The KOllaborator

PERSPECTIVES IN ELDER CARE

Vol. 1, No. 1

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Welcome to The KOllaborator, formerly PARRI News

Led by federal and state government agencies, state provider associations, and advocacy organizations, Pennsylvania began its journey to eliminate physical restraints in long term care facilities across the Commonwealth 11 years ago. Kendal was invited to participate in the deliberations based on its 30+ year tradition and long standing commitment to maintaining the autonomy and dignity of the frail, elderly person through resident-centered care. The outcome of the discussions was the establishment of a train-the-trainer project that eventually led to the Pennsylvania Restraint Reduction Initiative (PARRI) funded by the Pennsylvania Association of County Commissioners.

The initial two years of the project focused on the development of eight regional restraint elimination training sites that would serve as resources for other providers in their geographic area. Once this goal was accomplished, it became apparent that more attention to restraints, falls, and other care practices would be best served if the initiative could continue. The funding was secured and is guaranteed until June 30, 2008.

One of the products developed by the Kendal Outreach team was a biannual newsletter, *PARRI News*. Initially prepared, produced and disseminated by the Health Care Financing Administration (now Centers for Medicare and Medicaid Services or CMS), the responsibility was then transferred to the PARRI team. *PARRI News* focused on facility experiences in eliminating restraints and related safe care practices, tips from the team members, regulatory issues, and PARRI activities.

Since these issues impact all long term care facilities nationally, it seems an appropriate time to expand the newsletter beyond Pennsylvania. Therefore, we're pleased to launch The KOllaborator to signify Kendal Outreach's role as a collaborator, sharing experiences and expertise across the nation and abroad. This first issue features the "Best of PARRI" articles printed in earlier issues of PARRI News. We hope you find them useful for your staff and facility.

What do we ask in return? To help all of us grow as professionals caring for the elderly, and ultimately to improve the quality of life for those we serve, we would appreciate articles from you about your community, care questions to which you would like feedback from other organizations or from the Kendal team, and suggestions for featured writers to the newsletter. We will be approaching many leaders in the field to share their thoughts with our readers, but we all know "leaders" in our own organizations who never get the opportunity to share their stories. We want to hear from them, too. Just send feedback and comments to The KOllaborator:

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1107 East Baltimore Pike
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We want to make The KOllaborator meaningful for you, your staff, board, residents, and their families.

Director for Kendal Outreach

ABOUT KENDAL OUTREACH: Kendal, the pioneer of restraint-free care, has 35 years of management and operational experience in the development and execution of comprehensive approaches to safe, individualized care practices that have led to successful outcomes for many organizations. Whether exploring programs to improve existing practices or addressing challenges, our consultants offer guidance and processes specific to organizational needs. Kendal consultants have over 100 years combined LTC experience and serve as educators with the Pennsylvania Restraint Reduction Initiative and the Pennsylvania Nursing Care Facilities Best Practices project. The longstanding value of maintaining the autonomy and dignity of the frail, elderly person through resident-centered care underlies Kendal's dedication to promoting the well-being and quality of life of those served.

Improving the Nursing Home Environment for Residents with Dementia

Those of us who work in long-term care can never truly understand what it would be like to experience the nursing home environment from the perspective of a resident with dementia. However, we can step back a moment and reflect on the environment in which we work, and where our residents with dementia live.

Current research is exploring how the physical environment can play an influential role in the increased behavioral disturbances of residents with dementia. One of the first psychologists to examine the relationship between the person and environment was Curt Lewin who suggested that behavior is a function of both the person and the environment.[1] The basic assumption of dementia care is that a person with impaired cognition is very susceptible to influence from the environment. Both over- and under-stimulation can cause agitation, confusion, or wandering behaviors in residents with dementia.

To further understand the environmental impact on residents with dementia, consider a typical nursing home environment. It is an endless sea of sights and sounds, often occurring simultaneously. The public address system with overhead announcements; call bells and lights; housekeeping equipment including vacuum cleaners and floor buffers; ringing telephones; fire alarm tests; social activities; and residents or staff calling out to others, provide a range of auditory "noise." Our environments often are not the soothing, comforting places that we wish they could be. This may have profound negative effects on our most frail and confused residents.

