

# Past Roles, Present Solutions

BY KAREN RUSSELL, REGIONAL DIRECTOR

At the Loyalhanna Care Center in Latrobe, Pennsylvania, a certain resident's past role has come to play an important part in his current plan of care. Mr. P is a pleasant gentleman with Lewy Body Dementia.<sup>1</sup> This diagnosis carries with it the potential for recurrent visual hallucinations, parkinsonism, falls, syncope and REM sleep disorders. His behaviors have been quite challenging at times, especially when they escalate in the late afternoons and evenings. The staff is acutely aware of his high risk for falls during these episodes and they have tried many different interventions to help reduce the behaviors and his risk of falling and injury. It is common practice for long-term care providers to consider past interests like gardening, painting, or knitting as potential interventions to help redirect a resident demonstrating challenging behaviors. At times though, it is difficult to develop new ideas that are meaningful and individualized. In Mr. P's case, conversation with his family and a review of his past roles helped the staff to come up with a unique intervention that proved remarkably successful.

For many years Mr. P had been the executive director of a local YMCA where he also taught swimming to children. His family had commented to staff on how much joy and satisfaction these experiences had brought him during his lifetime. He loved the water and often swam at the end of the day before heading home from work. Staff members mentioned that they often observed Mr. P moving his arms in a swimming motion when he was propelling his wheelchair or when walking with staff.

Based on his past routine of swimming in the evenings, and his overall enjoyment of the water, the facility changed his bath time from the morning to the evening. It was observed that Mr. P seemed calmer when offered a chance to be in the water. His reaction to the whirlpool baths encouraged the facility to make this part of his routine evening care. An order was obtained to offer him a whirlpool EVERY evening. In the whirlpool tub he had the opportunity to splash his arms around and kick with his legs in "swimming" motions. Other than the staff getting wet, the outcomes were positive. The soothing effect of the water provided a relaxing outlet for him before bedtime. This contributed to a safer sleep environment for him because he was less restless. In addition, the administrator reported that in the first eleven days of initiating the evening "swims," the facility decreased its prn psychotropic drug use with Mr. P by more than 40%.

For the time being, it appears that the staff at Loyalhanna have provided an intervention that not only helps to decrease behavior issues, but more importantly provides comfort and meaning to this resident. And, the experience of finding a good individualized intervention to help Mr. P has encouraged the staff to think about those they care for in new ways.

<sup>1</sup> Lewy Body Dementia (LBD) is characterized by distinct cognitive impairment with fluctuating confusion, disturbance of consciousness, visual hallucinations, delusion, falls, and significant parkinsonism. The illness is associated with protein deposits called Lewy bodies found in the cortex of the brain. It is similar to Alzheimer's disease, but symptoms are typically different on close examination, with different signs found in the brain after death. LBD is the second most frequent cause of hospitalization for dementia, after Alzheimer's disease. (See [www.psychejam.com/lewy\\_body\\_dementia.htm](http://www.psychejam.com/lewy_body_dementia.htm).)

## IN THIS ISSUE:

PA FIRST Training Program	2
Carpe Diem for Assessment	3
Improving Care Fall Prevention	5
Keeping Restraints Off	7
PARRI's 10th Entrapment Program	8
News Notes Upcoming Events	10
	11

PLEASE ROUTE OR COPY:  DON  RNs/LPNs  Social Service  RNAC  
 CNAs  Activities  Rehab  Staff Dev  Dietary  NHA  Adm  
 Other \_\_\_\_\_  Other \_\_\_\_\_  Other \_\_\_\_\_

# PA FIRST<sup>1</sup> Training Program Brings Providers Together to Discuss Fall Management

**A**s part of the PA FIRST initiative, a two-hour program was offered by the fall management team at Jefferson Manor Health Center in Brookville, Pennsylvania on June 14. The Jefferson Manor staff started the presentation with a review of their physical restraint elimination process and the subsequent development of a strong fall management program. They also shared information on changes to fall management policy/procedure, refined assessment tools, new communication sheets, and fall risk assessments for front line staff. Participants spoke highly of two case studies that were shared, and enjoyed a facility tour that included observation of alternative seating options in the therapy suite and a visit to the new sensory lounge that is used

for residents exhibiting challenging behaviors. They closed the day with a question and answer session. One participant commented, "The program will help us recognize that this does not happen overnight, it has to be a long thoughtful process. It was a good way to reinforce the knowledge that we are on the right track." A big thank you to Jefferson Manor for their commitment to assisting local providers with fall management and prevention.

<sup>1</sup> FIRST is an acronym for **F**all Interventions, **R**esources, **S**ystems, and **T**raining. The PA FIRST project has been designed to address the increased need of Pennsylvania long-term care providers to develop a more comprehensive fall management and prevention system and protocol.



