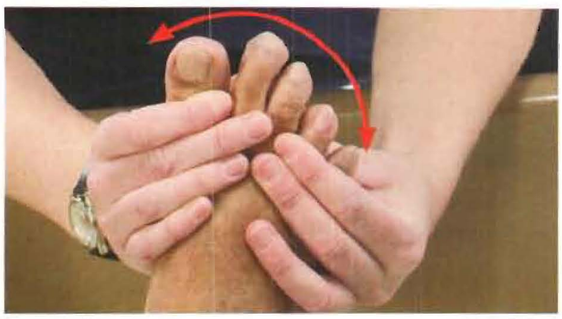

Fig. 16-22. *Gently spread the toes apart.*

16. Return the client to a comfortable resting position and cover as appropriate. If you raised an adjustable bed, be sure to return it to its lowest position.
17. Wash your hands.
18. Document the procedure. Note any decrease in range of motion or any pain experienced by the client. Notify the supervisor or the physical therapist if you find increased stiffness or physical resistance. Resistance may be a sign that a contracture is developing.

5. Explain guidelines for maintaining proper body alignment

Clients who are confined to bed need to maintain proper body alignment. This promotes recovery and prevents injury to muscles and joints. Chapter 12 includes specific instructions for positioning clients. These guidelines help clients maintain proper alignment and make progress when they are able to get out of bed:

Guidelines: Alignment and Positioning

- Observe principles of body alignment. Remember that proper alignment is based on straight lines. The spine should lie in a straight line. Pillows or rolled or folded blankets can support the small of the back and raise the knees or head in the supine position. They can support the head and one leg in the lateral position (Fig. 16-23).

Fig. 16-23. *Pillows or rolled or folded blankets help provide extra support.*

- Keep body parts in natural positions. In a natural hand position, the fingers are slightly curled. Use a rolled washcloth, gauze bandage, or a rubber ball inside the palm to support the fingers in this position. Use bed cradles to keep covers from resting on the feet if the client is in the supine position.
- Prevent external rotation of hips. When legs and hips turn outward during long periods of bed rest, hip contractures can result. A rolled blanket or towel that is tucked alongside the hip and thigh can prevent the leg from turning outward.
- Change positions frequently to prevent muscle stiffness and pressure injuries. This should be done at least every two hours. Which position the client uses will depend on the client's condition and preference. Check the client's skin every time you reposition her.
- Give backrubs as ordered for comfort and relaxation.

6. List guidelines for providing basic skin care and preventing pressure injuries

Immobility reduces the amount of blood that circulates to the skin. Clients who have restricted mobility are at an increased risk for skin deterioration and pressure injuries. Breaks in the skin can cause serious, even life-threatening, complications. It is much better to prevent skin problems and keep the skin healthy than it is to treat skin problems after they happen. In addition to the

observing and reporting information located in Chapter 9, these guidelines are important for home health aides, as well as family caregivers, to follow.

Guidelines: Basic Skin Care

- Report changes you observe in a client's skin.
- Provide regular care for skin to keep it clean and dry. Check the skin daily, even when complete baths are not given or taken every day.
- Reposition immobile clients often (at least every two hours).
- Provide frequent and thorough skin care as often as needed for clients who are incontinent. Change clothing and linens often as well.
- Do not scratch or irritate the skin in any way. Keep rough, scratchy fabrics away from the client's skin. Report to your supervisor if a client wears shoes that cause blisters or sores.
- Avoid harsh soaps or laundry detergents. Report to your supervisor if your client has these products in the home.
- Massage the skin frequently, using light, circular strokes to increase circulation. Do not massage bony areas. Do not massage a white, red, or purple area or put any pressure on it. Massage the healthy skin and tissue around the area.
- Elderly clients may have very fragile, thin skin. This makes the skin more susceptible to injury. Be gentle during transfers. Avoid pulling or tearing fragile skin.
- Clients who are overweight may have poor circulation and extra folds of skin. The skin under the folds may be difficult to clean and to keep dry. Pay careful attention to these areas and give regular skin care. Report signs of skin irritation.
- Serve clients well-balanced meals. Proper nutrition is important for keeping skin healthy. Nutrition affects the color and texture of the skin. Very thin clients may be malnourished, which puts them at risk for skin injuries and poor wound healing. Be gentle when moving and positioning them. Chapter 22 contains information about nutrition.
- Keep plastic or rubber materials from coming into contact with the client's skin. These materials prevent air from circulating, which causes the skin to sweat.
- The care plan may include instructions on giving special skin care for dry, closed wounds or other conditions. The skin may have to be washed with a special soap, or a brush may have to be used on the skin. Follow the care plan and ask your supervisor if you have any questions.