The Occupational Safety and Health Administration (OSHA) has established a workplace standard of noise of 90 decibels that should not be exceeded for more than eight hours. The "threshold of pain"—the point at which the average person experiences pain—is at the 140 decibel level. Table 1, below, illustrates the results in decibel levels of commonly occurring sounds recorded in six long-term care facilities.

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TABLE 1.

SOUND LEVELS RECORDED IN SIX LONG-TERM CARE FACILITIES[2]

Decibel Level	Source (range in decibels)
140 *is the threshold of pain*	
100	Band (95-101)
83	Cleaning equipment (80-85)
82	Phones (72-95)
81	Call bells (76-85)
80	Church groups (77-85)
78	Door buzzers (76-80)
77	Intercom (76-78)
75	Yelling by staff, residents (73-80)
73	Normal conversation at station (70-75, increased at shift change)
15 *is the threshold of hearing*	

[1]Kovach, C.R. (2000). Sensoristasis and imbalance dementia. Journal of Nursing Scholarship, Fourth Quarter
[2]The Sound of Music? American Society of Consultant Pharmacists, 1998 (online publication)

Improving the Nursing Home Environment for Residents with Dementia (*continued from p.2*)

Another study by researchers at the Georgia Institute of Technology of 92 metro Atlanta nursing homes revealed that noise increases of six or more decibels were a factor in 18% of almost 4,000 night-time awakenings.[3] Even modest increases in noise above the background level can disturb the sleep of nursing home residents.

What are some simple, practical solutions to reducing the noise level in nursing homes?

- Limit the use of your public address system, or better yet, eliminate it completely. Use personal pagers or voice mail options on the telephone.
- Encourage staff to be sensitive to noise and light when residents are sleeping. Whenever possible, make it a goal not to wake residents when they are sleeping at night. Also, be aware that noise is often generated around change of shift times and can disturb residents who also "want to go."
- Develop a cleaning schedule that is sensitive, especially during vacuuming and other loud activities. Perhaps more residents can be away from the cleaning activity. Scheduling programming off the unit at times when noisy housekeeping cleaning equipment is utilized may help.
- Be sensitive to resident behaviors that can cause agitation or restlessness in other residents. For example, a resident who is constantly calling out can create a domino effect and increase restless, anxious behaviors in other residents in their immediate area.

[3]Georgia Research Tech News. Quiet on the Search for Ways to Reduce Noise and Improve Homes. October, 2002 (online resource)

- Be aware of greater noise levels through increased activity programs during special or holiday events. Residents who are sensitive to over-stimulation may benefit from a quieter activity in another part of the facility.
- Be sensitive to the level of noise at the nursing station and in communal lounges. Are residents with dementia exposed to call bells sounding for long periods of time? Are televisions or radios playing without any regard for programming content?

When assessing behavioral disturbances in residents, explore what is going on in the environment when the behavior occurs. Levels of noise that we accept may be very disturbing to residents who, because of their disease, cannot process the sensory overload. Activities can play a key role in determining the fine balance between over-stimulation and sensory deprivation. Not enough sensory stimulation can be as detrimental as sensory overload. A comprehensive individualized assessment can help your interdisciplinary team determine the degree of social stimulation most suitable for individual residents. For example, someone who never enjoyed participating in large groups might find that type of activity unpleasant and even scary. As the disease progresses, an ongoing assessment is essential in determining your residents' changing needs.

AUTHOR: Janet Davis, BA, ACC, Educator/Consultant, Kendal Outreach, LLC

Reprinted from PARRI News, Volume 5, No. 2

Pennsylvania Concludes Best Practices Program

The Nursing Care Facilities Best Practices Project was a research demonstration project created to assist Pennsylvania's long-term care facilities improve the quality of care provided to residents. The main objectives were to evaluate the quality of care across multiple domains in long-term care facilities in Pennsylvania by using Quality Indicators, to create and implement a set of evidence-based best practice protocols designed to improve quality of care, and to evaluate the effectiveness of protocol implementation. The project was implemented in three phases from 2001-2006. These protocols were successful in improving care outcomes and had added benefit of improving intrafacility systems and communications. The Pennsylvania Department of Health funded this unique study facilitated by nationally known experts in the field of aging.

