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A Team Approach to Dynamic Programming ON THE SPECIAL CARE UNIT

Abstract: The link between boredom, agitation, and therapeutic programming for individuals with dementia is a strong one. Research indicates that carefully planned activities can have a powerful impact on behavior, functioning, and mood of residents. Interdisciplinary staff involvement, careful assessment of residents' needs and interests, and the use of both diversional and therapeutic activities programs are examined in this article.

Some sit for hours around the nursing station with nothing to do. A few are asleep in their chairs; while others pick at clothes or furniture. Some get into altercations with others over the seating arrangement, personal items, snacks, or attention from staff. Others wander from room to room picking up shoes and clothes, distributing them elsewhere. When the commotion increases at the nursing station, all become more restless and agitated.

This is a typical scene for the nursing home special care unit (SCU). Lots of residents with little to do. Residents with dementia frequently sit for long periods of time and often end up creating their own stimulation in the absence of enough structured activities and leisure time options (Aronstein, Olsen, & Schulman, 1996). Research on behavioral disturbances in older adults with dementia can give therapists, program coordinators, and nurses some understanding and direction in regard to this problem.

Cohen-Mansfield, Werner, and Marx (1992) surveyed professional caregivers of nursing home residents with dementia and agitation to examine the link between unoccupied time and agitation. Members of the nursing staff felt that boredom triggered agitation 54.9% of the time. After this preliminary study of staff, Cohen-Mansfield and colleagues studied the relationship between agitation and boredom in a small group of agitated nursing home residents. Sixty-three percent of the time residents were unoccupied. Moreover, residents manifested greater numbers of agitated behaviors when they were unoccupied and fewer agitated

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TABLE 1

Suggested adapted recreation, leisure education, and therapeutic programs for SCUs

ADAPTED RECREATION

- Open recreation in leisure lounge or activities areas
- Adapted bowling or bocce league

- Special recreational events
- Gardening or adapted gardening
- Free-time kitchen activities (e.g., dishes, table setting and clearing, snack preparation)
- Computer games or table games
- Community recreational outings (e.g., shopping, lunch, community events)
- Pets, photography club, dancing club, or other hobbies

LEISURE EDUCATION

- Leisure education for staff and families
- Signs directing residents to activities
- Re-education of residents on "how to use" recreational items
- "Leisurely Look Newsletter" program to raise awareness of recreational opportunities and self-expression

RECREATION THERAPY

- Air mat therapy
- Exercise-to-music therapy
- Sensory integration
- Hands and feet stimulation
- Cognitive and feelings group
- Afternoon social group
- Falls prevention program
  - Morning walking group
  - Balance and strength group

Illustrations by Jon DiVenti

behaviors when involved in structured or social activities.

While most nursing home units meet the basic health and safety needs of their residents, there is a clear problem in regard to unoccupied time and quality therapeutic programs for residents with dementia. The Joint Commission (1994) states there are five areas that make SCUs different from the rest of the nursing home. First, admission to the unit is limited to residents with dementia. Second, the unit is staffed with a multidisciplinary staff who have been specially selected and trained to work with individuals with dementia. Third, the physical environment is designed for the safety and freedom of the residents. Fourth, family input is considered critical for success in planning care and decision making. Fifth, the activities provided are specifically designed for individuals with cognitive impairments.

It is this last area, the therapeutic activities, that is often the most difficult to implement and maintain. It requires a team approach, creativity, and good communication. This article will discuss a model of therapeutic programming for special care units and will address some ways to enlist the entire SCU team to attain dynamic, high-quality recreational opportunities for residents with dementia.

THE GENERIC STAFF

The concept of a generic specialized staff is not a new one. It assumes that all members of the SCU team will be cross-trained to work with residents with dementia (Maas, Swanson, & Buckwalter, 1994). Beyond this basic training, for the purposes of therapeutic programming, all staff including nursing, housekeepers, dietary staff, social workers, administrators, and rehabilitation staff need to guide the residents to opportunities for purposeful, meaningful activity. That does not mean simply bringing bored or disruptive residents into a therapeutic program that is underway. Instead, staff should be able to redirect residents to an independent activity center or engage residents in a social conversation or a diversional activity.