*Participants at Jefferson Manor's fall management training session, June 14, 2005.*

## Did you know?

**DID YOU KNOW** that the Pennsylvania Restraint Reduction Initiative (PARRI) is a grant-funded project available as a resource to all long term care facilities in Pennsylvania as they work to improve care and to create a higher quality of life for their residents? The nature of the team's work ranges from facilitating staff educational programs to working with interdisciplinary teams. If requested, PARRI will assess residents who may be falling frequently, who are physically restrained, or who exhibit increasingly challenging behaviors. Do not hesitate contacting any member of the training team for assistance.

- Neil Beresin, Regional Director, 215-844-6139 or [nberesin@kcorp.kendal.org](mailto:nberesin@kcorp.kendal.org) (eastern region)
  - Janet Davis, Regional Director, 610-932-8002 or [jdavis@kcorp.kendal.org](mailto:jdavis@kcorp.kendal.org) (central region)
  - Karen Russell, Regional Director, 814-375-6011 or [krussell@kcorp.kendal.org](mailto:krussell@kcorp.kendal.org) (western region)
  - Sara Wright, Geriatric Nurse Practitioner, 610-683-5839 or [swright@kcorp.kendal.org](mailto:swright@kcorp.kendal.org)
  - Mary Scharf, Project Coordinator, 610-388-5580 or [mscharf@kcorp.kendal.org](mailto:mscharf@kcorp.kendal.org)
- All requests for program information or educational material should be sent to Mary.

# CARPE DIEM for Assessment

BY SARA WRIGHT, GERIATRIC NURSE PRACTITIONER

I visit many facilities through my work with the Pennsylvania Restraint Reduction Initiative. These visits have confirmed that there are more commonalities between skilled nursing facilities than there are differences, especially with reference to the residents living there. On a daily basis, staff are required to meet the needs of frail older residents, dependent in more than one area of “activities of daily living,” and having multiple treatments, multiple medications, and varying levels of cognitive ability. The most often-cited resource for meeting the basic care and assistance needs of frail older persons appears to be in limited supply. Blamed repeatedly as THE obstacle that prevents the grand talent, knowledge, and creativity of providers from emerging, it is uttered like an oath and blamed for a multitude of evils. This resource is TIME.

Recently I was asked to review a particular resident who was demonstrating behaviors that were resulting in undesirable outcomes and to determine contributing factors that may have been predisposing the resident to the behaviors. When the interdisciplinary meeting started, there were only 15 minutes available to review the resident. As it happened, the fifteen minutes were not uninterrupted. Time was spent in greeting staff and exchanging pleasantries, and more time was spent looking for chart parts and various documentation. Within 300 seconds (five minutes), three potential contributing factors were identified for which interventions could be formulated to attempt to minimize difficult behavior. Another 120 seconds revealed two additional factors that warranted further consideration. Essentially, about seven minutes (420 seconds) were needed to identify elements that may have been having an impact on this resident’s behavior, but there wasn’t enough time. Comments citing TIME as an insurmountable barrier to initiating assessment reviews for potential contributing factors to problematic behaviors and developing individualized interventions may be a mistaken notion.

It is not my intent to portray myself as a time management expert. Rather, experience as a charge nurse, director of nursing, and nurse practitioner has taught me that time must be protected and its use carefully planned and focused, as is true for any precious and limited resource. This can be a challenge when one is proficient with multi-tasking, a survival technique health care providers carefully cultivate. Perhaps the time spent attempting to juggle many tasks simultaneously obscures the need that some challenges require: that a *small* measure of time, well focused on particular details, may prove to have a more far-reaching effect on clinical outcomes. Following are some additional suggestions that may be helpful in striking a balance between the multiple tasks and responsibilities imposed upon us.

“Discovery consists of seeing what everybody has seen and thinking what nobody has thought.”

Albert von Szent-Gyorgyi  
US. Biochemist

→ **Develop a resident-centered approach to problem solving.**

A chronic condition, such as diabetes, will produce a much longer list of potential care plan problems than focusing on *how* diabetes has affected Mrs. Doe, for example.

→ **Be clear and specific when defining or stating a problem.**

Falls are clearly a problem. However, appropriate interventions can best be developed for *specific* fall risk factors such as *lower extremity weakness* or *reduced ambulatory endurance secondary to Chronic Obstructive Pulmonary Disease (COPD) predisposing to falls*. Being specific is especially crucial when defining troublesome behaviors. Descriptions such as *physical restlessness: inability to sit still in wheelchair* give better insight into a behavior and lend to better direction as to where to focus the assessment.

continued on page 4

### →Zero in on objective data for assessment to avoid “assumption.”

During a fall team review meeting it was reported that a resident “slipped in tub room.” Several minutes were spent devising care interventions aimed at preventing future “slipping” events in the tub room. However, the staff member actually present during the incident disputed the use of the word “slip.” Upon further questioning with the staff member, it was *objectively* determined that the resident’s “legs seemed to grow weak and he was gently lowered to the floor.” It is human nature to *assume* a fall in a tub room was likely an event of slipping, but *assessment* allowed this fall team to initiate more appropriate care interventions to get to the root cause(s) of this episode of weakness.