Over the span of all three phases, seventy-seven long-term care facilities participated in the project. Test facilities implemented one of five Best Practices protocols: Self-Care for Seniors©, a program designed to help residents maintain independence in ADLs, Managing Pain in Nursing Home Residents©, Managing Depression in Nursing Home Residents©, Prevention of Pressure Ulcers in Nursing Home Residents©, and Management of Urinary Incontinence in Nursing Home Residents©.

Each test facility that implemented a care protocol was assigned a nurse educator from Kendal Outreach, LLC. The nurse educator provided training to all facility staff on the specific protocol, initial and ongoing support and guidance to establish a steering committee, and feedback and support in strengthening patterns of communication among disciplines and departments. The nurse educators also assisted facilities to put quality assurance procedures in place that monitored consistency in protocol implementation and ensured that care was being delivered in a manner consistent with protocol guidelines.

Outcomes were measured by use of the Quality Indicators and Quality Assurance Monitors during the first two phases of the project, and by the Quality Assurance Monitors with information provided by the facilities during the last phase. In addition to positive outcomes in all care areas, test facilities were pleased with improved functioning of internal systems, strengthened interdisciplinary communications which led to stronger care approaches, and increased job satisfaction.

If you are interested in more information, or would like to implement the protocols in your facility, contact Mary Scharf by phone at (610) 388-5580; or email, mscharf@kcorp.kendal.org.

AUTHORS: Sabita Balgobin, RN, MSN and Ruth Bish, RN, Nurse Educators, Kendal Outreach, LLC.

Interventions to Promote Sleep in Residents with Dementia

Changes in sleep patterns accompany the normal aging process. However, for elders diagnosed with a dementia syndrome, sleep disturbances can present a special challenge to staff in long term care. The presence of a sleep disturbance has been identified as a major risk factor for nursing home placement for persons diagnosed with dementia.

A marked change in the sleep-activity cycle occurs even in the early stages of dementia and increases in severity as the disease progresses.[1] Sleep, along with other biological rhythms, is strongly influenced by the brain's response to light exposure. It is not uncommon for the elderly to gradually move from keeping a 24-hour circadian day to a 21-hour circadian day.[2] Unfortunately, the parts of the brain that regulate these biological or circadian rhythms are also those areas that are affected by the deterioration associated with the dementia. As a result, residents with dementia may develop markedly fragmented sleep patterns with frequent, short periods of napping throughout the day and night being more common than a six- to eight-hour period spent sleeping in a bed or recliner.

Dementia robs the person of the ability to recognize the subtle activities and signs that help to distinguish daytime activities from nighttime activities. Known as "zeitgebers," they include cues such as the aromas and activities associated with meal preparation that stimulate hunger, along with the subtle changes in lighting as the sun completes its daylight journey leading into twilight and ultimately darkness. Not only does the dementia itself affect the ability to recognize these zeitgebers, but consider the environments prevalent in long term care facilities. Meals are prepared in kitchens removed from resident living areas; incandescent lights burn at the same intensity 24 hours a day, seven days a week in many areas of the facility; and three shifts of staff remain busy and give the impression of a non-stop work routine to a confused elder's mind.

It is no small wonder residents with dementia experience alterations in sleep patterns, especially within the nursing home environment. Although little can be done to stop the progression of dementia, many interventions are available to staff to address the problem of alterations in sleep patterns for residents affected with this disease. The following table outlines common contributing factors and a variety of interventions that may be helpful to promote sleep for residents with dementia.