It also means implementing some regularly scheduled programs on the unit. One recreation therapist or activities professional alone cannot prevent the boredom and agitation of 20 to 50 residents around the clock. The entire team must be trained and responsible for residents' active involvement.

PROGRAM DESIGN PROCESS

There are two major types of activities for the SCU. The first type of activities are those deemed therapeutic, which have the intent of attaining specific goals and objec-

tives from the care plan. These activities are based on the individual resident's assessment and are led by a therapist or an activities professional. The second type are classified as diversional activities and are used to entertain, divert attention, or fill time and prevent boredom. These activities can be self-guided or led by nurse's aides, family members, or others. Both types of activities, therapeutic and diversional, are needed to maintain a high quality of life for the resident who cannot structure his or her own leisure time (Buettner & Martin, 1995).

Assessment is the first step in quality programming and should include cognitive and physical functioning as well as past leisure interests (Buettner & Martin, 1995). All activities provided must be appropriate for the age and dementia stage of the residents. The therapist should select tools to measure cognitive strengths and deficits, screen for depression, and assess strength, flexibility, and ability to move about independently. It is also important to obtain information from the residents and their families, friends, or companions regarding likes and dislikes. A leisure interest profile should then be used to examine past involvement with hobbies, games, social interests, outdoor pursuits, and cultural events.

Programs of therapeutic and diversional activities are then designed to match the residents' levels of functioning, needs, and interests. Therapeutic recreation programs fall into three major areas: adapted recreation, leisure education, and therapy (Peterson & Gunn, 1984). Examples of the three types of programs are shown in Table 1.

The therapeutic programs should fit into the unit routine or schedule of care activities already in place (Buettner & Ferrario, in press). Findings from one study of predictors of activity participation indicate that time in rehabilitation therapy or alone in one's room limits participation in recreation programs (Voelkl, Galecki, & Fries, 1996). Therefore, to enhance participation, therapeutic programming should mesh into other unit activities. For example, programs of interest to particular residents should be set up around the individual's bath or physical therapy schedule to avoid conflicts. Beyond individual schedules, each SCU has high-need times when recreation therapy sessions can be helpful. For example, early morning between rising and breakfast is often a time when falls occur (Commodore, 1995). This is an ideal time to schedule a structured walking or falls prevention program. Another high-need time is at change of shift. A program that takes the residents away from the nursing station at that time of day is often helpful. An example of a beneficial program might be the delivery of mail and messages to residents at an activity center set up at the far end of the unit.

Transitions between programs are also very important and need to be

TABLE 2

File card activity ideas

- Give out mail and messages, help residents write response
- Activity walker: help residents take walks with the activity walkers
- Take residents for a walk outdoors or around the sensory trail
- Fold towels or ball socks
- Fix-it bin: give residents a bin of objects to tinker with
- Activity table cloth: spread out on a table for three to four residents to use
- Drawing or painting with supplies from expressive arts bin
- Flower arranging
- Video movie of family/friends and discussion
- Large cards or dominoes
- Sewing cards
- Hairbrushing
- Dusting or cleaning
- Application of hand lotion
- Table ball game
- Reading program
- Tic-tac-toe game
- Using exercise bands with music
- "Price is Right" game
- Dancing to 1930s or 1940s tunes
- Tether volleyball game with two to five residents
- Bowling for dollars: use fun money to play
- Give out "Simple Pleasures" items:
  - Activity purse or tackle box
  - Butterfly or fish constructed of soft material
  - Wave machine
  - Message magnet game
  - Test your strength game
  - "Squeezies" for manipulation with hands
  - Home decorating books
  - Activity vest or muff