### →Go to the source.

To collect assessment data efficiently, seek out those intimately involved in the resident’s daily care. A charge nurse will be able to report the last time a bowel movement was recorded. However, it is the direct caregiver who will be able to report that the resident is not requesting to use the toilet as frequently or seems to be spending more time straining to have a bowel movement than usual. The same holds true for almost any situation such as transferring, eating, or dressing. For rehabilitation progress, seek out the therapist along with the assigned CNA or restorative staff.

### →Think “function” with every assessment question or query.

A resident was recently admitted to a nursing facility following hospitalization for multiple unstable chronic conditions and throughout the initial days of admission, was found on the floor in various locations within the facility and without sustaining any injuries. Staff and family determined that the resident’s usual mode of “ambulation” was to crawl, a *functional adaptation* that developed during a past history of a lower extremity ulcer that made weight bearing painful. Although the ulcer was well healed, the resident still reverted to crawling and self-transferring by kneeling. Pairing a resident-centered *functional* approach to assessments completed by nursing, therapy, and social service staff may help frame the general questions used during an admission process to yield more specific findings, i.e., “Describe how Mr. T usually gets around the house or in and out of bed.”

### →Mind those medicines!

Administration of the seemingly endless pills present within the nursing home population is the *easy* but time consuming part. Being knowledgeable about all their effects, either intended or *unintended*, is most important in the long run. Simply taking the moment required to look up a drug profile or to recognize that a resident receiving an anti-coagulant is at a higher risk for more severe injury should a fall or an innocent bump occur could go a long way towards initiating preventative interventions. When medications are prescribed for behavioral or psychiatric reasons, it is important to recognize the effects these drugs have on other organ systems *in addition* to the central nervous system effects. Such recognition can alert staff to be observant for signs and symptoms of orthostatic blood pressure changes or changes in bowel habits and to plan accordingly to prevent falls or troublesome “sentinel events” that can lead to survey woes. Additionally, it only takes moments to determine if any recent changes have occurred in a resident’s medication regimen, or if laboratory studies and drug level reports are current.

As caregivers, we have continuous access to the vast amount of assessment information that is collected every shift, on every resident. Taking a few well-focused moments to look at a particular challenge may result in a solution easily hidden within such a wealth of information. **Seize those moments!**

# Improving Care through Fall Prevention: One Provider's Story

BY CATHY REESE, ASSISTANT DIRECTOR OF NURSING  
HOLY FAMILY MANOR, BETHLEHEM, PA

Over the past year, the nursing staff at Holy Family Manor has managed to reduce the number of falls by 25% while using fewer physical restraints despite an increased resident turnover. The biggest single factor contributing to a decrease in falls during this time was the *holistic* approach that was taken with each resident. We felt that our nursing care practices have significantly improved as a result of our new approach.

Our new approach began to take root in January 2001 through the work we did with the Pennsylvania Restraint Reduction Initiative (PARRI) training team. It was at this time that we embarked on an intensive two-year process to significantly reduce the number of physical restraints and side rails in the facility. While going through this process we had many “light bulb” moments that helped staff gain new perspectives on how we typically deliver care and respond to our residents. I can honestly say that it was during the process of restraint reduction that I developed a more holistic approach to assessing the resident, and I soon came to understand the interconnectedness of symptoms, behaviors, falls, and our staff's response to them. The following example may help highlight what I'm referring to.

If an aphasic resident has pain (A) that s/he cannot express easily, this pain may often effect behavior (B), which may cause them to become restless (C). We have observed that the resident's restlessness (C) may lead him/her to attempt to stand independently (D) which consequently may result in a fall (E). The sequence of A leading to B leading to C, etc., was often missed. Through the restraint reduction process, we developed that sequential approach and recognized that if our staff consistently addressed the initial pain with administration of an analgesic or another pain relieving intervention, we were more likely to prevent a fall by increasing our resident's comfort than by using a restraint. Our previous approach to such a situation would most likely have included interventions with psychotropic medications or physical restraints. Such a one-dimensional approach assumed the resident's restlessness was due to dementia and didn't consider precipitating factors. The restraint reduction process taught us to search for the potential causes of the problem and direct our interventions towards those factors, rather than just treating the problem. We rarely ever do this now, and if we do, we're better at catching ourselves and re-directing care.