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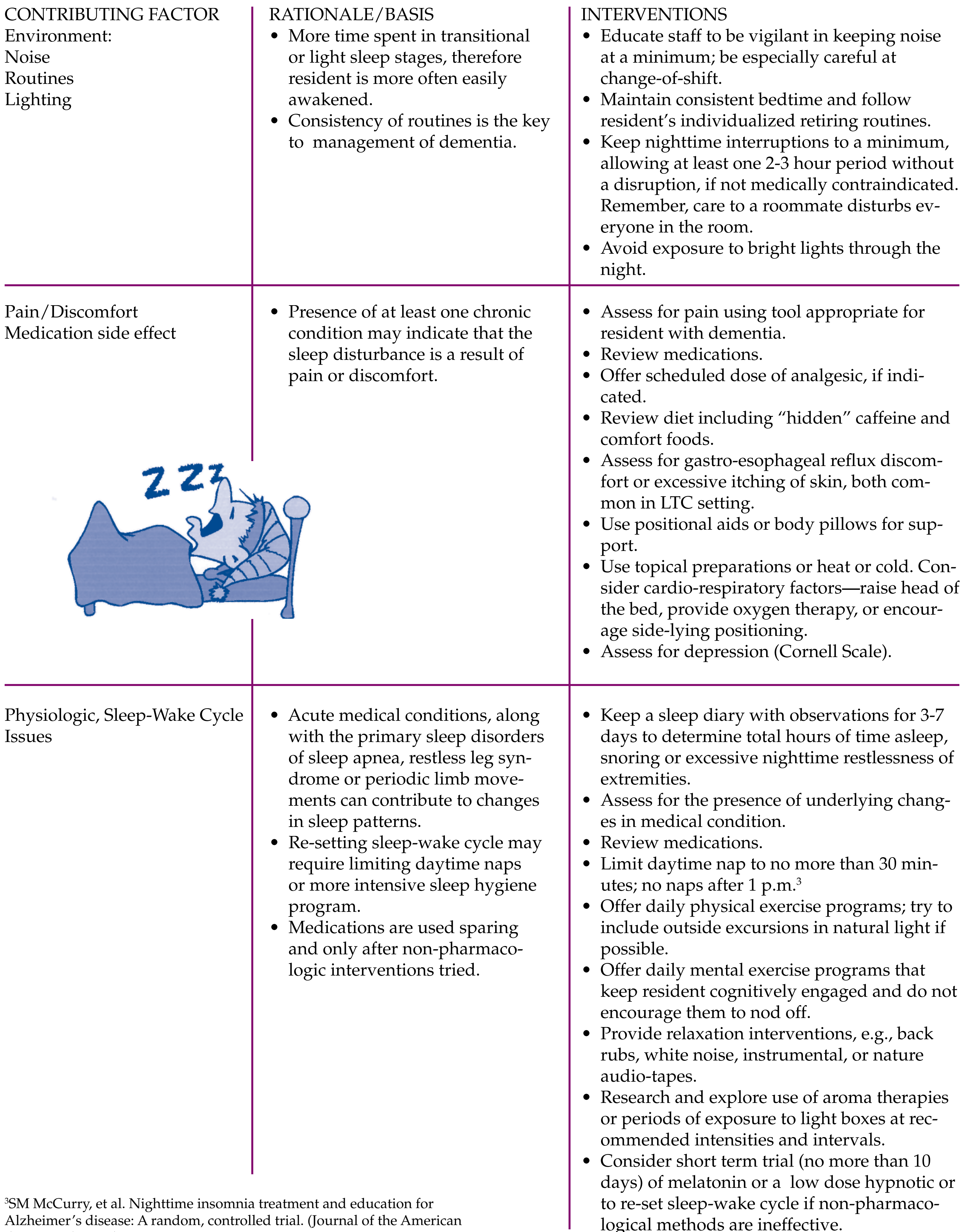
[1]International Psychogeriatric Association. Behavioral and Psychological Symptoms of Dementia (BPSD), educational pack, 2002.

[2]Ibid.

