

DELIVERING DIGNITY: SECURING DIGNITY IN CARE FOR OLDER PEOPLE
IN HOSPITALS AND CARE HOMES (cont'd)

The Key Role of Senior Staff

Senior staff should lead by example so everyone understands the expected care standards. Processes should be in place to:

- Empower them to determine the right staff numbers (with the right skills) on duty, ensuring adequate support in emergencies;
- Be accountable for care standards, continuity, dignity, etc., and the steps needed to achieve these goals;
- Discuss clients' and caregivers' feedback daily and promptly respond to them; and
- Make it part of a routine (e.g., between shift changes or formal sessions) for staff to reflect on their care provision and ways to improve it (see "Schwartz round").

The Responsibilities of Boards and Senior Management

Dignified care requires strong and committed leadership that delivers a coherent approach to dignity at every level and in every part of the organisation. The Board and Senior Management should:

- Invest time and resources to identify strategies for delivering high-quality care;
- Put in place robust processes to collate feedback so emerging risks can be identified and responded to;
- Begin meetings with a client's story and the lessons learnt to encourage a person-centred outlook;
- Interact with clients and their caregivers to understand ground realities; and
- Keep clients' needs in mind (especially those with dementia or disability) when refurbishing, redesigning or procuring medical furnishings and equipment.

Building a Caring Community in Care Homes

Task-oriented approaches should be changed into person-centred activities (e.g., turn bathing and dressing

routines from tasks to be completed quickly into a time for residents to choose their clothes and prepare for the day).

Care homes should:

- Develop individualised care plans: This identifies the client's wishes, preferences, priorities and addresses the support required to maintain their sense of dignity and personal identity (see "Six Senses" framework);
- Create care environments with communal areas so clients can socialise, enjoy hobbies, welcome and offer hospitality to visitors;
- Make homes a part of the wider community by fostering links with schools, religious bodies, volunteer groups, etc.; and
- Invest in technology to improve quality of care and support clients in leading active, independent lives (e.g., help clients keep in touch with loved ones through *Skype*, etc.).

Listening to Older People, their Families and Carers

Loved ones provide clients with vital emotional support and can offer staff invaluable knowledge about the client. Provide training for staff so that they are better able to work with clients' loved ones:

- Consider how best to manage visiting hours so as to engage families;
- Ensure issues raised after working hours are logged and followed up promptly when not immediately resolved;
- Approach clients' loved ones as partners in care (e.g., to provide company and help at mealtimes), not as a nuisance or interference;
- Recognise the right for clients and their families to choose, as far as is practicable, where the client passes away and how their end-of-life care is managed; and
- All staff should have an understanding of end-of-life care (see "Gold Standards Framework" for End-of-Life Care).

**WII-FIT FOR IMPROVING GAIT
AND BALANCE IN AN ASSISTED
LIVING FACILITY:
A Pilot Study**

Journal of Aging Research, Volume 2012 (March 2012) by **Kalpna P. Padala; Prasad R. Padala; Timothy R. Malloy; Jenenne A. Geske; Patricia M. Dubbert; Richard A. Dennis; Kimberly K. Garner; Melinda M. Bopp; William J. Burke** and **Dennis H. Sullivan** (Accessed: 1 October 2012)

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Falls are common for persons living with Alzheimer's dementia (AD) and can lead to significant morbidity and mortality. Poor balance and gait abnormalities, such as shortened step length, increased stride length variability and decreased gait speed

seen in AD are risk factors for falls. Persons living with AD have a threefold increase in falls compared to cognitively intact older persons, causing fractures, hospitalisation and increased rate of institutionalisation. Exercise interventions improve gait and

WII-FIT FOR IMPROVING GAIT AND BALANCE IN AN ASSISTED LIVING FACILITY: A PILOT STUDY (cont'd)

balance, with even low-intensity exercises found to be useful in improving deconditioned elders.

This research article elaborates on a pilot study conducted in the United States to determine and compare the effects on balance and gait of a Wii-Fit (Nintendo gaming console) programme, compared to a walking programme on subjects living with mild AD in an assisted living facility. Results demonstrate the safety and efficacy of the Wii-Fit programme and also showed its use resulted in significant improvements in balance and gait, comparable to those in the monitored walking programme. However, it is noted that results need to be confirmed in a larger, methodologically sound study.

Methods

- Subjects: 22 residents living in an assisted living facility aged 60 years and older with a history of mild AD along with a Mini Mental State Examination (MMSE) score ≥ 18 were divided into two equal groups and assigned to either the Wii-Fit or the walking group, subjects using canes/walkers were included.
- Subjects were randomised. Both groups participated in the exercise activity for 30 minutes daily, resting when they felt overly exhausted, five times a week for eight weeks.
- Exclusions: Individuals with myocardial infarction, transient ischaemic attack or stroke in the previous six months, serious mental illness which impacted memory, active cancer diagnosis with the exception of skin cancer, poor prognosis for survival, severe sensory or musculoskeletal impairments, or requiring a wheelchair for ambulation.
- Outcome measures: The primary outcome measure of the programmes was the Berg Balance Scale (BBS) – a valid and reliable measure used to assess balance impairments in the elderly. The Tinetti Test (TT) and the Timed Up and Go (TUG), which measure the ability to perform specific tasks and functional mobility respectively, were also used. Functional ability, quality of life and cognition were measured as secondary outcomes.

The Wii-Fit Intervention Group

- A Wii-Fit console was connected to the television in the exercise area.
- The walk to and from the exercise area constituted warm-up and cool-down for the programme.
- Residents performed three components of exercises (10 minutes each) including yoga (e.g., half-moon, warrior pose, chair and sun salutation), strength training (e.g., single leg

extensions, lunges and torso twists) and balance exercises (e.g., soccer heading, ski slalom, ski jump, table tilt, balance bubble and penguin slide).

- Wii-Fit activities involving aerobic exercises were not recommended as some subjects used assistive devices.
- Exercises were carried out one-on-one with assistance from research personnel.

The Walking Intervention Group

- The walk to and from the exercise area constituted warm-up and cool-down for the programme.
- Residents walked indoors in groups of three or four, at their own pace, accompanied by research personnel.

Results, Discussion and Conclusions

- With intervention, the mean BBS score improved in both groups.
- For the Wii-Fit group, the mean BBS continued to improve after the fourth week while the score for the walking group plateaued.
- Study shows the feasibility of using Wii-Fit in an assisted living environment for persons with mild AD who have a baseline BBS of less than 45 (high risk for falls).
- The Wii-Fit programme was as effective as the robust monitored walking programme in leading to significant improvements in balance, gait and physical performance in persons living with mild AD.
- As Wii-Fit exercises are enjoyable, easily accessible and not limited by the availability of safe walking places, it may result in greater adherence as it is more socially engaging and entertaining.
- For the walking programme, having participants walk together as a group with research personnel helped increase compliance.

Limitations

- Results need to be confirmed in a larger, more methodologically sound study. In addition, results would be more suitable for clinical practice if the intervention groups were led by peers/family or the exercises done independently.
- Study is only applicable to those with mild dementia (MMSE ≥ 18) and those who are ambulant or ambulating with a walking aid.
- Other limitations include the small sample size, inclusion of the BBS as the primary outcome measure, nonblinded assessors, lack of usual care control group and failure to strictly control the intensity of exercises in each group.

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