Other contributing factors that have led to our facility's success in decreasing the number of falls include designating a specific person to be the Safety Coordinator. This person not

only evaluates all falls but serves as a contact/support resource for the safety committee, assisting them with implementation of interventions to prevent resident falls. As Safety Coordinator, I have come to realize the benefits of including all staff when developing ideas to prevent falls. This has provided an informal educational opportunity, has helped staff recognize that they play an important role in fall prevention, and has increased their focus on safety. Most importantly, they have been empowered to put their own ideas into action.

The process has caught on. In contrast to last year when I received very few calls from the staff regarding safety issues, I now receive calls often. Typical requests include evaluating a resident “because she is more confused and restless and I'm not sure what to do,” as well as calls reporting staff interventions such as initiating a bed sensor on a resident because s/he attempted to get out of bed unassisted. One staff member, without involving me, ordered a non-skid mat to be placed in front of an automatic chair-lift recliner because the resident using it was slipping at times while getting up. In another instance, a resident with Alzheimer's disease seemed to frequently become agitated whenever she toileted and when care was performed in the bathroom. She went into an agitated state after PM care, attempted to hit the caregiver, lost her balance and fell. During investigation and interview of the aide, the aide reported that she believed that the cabinet mirror on the wall opposite the toilet was upsetting the resident. The nursing assistant explained how the resident looked at the mirror continuously and became more and more upset as time went on. It was as if the resident did not recognize herself in the mirror and thought that there was someone else in the room. Since this incident, we have placed an attractive picture on top of the mirror and the nursing assistant has been performing care at the resident's bedside. The resident appears to be calmer and has, at times, even assisted with her care—something she had never done in the past. It is these actions initiated by direct care staff that have had a significant impact on our fall prevention program.

The tracking of when falls most commonly occur, and the analysis of the trends that appear has helped us to zero in on areas that need increased attention. For instance, we noticed a particular unit was having a significant number of falls on the evening shift, and we immediately organized a group activity during this time. This group activity has dramatically reduced our number of falls in this area.

We have also found that the sooner our staff can put a plan

continued on page 6

into action, the safer residents will be in the long run, so we are quick to develop “immediate need” care plan interventions. Finally, administrative support has enabled us to purchase some equipment and accessories such as low beds, defined perimeter mattress covers, different kinds of chairs and floor mats, and wheelchair anti-rollback devices for those situations where there has been an identified need.

Following is a list of some of the key assessment questions and potential interventions which we have found to be helpful in promoting our fall prevention work.

❖ **Seating.** Does the resident look comfortable in his/her chair? Is his/her body in good alignment? Have the resident’s falls been from the chair?

*Potential interventions:* An occupational therapist screen/evaluation; alter the seat height, change the angle, “drop” the seat; begin “trial” periods with different chairs such as the Rock-N-Go\* and Broda\* Pedal chairs. Historically, we have had a lot of success with these chairs due to their comfort and ease of mobility.

❖ **Environmental safety.** Is the residents room cluttered? Is there a direct path to the bathroom? Are things s/he need accessible and within reach? Are there tripping or slipping hazards within the environment?

*Potential interventions:* Keep the room clean, make sure there is a clear path to the bathroom, use non-skid flat rubber mats, keep personal belongings in reach, provide a reacher to reduce the chance that the resident will extend his/herself to retrieve things which may lead to falls.

❖ **Pain.** Is the resident complaining of pain? Is s/he showing non-verbal evidence of pain? Is restlessness, agitation, anger, or self-isolation observed? Is there a diagnosis that would indicate pain could be an issue?

*Potential interventions:* Request a trial period of routine pain medication to see if behaviors ease or decrease, look at “in and out of bed positioning.” Is the resident repeatedly trying to get up? If so, question if it is pain related and go after it.

❖ **Bowels.** Is the resident moving his/her bowels? What is the consistency of the stools? Is restlessness related to bowel movements/habits?

*Potential interventions:* Review resident’s bowel record and regimen, follow bowel training protocol, ask physician to change resident’s bowel regimen, trial bowel program.

❖ **Equipment safety.** Do the resident’s shoes provide needed support and non-skid soles? Are the rubber tips on his/her walker and/or cane in good condition? Is the commode sturdy? Are wheelchair breaks tight?

*Potential interventions:* Ask the family to provide needed

footwear, replace worn out equipment, tighten brakes on wheelchair, develop a more consistent system-wide equipment maintenance safety program.

❖ **Side rails.** Is the resident using rails (quarter, half or full) for re-positioning and/or to facilitate transfer in or out of bed independent of staff? Is s/he restless or at risk for climbing over or going through the rail opening(s)? Are frequent attempts being made to exit the bed?

*Potential interventions:* Consider using a defined perimeter cover or bolster if resident is: (a) not using rails independently, (b) at high risk for falls or entrapment, (c) confused, or (d) attempting to climb over rails. Consider using low bed with floor mats. (Floor mats have to be used with caution because they can be a tripping hazard for ambulatory residents.) Don’t forget that half- and quarter-length rails can be injurious to residents as well as full rails.