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carefully scheduled with nursing services in mind (Buettner & Ferrario, in press). When a structured program ends, residents should not be left sitting with nothing to do. All staff should be trained to provide a recreational item of choice to the resident when completing care. For example, as the exercise-to-music therapy program ends, residents can be given a magazine or sewing card to use independently while waiting for the passing of juices and nourishments. Another example can be seen before mealtime in the dining room. Residents are often brought to the dining area and seated at tables with nothing to do until the meal is served. This is a perfect time to use sensory table cloths with lower functioning residents, to have higher functioning residents help set tables, and to provide others with individual basins and sponges for a sensory hand washing program. For staff who cannot think of an activity to set up, index card files of "things to do" can be designed and placed strategically in the dining room, nurses station, and activities center. See Table 2 for suggestions.

CONSIDERATIONS FOR THERAPEUTIC PROGRAMMING

Research has demonstrated efficacy for a specific type of therapeutic programming called neurodevelopmental sequencing (NDSP). Neuro-

TABLE 3

Leisure Lounge or Mobile Cart Materials

SIMPLE PLEASURES ITEMS
- Activity purses or briefcases
- Tackle boxes
- Wave machine
- Home decorator books
- Fabric balls
- Activity table cloth
- Activity vest
- Activity aprons
- Wall mounted activities: fishing, ring game, flower arranging, and laundry hanging

ART MATERIALS

- Nontoxic paints
- Large brushes
- Black paper and chalk
- Paper of various colors and textures
- Old greeting cards
- Yarn, ribbon, etc.
- Nontoxic clay

TABLE GAMES
- Large face cards
- Large dominoes
- Board games (no small pieces)
- Tablecloth checkers or tic-tac-toe

SPORTS
- Soft, spongy material basketball
- Putting green
- Shuffleboard
- Bocce ball game
- Horseshoes
- Tether volleyball
- Soft, spongy material football

MUSIC RESOURCES
- Portable stereo or keyboard with headphones
- Collection of music and stories on tape
- Songbooks
- Bells and drums
- Stereo system
- Piano or keyboard

EXERCISE RESOURCES
- Walking mile chart
- Exercise bands
- Weight jugs
- Ribbons
- Balloons
- Air mat

OTHER
- Magazines and books
- Catalogs
- Junk mail
- Dresser of objects to rummage through
- Remote control jeep
- Pinball

Illustrations by Jon DiVenti

developmental sequencing not only can reduce behavior problems but also improve specific areas of function (Buettner & Ferrario, in press; Buettner, Kernan, & Carroll, 1990; Buettner, Lundegren, Lago, Farrell, & Smith, 1996). This program begins by assessing the current functioning levels of the residents, along with their needs and interests. It uses principles taken from neurodevelopmental theory and sensory integration to address individuals' leisure time difficulties through a variety of sensorimotor activities (Buettner, 1994). The main goals of this program are to improve residents' strength, flexibility, ability to move about, and make leisure choices. It also has the proven benefit of significantly reducing problem behaviors.

All too often, activities programs are evaluated in terms of numbers attending. This leads to large group programs with too much stimulation and not enough individual attention for residents with dementia (Buettner, 1994) and residents who need small group activities that are based on their functioning levels (Buettner et al., 1996). The residents attending should understand the meaning of what they are doing and be able to actively participate. Just the right amount of challenge and stimulation is needed (Voelkl, 1990). If the activity is too difficult, residents will become frustrated. If it is too easy, residents may become bored and may fail to benefit. If there is too much noise or confusion, agitation may result (Hall & Buckwalter, 1987). The activity leader must understand it is the active involvement of the residents that is important, not the finished product (Buettner & Martin, 1995).

The main thrust of therapeutic programming should be to help residents maintain or improve functioning (Buettner & Martin, 1995). Therapeutic programs can also take on a wellness or preventive component, such as preventing falls (Buettner & Waitkavicz, in press). Therapeutic programs should provide activities that will keep residents walking, talking, and eating independently. Programs to enhance balance, strength, flexibility, use of upper extremities, and self-expression are critical to maintaining the older adults' hierarchy of skills (Kemp & Mitchell, 1992). Such therapeutic programs should be sensorimotor in nature with opportunities for free movement, simple choices, and expression of feelings (Buettner, 1994). Residents should be reassessed every 10 to 12 weeks, and programs must be constantly adjusted to meet their needs.