For clients who are immobile or who cannot change positions easily:

- Keep the bottom bedsheet tight and free from wrinkles and the bed free from crumbs. Keep clothing or gowns free of wrinkles, too.
- Do not pull the client across sheets during transfers or repositioning. This causes shearing, which can lead to skin breakdown, as explained in Chapter 12.
- Place an absorbent bed pad under the back and buttocks to absorb moisture or perspiration that may build up. This also protects the skin from irritating bed linens. Absorbent pads are also available for wheelchairs.
- Relieve pressure under bony prominences. Use pillows and other positioning devices to keep elbows and heels from resting on the surface of the bed (Fig. 16-24).

Fig. 16-24. *This foam boot suspends the heel to help reduce pressure.* (© MEDLINE INDUSTRIES, INC. 2020)

- A bed or chair can be made softer with flotation cushions or special foam overlays.
- Use a bed cradle to keep top sheets from rubbing the client's skin. A bed cradle is made of metal or from a cardboard box (Chapter 12).
- Clients seated in chairs or wheelchairs need to be repositioned often, too. Reposition clients at least every hour if they are in a wheelchair or chair and cannot change positions easily.

7. Describe the guidelines for caring for clients who have fractures or casts

Fractures are broken bones caused by accidents or by osteoporosis. Osteoporosis causes brittle bones that crack or break easily. Osteoporosis occurs more frequently in elderly people, particularly women. It may be due to any one or a combination of the following: a lack of calcium in the diet, the loss of estrogen, a lack of regular exercise, reduced mobility, or age. Signs and symptoms of a fracture are pain, swelling, bruising, changes in skin color at the site, and limited movement.

When bones are fractured, the sections of broken bone must be placed back into alignment so the body can heal. The body can grow new bone tissue and fuse the sections of fractured bone together. The bone must be unable to move to allow this healing to occur. This is often, although not always, accomplished by the use of a cast.

Casts are generally made of fiberglass. A fiberglass cast is lightweight and dries quickly after it is made. A cast must be completely dry before a person can bear weight on it.

Guidelines: Caring for a Client Who Has a Cast

- Elevate the extremity that is in a cast (Fig. 16-25). This helps stop swelling. Use pillows to assist with elevation. If the client is in bed, elevate the arm or leg slightly above the level of the heart.

Fig. 16-25. *To stop swelling, elevate the extremity that is in a cast.*

- Observe the affected extremity for swelling, skin discoloration, cast tightness or pressure, sores, skin that feels hot or cold, pain, burning, numbness or tingling, drainage, bleeding, or odor. Compare to the extremity that does not have a cast. Report any of these signs or symptoms to a supervisor, along with any signs of infection, such as fever or chills.
- Protect the client's skin from the rough edges of the cast. The stocking that lines the inside of the cast can be pulled up and over the edges and secured with tape. Inform your supervisor if cast edges are irritating the client's skin.
- Keep the cast dry at all times. Although fiberglass is waterproof, the padding inside the cast is not. Some fiberglass casts may have a waterproof lining, but unless instructed otherwise, keep the cast dry. Keep the cast clean.
- Do not insert or allow the client to insert anything inside the cast, even when the skin itches. Pointed or blunt objects may injure the skin, which is already dry and fragile. Skin can become infected under the cast.
- Assist the client with cane, walker, or crutches as needed (Chapter 12).
- Use bed cradles as needed to reduce pressure from bed linens.

8. List the guidelines for caring for clients who have had a hip replacement

Weakened bones make hip fractures more common. A sudden fall can result in a fractured hip that takes months to heal. Preventing falls is very important. Hip fractures can also occur because of weakened bones that fracture and then cause a fall. A hip fracture is a serious condition. The elderly heal slowly, and they are at risk for secondary illnesses and disabilities.

Most fractured hips require surgery. Total hip replacement (THR) is the surgical replacement of the head of the long bone of the leg (femur) where it joins the hip. After the surgery, the person may not be able to bear full weight on that leg while the hip heals. A physical therapist will assist after surgery. The goals of care include surgical incision healing, slowly strengthening the hip muscles, mobility and gait improvement, and increased endurance.

The client's care plan will state when the client may begin putting weight on the hip, and it will also give instructions on how much the client is able to do. The HHA should help with personal care and using assistive devices, such as walkers or canes.