AUTHOR: Sara Wright, MSN, CRNP, Geriatric Nurse Practitioner, Educator/Consultant, Kendal Outreach, LLC

Reprinted from PARRI News, Volume 6, No. 1

CONTRIBUTING FACTOR	RATIONALE/BASIS	INTERVENTIONS
Environment: Noise Routines Lighting	• More time spent in transitional or light sleep stages, therefore resident is more often easily awakened. • Consistency of routines is the key to management of dementia.	• Educate staff to be vigilant in keeping noise at a minimum; be especially careful at change-of-shift. • Maintain consistent bedtime and follow resident's individualized retiring routines. • Keep nighttime interruptions to a minimum, allowing at least one 2-3 hour period without a disruption, if not medically contraindicated. Remember, care to a roommate disturbs everyone in the room. • Avoid exposure to bright lights through the night.
Pain/Discomfort Medication side effect 	• Presence of at least one chronic condition may indicate that the sleep disturbance is a result of pain or discomfort.	• Assess for pain using tool appropriate for resident with dementia. • Review medications. • Offer scheduled dose of analgesic, if indicated. • Review diet including "hidden" caffeine and comfort foods. • Assess for gastro-esophageal reflux discomfort or excessive itching of skin, both common in LTC setting. • Use positional aids or body pillows for support. • Use topical preparations or heat or cold. Consider cardio-respiratory factors—raise head of the bed, provide oxygen therapy, or encourage side-lying positioning. • Assess for depression (Cornell Scale).
Physiologic, Sleep-Wake Cycle Issues	• Acute medical conditions, along with the primary sleep disorders of sleep apnea, restless leg syndrome or periodic limb movements can contribute to changes in sleep patterns. • Re-setting sleep-wake cycle may require limiting daytime naps or more intensive sleep hygiene program. • Medications are used sparing and only after non-pharmacologic interventions tried.	• Keep a sleep diary with observations for 3-7 days to determine total hours of time asleep, snoring or excessive nighttime restlessness of extremities. • Assess for the presence of underlying changes in medical condition. • Review medications. • Limit daytime nap to no more than 30 minutes; no naps after 1 p.m.[3] • Offer daily physical exercise programs; try to include outside excursions in natural light if possible. • Offer daily mental exercise programs that keep resident cognitively engaged and do not encourage them to nod off. • Provide relaxation interventions, e.g., back rubs, white noise, instrumental, or nature audio-tapes. • Research and explore use of aroma therapies or periods of exposure to light boxes at recommended intensities and intervals. • Consider short term trial (no more than 10 days) of melatonin or a low dose hypnotic or to re-set sleep-wake cycle if non-pharmacological methods are ineffective.

[3]SM McCurry, et al. Nighttime insomnia treatment and education for Alzheimer's disease: A random, controlled trial. (Journal of the American Geriatrics Society) 53:793-802, 2005.

I Know My Resident Is in Pain . . . .

Through my work with the Pennsylvania Restraint Reduction Initiative, I have had the opportunity to meet many dedicated nurses and caregivers. Knowing that pain is a major issue for long term care residents, I thought it might be interesting to ask for staff responses regarding ways that residents have demonstrated pain. The responses are clear reminders to pay close attention to the residents, even when they aren't able to speak. Some of the replies shared with me were unique reminders that we should always pay close attention to what our residents are telling us, even when they aren't speaking.

The following are responses to the statement, "I know my resident is in pain when. . ."

• "I notice how they hold their bodies. I often see clenched fists and stiff upper body positioning. I notice the 'death grip' that residents will use to hold onto chairs or staff or whatever they can grab. This positioning may be their response to an uncertain situation, but frequently they are experiencing pain and are trying to protect themselves from additional discomfort." *Pat Slaughter, OTR*

• "One of my residents will neatly pile up his food. This guy is usually a very good eater and he feeds himself. We started to notice this behavior and it became more frequent. There was nothing else that was different; he would just start piling up the food. One of the nurses gave him some Tylenol one day and we noticed about an hour later he was digging around in the food cart that was filled with empty trays and discarded food. We got him a fresh tray from the kitchen and he ate everything. The next time he started to pile up his food he got the Tylenol right away and then we got a tray for him about a half hour later. He has been eating well since. I don't think we ever figured out if he was having headaches for sure, but something was bothering him." *Brian C. White, CNA*