Therapeutic programs should provide activities that will keep residents walking, talking, and eating independently.

CONSIDERATIONS FOR DIVERSIONAL PROGRAMMING

Preliminary research has demonstrated that diversional recreational interventions are useful in diffusing agitation and reducing boredom of nursing home residents with dementia (Aronstein et al., 1996). Those residents who are not scheduled for a small group therapeutic recreation program also need things to do. To meet these residents' needs, safe recreational items that are appropriate for age and dementia stage should be set up and available at various locations throughout the unit. If space is available, SCU staff and families might set up a leisure lounge stocked with interesting independent activities (see Table 3 for suggestions). A mobile leisure cart is also recommended for residents who prefer to stay in their rooms (Buettner & Martin, 1995; Voelkl et al., 1996). Some residents enjoy pushing the cart around the unit and providing recreational items to others (Buettner & Greenstein, 1996).

A diversional activities program called "Simple Pleasures" is currently being studied in three nursing home SCUs in upstate New York (Buettner & Greenstein, 1996). This program involved designing 30 inexpensive, easy-to-make recreational items for individuals with dementia. After pilot testing the items for safety and resident preferences, plans and patterns have been developed for each of the items so families and nursing home and community volunteers can fabricate the items for the residents. Each item has a simple "how-to-use" handout available for staff and visitors in a large notebook on the unit. The ultimate goal is to have a myriad of easy-to-make and easy-to-use sensorimotor interventions available to residents, staff, and families.

In addition to the availability of diversional recreational items, staff training is vital. All staff members should understand that it is important to assist residents to the activity centers located throughout the unit and set up the activity on the schedule. For example, after breakfast, lunch, and dinner, residents can be guided to small activity centers set up at the end of hallways to listen to a story on tape, a public radio broadcast, or a classical music concert. Others might take part in a tethered volleyball game in the leisure lounge. Another small group might receive a

TABLE 4

Sample Program Schedule

6:00 a.m. to 8:00 a.m.	CNA: Bathing 1 or Dressing and Grooming Program (resident rooms) RT: Morning Walking Groups and Falls Prevention (hallways to dining room) Nursing: Morning Hydration and Health Assessment (dining room)
8:00 a.m. to 9:00 a.m.	Breakfast Groups (dining room) RT: Pancake cooking group Nursing and CNA: Cultured diners group (dining/eating group) Nursing and CNA: Finger foods group/assisted diners group
9:00 a.m. to 9:30 a.m.	CNA: Continence program 1 CNA, SW: Housekeepers: Assist residents to activities centers, set up activities
9:30 a.m. to 10:00 a.m.	RT: Exercise-to-music therapy Public radio show Activity Center 1 Volunteer pet care Activity Center 2 CNA: Nails and hair Activity Center 3
10:00 a.m. to 10:30 a.m.	CNA: Continence Program 2 CNA: Bathing 2 Nourishment (juices and finger food snacks) pass
10:30 a.m. to 11:30 a.m.	RT: Air mat therapy program for exercise Nursing: Dancing and music in activity room Volunteers: Simple Pleasures items at Activity Centers 1 to 3
11:30 a.m. to 12:00 NOON	Pre-lunch activities in dining room CNA: Sensory table cloths group Activity Director: Table setting group COTA from rehabilitation department: Sensory hand washing group
12:00 NOON to 1:00 p.m.	CNA and Nursing: Lunch program Outdoor cafe dining group (weather permitting) Finger food picnic group
1:00 p.m. to 1:30 p.m.	CNA: Continence Program 3 Housekeeper, SW, ADON: Assist residents to activity centers, set up activities
1:30 p.m. to 2:30 p.m.	Volunteer Activity Aides: Adapted bowling league RT and Nursing: "Leisurely Look Newsletter" group Afternoon rest time
2:30 p.m. to 3:00 p.m.	Nourishment and juices RT and COTA: Snack group (prepare your own afternoon snack) CNA/Families: Outdoor walks or walk-the-dog program
3:00 p.m. to 4:00 p.m.	Volunteers and RT: Mail and messages group Visiting musician program
4:00 p.m. to 4:30 p.m.	CNA: Continence Program 4 Leisure lounge recreation of choice with after school volunteers/families Feelings group at Activity Center 2 Resident piano playing Activity Center 3
4:30 p.m. to 5:15 p.m.	Pre-dinner programming in dining room RT "Price is Right" cognitive game CNA: Sensory table cloths COTA: Sensory hand washing
5:30 p.m. to 6:30 p.m.	Dinner groups
6:30 p.m. to 9:00 p.m.	Family and friend activities programs CNA: Rolling bedtime preparation CNA: Bath time 3