Guidelines: Caring for Clients Recovering from Hip Replacements

- Keep often-used items, such as medications, phone, tissues, call signal, and water within easy reach. Avoid placing items in high places.
- Dress the affected (weaker) side first.
- Never rush the client. Use praise and encouragement often. Do this even for small tasks.
- Have the client sit to do tasks in order to save her energy.
- Follow the care plan, even if the client wants to do more than is ordered. Follow orders for weight bearing. After surgery, the doctor's order will be written as *partial weight-bearing* (*PWB*) or *non-weight-bearing* (*NWB*). **Partial weight-bearing** means the client is able to support some body weight on one or both legs. **Non-weight-bearing** means the client is unable to touch the floor or support any weight on one or both legs. Once the client can bear full weight again, the doctor's order will be written for *full weight-bearing* (*FWB*). **Full weight-bearing** means that both legs can bear 100 percent of the body weight on a step. Help as needed with cane, walker, or crutches (Chapter 12).
- Never perform ROM exercises on the operative leg unless directed by your supervisor.
- Caution the client not to sit with her legs crossed in bed or in a chair or turn her toes inward or outward. The hip cannot be bent or flexed more than 90 degrees. It cannot be turned inward or outward.
- An abduction pillow may be used for 6 to 12 weeks after surgery while the client is sleeping in bed. The abduction pillow immobilizes and positions the hips and lower extremities. The pillow is placed in between the legs. The legs are secured to the sides of the pillow using straps (Fig. 16-26). Follow instructions for application and positioning.

Fig. 16-26. *An abduction pillow is placed in between the legs to immobilize and position the hips and lower extremities.* (© MEDLINE INDUSTRIES, INC. 2020)

- G When transferring from the bed, use a pillow between the thighs to keep the legs separated. Raise the head of the bed to allow the client to move her legs over the side of the bed with the thighs still separated. Stand on the side of the unaffected hip so that the strong side leads in standing, pivoting, and sitting.
- G With chair or toilet transfers, the operative leg should be straightened. The stronger leg should stand first (with a walker or crutches) before bringing the foot of the affected leg back to the walking position.

Observing and Reporting: Hip Replacement

Report any of the following to your supervisor:

- O/R Redness, drainage, bleeding, or warmth in the incision area
- O/R An increase in pain
- O/R Numbness or tingling
- O/R Tenderness or swelling in the calf of the affected leg
- O/R Shortening and/or external rotation of affected leg
- O/R Abnormal vital signs, especially a change in temperature
- O/R Client cannot use equipment properly and safely
- O/R Client is not following doctor's orders for activity and exercise
- O/R Any problems with appetite
- O/R Any improvements, such as increased strength and improved ability to walk

A cast or traction may also be used to immobilize the hip. Traction helps to immobilize a fractured bone, relieve pressure, and lessen muscle spasms due to injury. A client in traction will require special care that will be included in the care plan. The traction assembly must never be disconnected. Careful skin care and repositioning according to the care plan are essential for all clients who are immobilized. Skin will rapidly deteriorate over pressure points. HHAs should report complaints of pain, numbness or tingling, or burning, as well as the presence of swelling, redness, bleeding, or sores.

The assignment sheet and the supervisor will explain the type of care to be provided. The HHA should only provide the care that is in the client's care plan.

9. List ways to adapt the environment for people with physical limitations

Many devices are available to assist people who are recovering from or adapting to a physical condition. Assistive equipment was first explained in Chapter 2. This equipment helps clients perform their activities of daily living. Each device is made to support a particular disability. Raised seating, for example, makes it easier for a client with weak legs to stand.

Personal care equipment includes long-handled brushes and combs. Plate guards prevent food from being pushed off the plate and make it easier to scoop food onto utensils. Reachers can help put on underwear or pants. A sock aid can pull on socks, and a long-handled shoehorn assists in putting shoes on without bending. Long-handled sponges help with bathing.

Supportive devices, such as canes, walkers, and crutches, are used to assist clients with ambulation (Chapter 12). Safety devices, such as shower chairs and transfer belts, help prevent accidents. Safety bars/grab bars are often installed in and near the tub and toilet to give the client something to hold on to while changing position.

It is important for the HHA to check for hazards that could cause weak or confused clients to trip or otherwise injure themselves. Keeping frequently used objects on low shelves may help clients avoid reaching. The items shown in Figure 16-27 can be useful as clients relearn old skills or adapt to new limitations.