❖ **Safety awareness.** Does the resident demonstrate an awareness of safety? Does s/he rise independently? Does s/he remember to lock the wheelchair brakes? Is the call bell used by the resident for assistance?

*Potential interventions:* Develop a toileting schedule; consider a trial period with a wheelchair anti-lock brake device, if appropriate; use low-seated chairs so the resident has less of a distance to fall; consider hip pads. Never leave the resident alone in the bathroom if at risk for falls.

There are many factors which can both effect and cause falls. The key to our success has been to improve our initial screening on admission, the assessment at the time of each fall, and the timely implementation of interventions. It has been critical for us to get to the root cause for why a fall has occurred and involve the direct caregivers, observe the resident in the environment where the fall took place, and review charts in search of other problematic elements specific to that resident.

It has been gratifying to see the quality of care improve as we strengthen our fall prevention program at Holy Family Manor. We feel we have gradually improved the lives of our residents, and our staff is gaining confidence in the fall prevention process.

Cathy Reese, R.N., BSN can be reached at 610-865-5595 or by e-mail, [creese@hfmanor.com](mailto:creese@hfmanor.com).

\*PARRI and Kendal Outreach, LLC have no connection with the manufacturers or distributors of these products. The mention of the products in this article does not imply endorsement by PARRI or Kendal.

# Keeping Physical Restraints Off Our Residents: One Provider's Story

BY KAREN RUSSELL, REGIONAL DIRECTOR

The DuBois Nursing Home has been a Pennsylvania Restraint Reduction Initiative (PARRI) training site for physical restraint reduction since 1999. Recently, I spent some time at the facility to discuss what factors have contributed most significantly to their ability to successfully maintain a restraint-free status for over six years<sup>1</sup>. The staff and administration are convinced that the clarity of their mission, as well as their understanding of the need to continually educate their staff, are the cornerstones of this accomplishment.

According to Carol Smith, ADON, DuBois continuously builds on many processes put in place over the last several years. “We have a good foundation but we must constantly revisit programs in place to make sure that they are current and successful. This ensures that our residents are getting the best care possible. For example, we recently revised our *Falling Star* program because we believed it had lost some of its original impact. Hopefully, a reformatted version will see improved outcomes for the residents in the program.”

For residents and their families, the education process about their restraint-free environment begins at the time of admission or pre-admission. DuBois staff do not waiver from the message that their facility will not use physical restraints. Smith acknowledged that there have been a few unique and challenging situations in which a family requested the use of a seat belt for safety upon admission. In one situation, several conversations with the family focused on the staff's concerns about using the belt and how they would implement the care plan with reference to safety. However, the family ultimately decided on an alternative placement. For current residents, staff emphasizes that family council and care plan meetings are great opportunities to provide education regarding safe, individualized environments. Some situations require more dialogue and education than others. One-to-one meetings are held with residents and/or their families who are anxious and ambivalent about care without physical restraints. “We are happy to address the concerns of the family, and we really do understand their fears related to potential injuries. I don't think many families are aware of the multiple ways we are able to increase safety without having to use belts and trays, and we are very thorough in describing exactly what we do to facilitate safety while allowing residents freedom to move.”

The Freedom Team, an interdisciplinary team formed in 1997 whose original purpose was to review residents in physical restraints, is still active today but with a different goal. Meeting

weekly—and with no physical restraints to review—the Freedom Team now reviews falls, use of psychotropic medications, behavior management challenges, and bed and side rail safety issues, all areas historically associated with the use of physical restraints.

As for continuing the staff educational process, a monthly one hour “Safety Speech” is presented and attended by all staff. The program includes information about the restraint-free philosophy and environment. In addition, case studies are used to demonstrate how the approach to physical restraint use has changed over the years. Smith commented, “If you explain to all staff the importance of looking at the individual and the specific circumstances related to a fall, for example, and then describe what we did seven years ago and how we address it now, they begin to really get it.” Other topics covered in the Safety Speech include facility policy about responding to personal sensor alarms, the *Falling Star* fall prevention program, and the procedures for equipment repairs and maintenance. In essence, general and specific information related to the safety of all residents is consistently and continuously communicated to all staff. The message is that *everyone* who works here has an obligation to maintain resident safety.

Communication with all direct care staff to ensure that interventions are implemented on a consistent basis is facilitated through the use of a Kardex system, as well as worksheets that staff carry for their daily assignments for each resident. For more specific problems, tools and procedures have been developed to address identified needs. “A common problem for many facilities,” cited by Smith, “is the use of personal alarms not in accordance with orders or care plans. We created a coded care card, placed in each resident's room, that has a care plan intervention for an alarm that indicates the type of alarm and when it is to be used. Our goal is to help staff as much as possible to ensure that care plan interventions are in place.”