CNA = certified nursing aide; RT = recreation therapist; COTA = certified occupational therapy aide; SW = social worker; ADON = assistant director of nursing.

visit from a volunteer musician or interact with pets. Higher functioning residents often enjoy taking charge of these programs at the various activities centers. A large, daily activities schedule of residents' names for the various programs should be posted in the dining room and near the nurses' station so all staff know where residents should go. This also helps when residents voice the concern, "I don't know what to do." Staff have options listed and readily available.

In both types of programs, therapeutic and diversional, consistency with flexibility must be maintained. If the residents need reduced stimulation, the staff must adjust the program with that goal in mind.

Programs should not be canceled for staff convenience. It would be equivalent to skipping a medication pass if the nursing staff had something else to do. Above all else, communication between the nurse manager and the recreation therapist is critical. A constant relay of information about resident health issues, appointments, and other concerns leads to the most suitable program opportunities.

DAILY SCHEDULE AND MONTHLY THEMES

The daily schedule is an integrated, multidisciplinary effort, which incorporates all staff and resident activities. This type of schedule is much different than the typical nursing home monthly activities calendar, in that individual residents are scheduled on a daily basis for specific programs based on individual needs and interests. A sample schedule is included in Table 4.

Themes are also used to add meaning and seasonal orientation to programs and activities. The theme should last anywhere from a week to a month and generally focuses on local community events or holidays. The theme is discussed in each regular program, it is the highlight of the unit newsletter, arts and crafts are developed around it, and a special event is planned as the culmination. Examples of some fun and successful program themes include: "Looking for Love in All the Wrong Places" to culminate with a Valentine's Day Ball (February), "When Irish Eyes are Smiling" to culminate with a St. Patrick's Day Auction (March), "Back to Nature" to culminate with an outdoor visit with farm animals, hayrides, and a strawberry social (July). The special events are an excellent way to involve families, staff, and community groups. They give the regular programs special meaning and create an atmosphere of fun and diversity.

OUTCOMES AND CONCLUSION

Research on recreation therapy as an intervention for individuals with dementia is just beginning. Several researchers in recent years have found that structured activities significantly reduce boredom, agitation, and other behavior problems (Aronstein et al., 1996; Buettner et al., 1996; Buettner & Martin, 1995; Rabinovich & Cohen-Mansfield, 1991). Other studies have demonstrated a reduction in falls (Buettner et al., 1990; Buettner & Waikavicz, in press), less noise and stress-related agitation, and less depression (Buettner & Ferrario, in press). Rovner, Steele, Shmuely, and Folstein (1996) also found that residents involved in a structured program of activities designed specifically for individuals with dementia were more likely to participate in activities, less likely to be restrained, and far less likely to need psychotropic medications.

It appears that the benefits of structured therapeutic and diversional activities programs are many. Each resident with dementia has a unique set of needs and interests and deserves the chance to live an active meaningful lifestyle free of sedation and restraints. This type of programming is hard work, especially at the start. It requires hiring qualified professional staff, constant education for paraprofessional staff, and interdisciplinary planning and communication. The rewards, however, are well worth the effort.