Fig. 16-27. *Many assistive devices are available to help residents adapt to physical changes.* (PHOTOS COURTESY OF NORTH COAST MEDICAL, INC., WWW.NCMEDICAL.COM, 800-821-9319)

10. Identify reasons clients lose bowel or bladder control

When people cannot control the muscles of the bowels or bladder, they are said to be **incontinent** (*in-KON-ti-nent*). Incontinence can occur in clients who are confined to bed, ill, elderly, paralyzed, have urinary tract infections, or who have circulatory or nervous system diseases or injuries. Diarrhea can also cause temporary incontinence. Incontinence is not a normal part of aging.

Clients who are incontinent need reassurance, understanding, and empathy from home health aides. It is also important for HHAs to keep clients clean, dry, and free from odor. Clients will need careful skin care as well. Urine and feces are very irritating to the skin. They should be washed off completely by bathing and proper perineal care. Absorbent pads should be placed on the bed to protect the bed.

Some clients will wear disposable incontinence pads or briefs for adults. These pads keep body wastes away from the skin (Fig. 16-28). HHAs should help clients change wet briefs immediately and then give perineal care. Incontinence pads should always be referred to as briefs or pads; they should not be called diapers. Clients are not infants and that term is disrespectful.

Fig. 16-28. *A type of incontinence pad.*

11. Explain the guidelines for assisting with bowel or bladder retraining

Clients who have had a disruption in their bowel and bladder routines due to illness, injury, or inactivity may need assistance in reestablishing a regular routine and normal function. The doctor may order rectal suppositories, laxatives, stool softeners, or enemas to assist the client. The Appendix at the end of this book has more information.

Problems with elimination can be embarrassing or difficult to discuss. Home health aides should be sensitive to this and always remain professional when handling incontinence or working to reestablish routines. It is hard enough for clients to handle incontinence without having to worry about caregivers' reactions.

Guidelines: Bowel or Bladder Retraining

- Follow Standard Precautions. Wear gloves when handling body wastes.
- Explain the training schedule to the client. Follow the schedule carefully.

- Keep a record of the client's bowel and bladder habits. When you see a pattern of elimination, you can predict when the client will need a bedpan or a trip to the bathroom.
- Offer a bedpan or a trip to the bathroom or commode before beginning long procedures (Fig. 16-29).

Fig. 16-29. *Offer regular trips to the bathroom.*

- Encourage the client to drink plenty of fluids. Do this even if urinary incontinence is a problem. About 30 minutes after fluids are taken, offer a trip to the bathroom or a bedpan or urinal.
- Encourage the client to eat foods that are high in fiber, as appropriate or assigned. Encourage the client to follow special diets as ordered. Chapter 22 provides more information on diet and nutrition.
- Provide privacy for elimination, both in the bedroom and in the bathroom.
- If a client has difficulty urinating, try running water in the sink. Have her lean forward slightly to put pressure on the bladder.
- Do not rush the client during urination or bowel elimination.
- Help clients with careful perineal care. This prevents skin breakdown and promotes proper hygiene. Carefully observe for skin changes.
- Discard wastes properly according to your agency's policies.
- Discard clothing protectors and incontinence briefs properly. Double-bag these items if ordered. This stops odors from collecting.
- Keep an accurate record of urination and bowel movements. This includes episodes of incontinence.
- Offer positive words for successes or even attempts to control bladder and bowels. However, do not talk to clients as if they are children.
- Never show frustration or anger toward clients who are incontinent. The problem is out of their control. Negative reactions will only make things worse. Be kind, supportive, and professional.
- When the client is incontinent or cannot use the toilet when asked, be positive. Never make the client feel like a failure. Praise and encouragement are essential for a successful program. Remember that each client has different needs and may respond to different types of encouragement. Finding out each client's needs and preferences is part of giving person-centered care. Some clients will always be incontinent. Be patient. Offer these clients extra care and attention. Skin breakdown may lead to pressure injuries without proper care. Always report changes in skin.

12. Describe the benefits of deep breathing exercises

Deep breathing exercises help expand the lungs, clearing them of mucus and preventing infections such as pneumonia. Clients who have had surgery, such as abdominal or hip replacement surgery, or who are paralyzed are often instructed to do deep breathing exercises regularly to expand the lungs. The care plan may include using a deep breathing device called an

incentive spirometer (Fig. 16-30). Incentive spirometry helps the client to take long, slow, deep breaths.

The client may need encouragement to use this device. The home health aide should encourage the client to use the device but should not insist that he do so. If the client refuses to do the procedure, the HHA should report to her supervisor.