The message at DuBois Nursing Home is that each staff person's professional mission is to promote a safe, restraint-free environment. And the staff is quite proud of their accomplishment. Communicating repeatedly their commitment to this type of care, as well as actively revisiting established processes and revising them when needed, enables the facility and its staff to reach better outcomes for the residents and identify on-going educational needs.

<sup>1</sup> DuBois Nursing Home does not use any physical restraining devices including belts (velcro or other types), full trays, lap cushions, or vests. They are committed to never using these devices.

## Tin and Diamonds:

July 2005 ushers in the start of the Pennsylvania Restraint Reduction Initiative's (PARRI) tenth year of providing support and technical assistance to Pennsylvania facilities in their effort to improve quality of care by reducing the use of physical restraints. Originally funded for two years, PARRI was launched in 1996 when restraint use in Pennsylvania was at 28%. Since that time, the use of physical restraints within Pennsylvania has fallen below 6%. PARRI continues to assist facilities to provide safe, restraint-free care. This tenth anniversary coincides with the Centers for Medicare & Medicaid Services' (CMS) goal of reducing physical restraint use to 2% nationally. The agency has directed the QIOs to help achieve this goal in its eighth scope of work for 2006.

The Pennsylvania County Commissions Association with the support of Mike Wilt, Executive Director of the PA Association of County Affiliated Homes (PACAH), has made funding available for PARRI to continue through June 2006. Their belief in the benefits of the project is evident through this financial support in an increasingly competitive market for shrinking funding dollars. Task Force member Jerome Arzt, Principle State Representative, Health Insurance Specialist, CMS, cites that "[The] local expertise and the historical commitment of The Kendal Corporation went far beyond anything originally envisioned in the [initial] federal project" and has contributed to the success of PARRI. In his former position as Team Leader, HCFA Region III, Arzt was instrumental in spearheading the effort from which PARRI originated. According to him, "Without doubt, [PARRI] became, and remains, the most successful and active physical restraint reduction initiative in the country...I can say that Pennsylvania's restraint rate has been dramatically reduced, a change which can be directly attributed to PARRI."

Arzt, along with task force member Bill Bordner, Director, Division of Nursing Care Facilities Bureau of Facility Licensure and Certification, agrees that the development of a state-based task force contributed to the overall success of the restraint reduction efforts. Bordner noted, "I believe the educational efforts of the PARRI project have raised awareness in nursing home providers that there are other, more effective ways of dealing with nursing home residents than physical restraints. This education—and the subsequent challenge to providers—have prompted facilities to look for other, less intrusive ways of dealing with behaviors. This has reduced restraints, reduced injuries associated with restraints, empowered residents, and given staff accomplishments never before seen in long-term care." This concept of a state task force remains a cornerstone of the PARRI project. It is through meetings and communications between the task force and PARRI team members that progress is shared, provider and regulatory issues are discussed, and needs are identified. This broad involvement assists PARRI in formulating goals and developing programs to meet the needs of staff, providers, and ultimately residents.

As for the PARRI team members, restraint reduction and elimination has never grown old, nor lost its appeal. Numerous "success" stories only serve to reinforce the positive impacts they have seen on the quality of care provided to residents in facilities that make a commitment to physical restraint reduction and elimination. Benefits of PARRI identified by Mike Wilt are "a free, readily

**Try not to  
become a man  
of success but  
rather to  
become a man  
of value.**

**Albert Einstein**

# PARRI PARRI

## Reflections on the PA Restraint Reduction Initiative's Tenth Anniversary Year

available team of professionals willing to help all types of facilities in restraint reduction and a resource when a facility encounters survey issues related to restraint reduction. The on-site training, response to requests for assistance, and the train-the-trainer concept are all very valuable,” according to Wilt. Beryl Goldman, Director, Kendal Outreach LLC and project coordinator for PARRI, notes that “between 1997 and 2004, PARRI educational sessions have reached audiences totaling more than 22,000 staff.” Further benefits of the PARRI project cited by her are “the team’s initiative in going beyond the original charge of the task force to areas that required attention and support... [and include] programs focused on activities, behavioral issues, dementia, recognition of caregivers, and environmental assessments. They have developed manuals...[and have] provided two major extensions to the original program [with] the development of chemical restraint training sites and the initiation of PA FIRST, a project designed to address the increased need of Pennsylvania long term care providers to develop a more comprehensive fall management and prevention system.”