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KEYPOINTS

DYNAMIC PROGRAMMING

Buettner, L.L. **A Team Approach to Dynamic Programming on the Special Care Unit.** *Journal of Gerontological Nursing*, 1998, 24(1), 23-30.

1. The link between boredom and agitation is a strong one. The greatest numbers of agitated behaviors occur when residents with dementia are unoccupied.

2. Carefully planned activities can have a powerful impact on behaviors, mood, and overall functioning of SCU residents. Therapeutic activities have the intent of attaining specific objectives from the care plan. Diversional activities are used to entertain, divert attention, fill time, and prevent boredom. Both types of activities are needed on the SCU.

3. After assessing residents' needs and interests, establishing an interdisciplinary program of diversional and therapeutic activities will add structure and improve quality of life for those who live and work on the SCU.

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Communication Strategies in Dementia

Simplify the MESSAGE

1. Short words.
2. Simple sentences ("Sit in the chair"); not compound or complex ("Sit in the chair and put on your socks").
3. No pronouns (it, that, they, them, she, he, here, there); only nouns (chair, dress, bathroom).
4. Begin each conversation (particularly at night) by identifying yourself and calling the person by name.

Simplify Your Speech STYLE

1. Speak slowly.
2. Say individual words clearly.
3. If you increase your speech volume, lower the tone; raise the volume only for deafness, not because you don't get a response you understand.
4. If you ask a question, wait for a response.
5. Ask only one question at a time.
6. If you repeat a question, repeat it exactly.
7. Use self-included humor whenever possible.

Use NONVERBAL Communication Effectively

General Principles

1. Think carefully about your facial expression, body position, and hand gestures. What are YOU communicating?
2. Convince yourself that your nonverbal style can be felt all the way across the room and by several people, not just the resident or staff person you are addressing.
3. Deliver every verbal communication with proper nonverbal gestures.

Specific Strategies

1. Stand in front of the person.
2. Maintain eye contact.

3. Move slowly.

4. If the person starts or continues to walk while you are talking to them, do not try to stop them as your first move. Instead, keep moving along in front of them and keep trying.

5. Use overemphasis and exaggerated facial expressions to emphasize your point, particularly if vision or hearing is impaired.

General Guidelines

1. Listen actively. If you don't understand, say you don't understand and ask them to repeat the statement. If the person becomes more upset, offer your best guess about what the problem is. If you receive a "no," try another guess but monitor their level of frustration.

2. If you have not really "gotten anywhere" in five minutes or more, you will probably do better to leave and either return in five minutes or have a colleague try. When possible, have another staff member watch you interact with a resident, make suggestions, and perhaps trade off with you.

3. Assume they know what they need. If the resident refuses to participate in an activity assume that there is a reason (they have become sad, angry, frustrated, embarrassed, anxious about their condition). Your first job is to check it out – not just ask something vague like, "Are you okay?" Get specific: "Are you uncomfortable? hurt? angry? sad?" (whatever).

4. Be sure to share all words, phrases, and techniques that work for a particular person and a particular situation (write it in the care plan). Use each other's techniques. Compare notes on successes and failures.

5. When encouraging participation in activities, use the following guideline: If you push the person too hard, they may have a catastrophic reaction. Do you have the time to manage a problem if one occurs? How hard you push should be determined by how much time you can afford to spend resolving problems.

6. Finally, if you say you are going to do something, DO IT. If you forget, find the person and apologize. Assuming that the person has forgotten the episode insults both your intelligence and theirs.

7. If you need to stop a resident-resident interchange, do it firmly and quickly, get them out of each other's territory, wait five minutes, and then return and explain to each one why you acted as you did. Use factual explanations, not "guilt trips."

Source: Smith, M. & Buckwalter, K. (2005). *When You Forget that You Forgot: Understanding and Managing Alzheimer's Type Dementia, Part 2.* Available at https://nursing.uiowa.edu/sites/default/files/documents/csomay/5%20-%20Dementia%20Overiew%20P2%20Support%20Materials.pdf