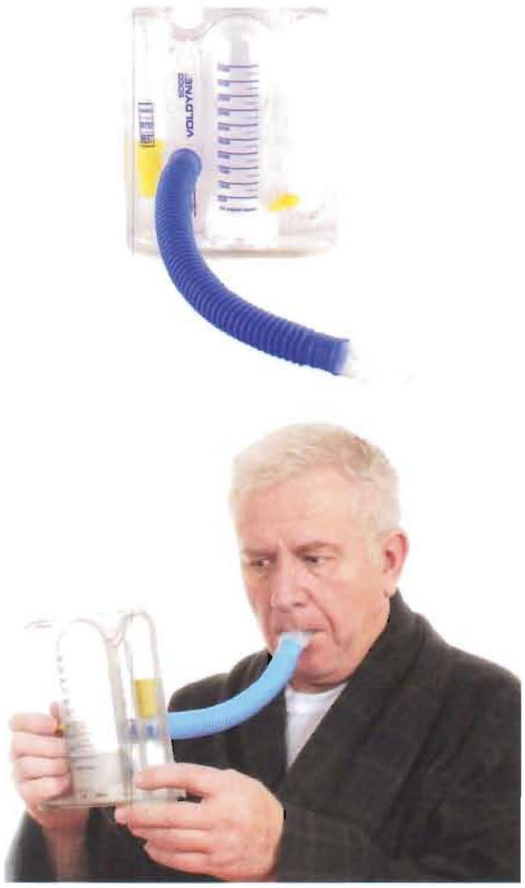

Fig. 16-30. *Incentive spirometers are used for deep breathing exercises.*

The HHA must make sure that she understands how to assist with these exercises and should ask her supervisor for instruction if needed. The following procedure is intended as general instruction only. The client should breathe slowly and steadily.

Assisting with deep breathing exercises

Equipment: emesis basin, 2 pairs of gloves, supplies for oral care, tissues, other PPE as required (such as mask, goggles, and gown)

1. Wash your hands.
2. Explain the procedure to the client. Speak clearly, slowly, and directly, maintaining face-to-face contact whenever possible.
3. Provide privacy if the client desires it.
4. Put on a gown, mask, and goggles, as indicated by Standard Precautions and the care plan. Be sure to put on an N95 mask if the client has known or suspected tuberculosis. Deep breathing exercises may stimulate the client to cough and produce mucus.
5. Put on gloves.
6. Position the client sitting upright if possible. Have him breathe in slowly and steadily, as deeply as possible through the nose. You should see the chest and then the abdomen expand and fill with air.
7. Have the client exhale through the mouth until all air is expelled.
8. Repeat this exercise five to ten times, as specified in the care plan.
9. If the client coughs or brings up mucus from the lungs during the exercise, offer the client tissues or the emesis basin to catch the mucus.
10. Dispose of the used tissues and clean and store the basin.
11. Remove gloves, goggles, gown, and mask.
12. Wash your hands.
13. Put on clean gloves.
14. Provide mouth care as desired, and help the client return to a comfortable position.

15. Remove and discard gloves.
16. Wash your hands again.
17. Document the procedure and any reactions you observe, including pain, prolonged coughing, and color or amount of mucus.

Chapter Review

1. What does rehabilitation involve?
2. In the home care rehabilitation model, who establishes the goals of care?
3. What attitude should the HHA adopt to assist clients in rehabilitation and restorative care?
4. List four things to observe and report about restorative care.
5. What is the purpose of range of motion (ROM) exercises?
6. When performing ROM exercises, where should the HHA begin? Which parts of the body should be exercised first?
7. List four guidelines an HHA should follow to help clients maintain proper alignment.
8. How often should an immobile client be repositioned?
9. How should a client's skin be massaged?
10. Why should an HHA avoid pulling the client across sheets during transfers and repositioning?
11. Why should an extremity be elevated when a person has a cast?
12. Why is a hip fracture a serious condition for an elderly person?
13. What is the difference between partial weight-bearing (PWB) and non-weight-bearing (NWB)?
14. Look at the assistive devices in Figure 16-27. Choose one and describe how it might help a client who is recovering from or adapting to a physical condition.
15. Why do clients who are incontinent need careful skin care?
16. Why should HHAs never refer to an incontinence brief as a diaper?
17. About how long after fluids are taken should the HHA offer to take a client to the bathroom?
18. Why can it be helpful to keep track of a client's bowel or bladder habits?
19. What situations may cause a client to need to do deep breathing exercises?