Removing physical restraints not only respects the resident’s right to be treated with dignity, but seems to remove unseen barriers that enable staff to develop relationships with residents and focus on the resident as a person. The empowerment of not only the residents, but also all levels of care providers that emerge through a restraint reduction process, continually re-energizes the PARRI team members. However, Arzt stated, “as the presumption of no restraints becomes more and more the accepted norm, this issue has been ameliorated, but not eliminated.” Goldman and Wilt echo the need for on-going efforts to keep providers focused on the issue of restraint reduction. “The continued high turnover of front-line staff makes continuity of this program very difficult. In addition, when the top management of a nursing home changes, the [PARRI] training team needs to once again receive a commitment from new management that physical restraint reduction is a continued priority,” said Wilt. Goldman agrees that “turnover of staff in many of the long term care facilities contributes to the challenges faced by not only the PARRI team, but also providers throughout the state and beyond. It is disheartening for us, and certainly for the facilities themselves, to begin any or all of the programs offered by the PARRI training team only to have them fall apart because key staff members have left. The widespread turnover problem also has made it difficult for providers to send staff to programs offered by the PARRI team...and has been the impetus for offering short programs through teleconferences so more staff can participate without leaving their sites.”

PARRI will continue its efforts to meet the needs of long term care providers throughout the Keystone State and will remain focused on reducing and eliminating physical restraint use through its tenth year.

For more about PARRI’s history and services offered, please visit the PARRI web site at [www.parrri.kendaloutreach.org](http://www.parrri.kendaloutreach.org).

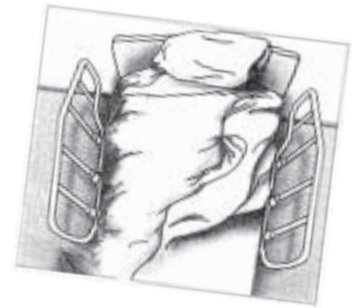
**Sara Wright, Geriatric Nurse Practitioner**

# Diagnosing Danger: Examining Bed and Side Rail Entrapment

## Full-day Program Offered to PA Providers

*“Very helpful. I like the practical application approach.”*

*“This entire program was excellent.”*



*“Information obtained today will be very helpful in our continued attempts with side rail reduction/options available as well as how to assess the zones. Thanks!”*

*“Five stars – the entire program was very well presented.”*



Janet Davis presenting at the “Diagnosing Danger...” regional program at Garvey Manor in Hollidaysburg, June 22, 2005.

In an effort to bring the most recent information available on bed and side rail safety to providers in Pennsylvania, the PARRI training team has been facilitating the program, “Diagnosing Danger: Examining Bed and Side Rail Entrapment” to address the goal of preventing injuries and deaths caused by bed system entrapment. The program encourages providers to re-think their current bed and side rail protocol in light of the Hospital Bed Safety Workgroup’s (HBSW) recent publication, *Draft Guidance for Industry and FDA Staff: Hospital Bed System Dimensional Guidance to Reduce Entrapment*.<sup>1</sup> Seven zones of entrapment were identified as potential hazardous areas of the bed system.<sup>2</sup>

During the program, participants were provided with a step-by-step guide to assessing bed systems for entrapment risk. Attendees explored how they might create safer sleep environments, offered information about sleep patterns that occur with normal aging and in the presence of dementia, examined various interventions and accessories to side rails and bed systems, and considered intrinsic and extrinsic factors that put residents at increased risk for entrapment and injury. Participants also viewed the video, [Do No Harm](#), produced by AARP for the Hospital Bed Safety Workgroup (HBSW). The video uses real-life situations to help the viewer understand the importance of individualizing the bed system for each person, especially confused older adults. (For information on the video, see last page of this newsletter.)

<sup>1</sup> This free publication is available on the web at [www.fda.gov/cdrh/beds](http://www.fda.gov/cdrh/beds).

<sup>2</sup> Bed system components include the mattress, frame, rails, and head/foot board. See *Draft Guidance for Industry and FDA Staff: Hospital Bed System Dimensional Guidance to Reduce Entrapment* available at [www.fda.gov/cdrh/beds](http://www.fda.gov/cdrh/beds).

Are you alert to the alarming number of bed and side rail entrapment injuries and deaths suffered by frail institutionalized elders? Are you aware of the prevailing myth that full or half side rails actually promote safety? Don’t wait until one of your residents suffers a tragic event that could have been prevented. Please call PARRI for additional information, technical assistance or support. See page 2 of this newsletter for contact information.

# N • E • W • S • . . . . N • O • T • E • S

- Janet Davis and Sara Wright presented a teleconference, “Physical Restraint Reduction and Medication Review: Building a Process” for Quality Insights of Pennsylvania on March 16, 2005.
- The PARRI training team presented “Issues in Long-term Care: Physical and Chemical Restraints” for Quality Insights of Pennsylvania May 24 (Harrisburg), 25 (Pittsburgh), and 26 (King of Prussia).
- Karen Russell and Sara Wright presented the program, “Falls: Solutions for Fixing a Fractured Process” at the Pennsylvania Health Care Association’s region III and V seminar on June 1 and 2 in Wilkes Barre and Langhorne, respectively.
- Mountain View Care Center in Scranton and St. Annes Retirement Home in Columbia, two PARRI training sites, held free training sessions on developing strong medication review programs. Comments reflected that the programs were very helpful to the participating facilities. Thank you to the training teams for their commitment to offering continuing education and assistance to local providers in their respective areas.
- PARRI has offered four teleconferences in 2005 on bed and side rail safety, falls, family friction, and dementia care. Attendance and enthusiasm have been strong. A total of 47 facilities and 250 staff have participated thus far this year.