• "I remember caring for a resident who was always trying to get himself on the floor. We often witnessed him putting himself there so we knew he was not falling. He did it around the clock. There was no pattern to this behavior and once he was on the floor he looked very content. A group of staff brainstormed and he was provided with some type of back brace, a firmer mattress, and he was started on some very mild and routine pain medication. After that, his trips to the floor were significantly decreased." *Jackie Kollar, LPN*

• "We currently have a resident who taps lightly on her forehead with her fingertips. She doesn't seem in distress when she is doing it, so initially we didn't act on it. Now we have recognized this as her way of letting us know she wants something for discomfort. When she gets her Tylenol, the tapping stops." *Debi Rodermoyer, LPN*

• "I noticed one of my residents behaving differently at mealtime. She began to shove her bread in her mouth and pocket it in her cheek. Initially, this went on for about one week. We took her bread away from her because we were afraid she would choke. We then discovered she was running a low-grade fever and we began to notice some swelling of her face. It turned out she had an abscessed tooth. Looking back, we think she was putting the bread in her mouth to comfort or protect her tooth." *Barb Tillen, CNA*

• "Working in speech therapy, I think I have a tendency to read what the face is telling me. I often suspect pain when I see clenched teeth and facial grimacing. I know that people might say, 'Well, that's obvious.' But more often it's looked at as stubbornness or a protest to eating. It is important to assess this resistive behavior. A comfortable resident is more likely to be a better eater." *Cindy Mason, SLP*

• "A few years ago I cared for a man who would wheel himself to a sunny window and spend the better part of the day there. He started to demonstrate some restless, angry behaviors on the days he was not at the window. One of the housekeepers would try to joke with him about whether he was going to 'get any tanning in today.' She was right in recognizing that he was only at the window on sunny days. We wondered if he was getting comfort from the warmth of the sun. We got an order for a topical analgesic that we started to use when he would act out. Sometimes we also gave Tylenol. The result was a much happier resident." *Lynn Mahler, RN*

• "We recently had a resident who began to demonstrate behavior that was unusual for her. She would lean forward in her chair and was very restless, making repeated attempts to stand. Utilizing a routine mild analgesic and a rocking chair periodically throughout the day really solved the problem." *Amanda Ott, RN*

AUTHOR: Karen Russell, LPN, Educator/Consultant, Kendal Outreach, LLC.

Reprinted from PARRI News, Volume 4, No. 1

If you would like to respond to the question, "I know my resident is in pain when..." or if you have a story or description of a resident in pain that you'd like to share with readers of our newsletter, please send to:

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Collaborating with the Interdisciplinary Team: A Medical Director's Perspective

The use of an interdisciplinary committee, coupled with a Continuous Quality Improvement (CQI) process, can be very effective in improving the quality of care and quality of life of nursing home residents. As a medical director, being an integral and equal part of that process has been very rewarding.

I have found that one of the best ways to help improve the quality of life of the residents in my facilities has been through active participation on some interdisciplinary committees. On these committees, staff from multiple disciplines interact to improve care and processes. The committees at the facilities that I work with are the monthly Quality Improvement Committee, the Psychotropic Review Committee, and the weekly Utilization Committee to discuss needs of the subacute patients.

At first, the Psychotropic Review Committee was set up by facilities to maintain compliance with federal regulations. Our committee initially was no different. The group often would consist of the pharmacist, the activity director, social workers, nursing staff, and a physician. Nursing would be represented by unit managers, primary nurses, and, at times, nursing assistants. We would discuss one third of the long-term residents each month. We would also discuss all of the short-term residents, the new admissions, and the challenging residents. Through a CQI process we would review the previous month's recommendations to see if there was follow through and its effectiveness. The pharmacist would report on compliance issues based on chart reviews. The pharmacist and I would make recommendations on dose reductions and medication changes.