## UPCOMING EVENTS

- |              |   |
|--------------|---|
| August 9     | • <b>Bed and Side Rail Safety</b> teleconference, PARRI training team                                   |
| August 9     | • <b>Chemical Restraint Reduction in Long Term Care</b><br>Mountain View Care Center training team      |
| August 16    | • <b>Chemical Restraint Reduction in Long Term Care</b><br>St. Annes Retirement Community training team |
| September 13 | • <b>Falls from an F-tag Perspective</b> teleconference, PARRI training team                            |
| October 19   | • <b>Charting the Course: Activity Care Planning</b> teleconference,<br>PARRI training team             |
| November 1   | • <b>Family Friction</b> teleconference, PARRI training team  |
| December 13  | • <b>Bed and Side Rail Safety</b> teleconference, PARRI training team                                   |

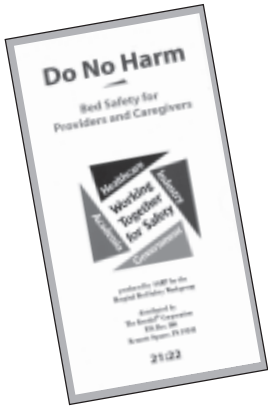
## AND

**Please note:** Centers for Medicare & Medicaid Services (CMS) has identified physical restraint reduction within its eighth Scope of Work for 2005/06 and has proposed a reduction in physical restraint use nationally to 2%. In an effort to support providers’ physical restraint reduction programs, PARRI’s training sites will be hosting training sessions from August through December, 2005. These educational sessions focus on core philosophy and process, with an emphasis on individualized assessment and safe alternatives to physical restraints. PARRI training sites have made

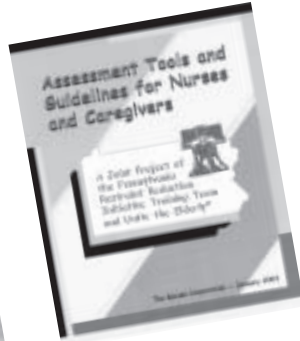
a firm commitment to provide care without physical restraints, and are enthusiastic about sharing their achievements on how they have accomplished this. All staff are welcome including administration, DONs, RNs/LPNs, nurse aids, therapies, social service, activities, and staff development.

For more information about these and other programs, contact Mary Scharf, 610-388-5580 or by e-mail, [mscharf@kcorp.kendal.org](mailto:mscharf@kcorp.kendal.org) or go to our website, [parri.kendaloutreach.org](http://parri.kendaloutreach.org).

# Educational Materials Available



• **Do No Harm**, a 22-minute video on bed and side rail safety is now available. Produced by AARP for the Hospital Bed Safety Workgroup (HBSW), it was developed to provide the viewer with evidence-based suggestions to decrease the possibility of injury or death from improper bed systems. Using real-life situations, the viewer will understand the importance of individualizing the bed system for each person, regardless of the health care setting. Cost is \$45.



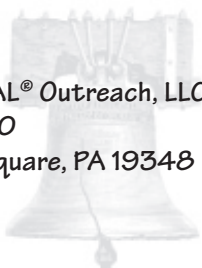
• **Assessment Tools and Guidelines for Nurses and Caregivers**, is a resource book with sections on: Bed Safety/Rails, Behavior Management, Environmental Safety, Fall Prevention, General Nursing, Medication Monitoring, Monitoring Devices, Pain, Restorative Nursing, Restraint Elimination, and Seating. Compiled by the PARRI training team with Untie the Elderly®, the cost is \$25 to Pennsylvania providers, \$40 to others.



• **Quality Care: Resource Catalogue for Health Care Providers and Caregivers** is a 16-page compendium of educational materials on quality care practices. Resource tools include training manuals, video and audiotapes, as well as program offerings on safe environments, proper assessment, bed and side rail safety, physical and chemical restraint elimination, and resident abuse. To order a free copy, contact Mary Scharf.

## PARRI

c/o KENDAL® Outreach, LLC  
P.O. Box 100  
Kennett Square, PA 19348



The Pennsylvania Restraint Reduction Initiative is made possible by a grant from the County Commissioners Association of Pennsylvania. Project implementation is under the direction of Untie the Elderly®, a program sponsored by KENDAL® Outreach, LLC, an affiliate of The KENDAL® Corporation.

FIRST CLASS  
US POSTAGE  
PAID  
PERMIT NO. 16  
KENNETT SQUARE, PA