We do not just focus on regulatory compliance anymore. Our discussion is centered around the most challenging resident situations, and our role is to take a hard look at both pharmacologic and non-pharmacologic interventions that might improve the residents' care. Since one of the purposes of the OBRA regulations was to reduce or eliminate chemical restraints, our Psychotropic Review Committee reviews the residents on anxiolytics, antipsychotics, and sedative hypnotics. We make sure that there have been attempted dose reductions, at least every six months, unless there has been documentation contraindicating them. The committee makes sure that every medication has a diagnosis. We also review behavior sheets to see if non-pharmacologic approaches were used, for instance, to quiet agitation prior to the use of prn anxiolytics. We look at the behavior monitor sheets to see if behaviors were appropriately being documented prior to the use of antipsychotics. We look at the problem behaviors and try to explore possible triggers. Common questions we consistently ask each other are: Can the behavior be related to the resident's pain or depression? Can the resident be expressing a need? What time of day does it usually occur? Have activity personnel or the nursing assistants witnessed these behaviors and do they know approaches not listed on the behavior sheet that might help? These questions are explored and recommendations are made. At times the recommendations involve medication changes, but often they involve new approaches to the resident. The pharmacologic recommendations often involve adding, increasing, or changing antidepressants or adjusting pain management. Actively participating in this present process has been beneficial to residents and has been personally and professionally very satisfying.

Quality of care is much more than regulatory compliance. The American Medical Directors Association has been encouraging long term care medical directors to take on roles and responsibilities that ultimately foster the delivery of better care to residents. I can think of no better way to improve care than participating on interdisciplinary committees that are working hard to improve care.

AUTHOR: Glenn M. Panzer, M.D., former President of the Pennsylvania Medical Directors Association; member of the Pennsylvania Restraint Reduction Initiative Task Force.

Reprinted from PARRI News, Volume 3, No. 2

KENDAL OUTREACH, LLC

Upcoming Events and Activities

Moods, Behaviors and Psychotropic Medications: Making Sense Through Assessment

May 4, 2007
Texas Association of Homes and Services for the Aging

Developing Funnel Vision for Effective Fall Management

Audio Conference

May 15, 2007
2:00 p.m. EST

The Restraint-Free Future

May 25, 2007
Florida Health Care Association, St. Petersburg Beach, FL

Bed and Side Rail Safety • *Audio Conference*

June 12, 2007
2:00 p.m. EST

Reducing Restraints Summit

June 27, 2007
Arizona Hospital and Healthcare Association, Phoenix, AZ

Abuse Prevention • *Audio Conference*

July 10, 2007
2:00 p.m. EST

KENDAL® OUTREACH, an affiliate of The Kendal® Corporation, is a not-for-profit consulting provider specializing in creative solutions for healthcare clients primarily devoted to long-term care.

The pioneer of restraint-free care, Kendal has over 30 years of management and operational experience in the development and execution of comprehensive approaches to safe, individualized, care practices. Whether exploring programs to improve existing practices or address challenges, our consultants offer guidance and processes that can lead to successful outcomes for your organization, your staff, and the people you serve.

The long-standing value of maintaining autonomy and dignity of the frail, elderly person through resident-centered care underlies our dedication to promote the well-being and quality of life of those served.

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- strategic planning
- education and training
  - full day
  - half day
  - teleconferences
- consultation

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Areas of expertise:

CLINICAL

- Physical Restraint Reduction
- Behavioral Management and Psychotropic Medication Review
- Nursing Assessments and Care Interventions
- Pain Identification and Management
- Depression
- Urinary Incontinence
- Working with Residents with Dementia
- Effective Activity Programming
- Resident Abuse Prevention

MANAGEMENT

- Clinical Audits for Quality Assurance
- Policy and Procedure Review
- Working with Families
- Team Building
- Survey Readiness Reviews
- Leadership Skills for Nurses
- Maintaining Optimal Level of Independence
- Evaluation of Staffing Patterns
- Structuring Consistent Care Giver Model

SAFETY

- Fall Prevention and Management
- Bed and Side Rail Safety

TECHNOLOGY

- Valid and Reliable Wellness Assessment Tools

Problem Solving
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