

# Adventures in Pain Management

by Leslie Stickley, Director of Nursing, St. John Neuman Nursing Home, Philadelphia, Pa.

No one should be in pain. This is a simple statement, but one not easily accomplished. The staff and residents of St. John Neumann Nursing Home (SJN) in Philadelphia have been on a long journey trying to reach that “pain-free” state. We have a long way to go but each step on the path has been an accomplishment in itself.

Over the last nine years we’ve worked diligently to eliminate physical restraints and side rails, and to develop a stronger medication review and reduction process. We also have aggressively focused on fall prevention. In the process, we have come to see how pain is linked to all of these problems. Restlessness, agitation, unassisted rising, combativeness—how many of these behaviors, especially for cognitively-impaired residents, result from pain and its inadequate management? Our journey has encompassed several key areas described below.

## 1. Assessing staff attitudes and knowledge

We started the process by assessing attitudes and knowledge of the staff. All of the “myths” related to pain were verbalized. “She’s a pill seeker.” “We’ll be giving meds non-stop.” “He’ll just want more.” “They’ll all end up addicted.” We heard them all, and set out to correct the misconceptions.

## 2. Staff and resident education

Education was the key at every step of the way. A series of five in-services on pain was initiated utilizing a workbook called *Understanding Pain Management* created by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Residents, nurses, physicians, ancillary staff, anyone coming in contact with our residents needed more knowledge of good pain assessment and management. We also held resident classes geared to overcoming the residents’ perceptions that pain is a normal part of aging. We followed with the JCAHO program, *Speak Out*, which addresses the notion that residents need to tell us about their pain and stand up for their rights.

## 3. Family education

We became more intentional about sharing pain-related information with families during admissions, family support meetings, and one-on-one meetings with individual residents. We have always strongly encouraged families to partner with us and develop relationships with the nurse managers on a loved one’s unit. Refocusing on pain was another way to cultivate this partnership.

## 4. Physician buy-in

We have quarterly staff meetings with our physicians and often discuss pain management. We are more assertive about seeking advice from our pharmacy consultant as well. If they feel someone is in pain, our nurse managers have become fierce advocates. Our end of life care team, “Guardian Angels,” pushes for medication changes if they see a need. The medical director may be asked to consult on a problem, and the administrator will also get involved in advocating for a resident if a challenging situation is identified. This support has been important to our overall success.

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# A Salute to the Physical Restraint Reduction and Psychotropic/Medication Review Training Sites

The original goal of the Pennsylvania Restraint Reduction Initiative (PARRI) was to establish physical restraint reduction and psychotropic/medication review training teams within nursing facilities located throughout the Commonwealth. To date, twenty-one physical restraint reduction and four psychotropic/medication review training sites are providing free training programs to facilities seeking to strengthen their restraint reduction process. These training sites commit their time and arrange staff schedules to meet the necessary criteria to be a PARRI training site and are a vital contributor to the success of the initiative. PARRI recently acknowledged all training sites for their contribution to the project with a Certificate of Appreciation. Our thanks to each facility and to all staff members involved in the training programs.



Mountain View Care Center staff receiving their certificate. Front row, left to right: Kim Klimasauskas, Social Worker; and Sirivanh Sophmixay, Nurse Manager; Melissa Novak, Dietitian. Back row, left to right: Cheryl Williams, Restorative Nurse; Patricia Capwell, Director Recreational Therapy; Leslie Collins, Director of Education; Cara Reed, Nurse Manager; Maryann E. Rubino, Director of Resident Care Services; Amy Miller, Director of Social Services; Suzie Pethik, Director of Admissions; and Trish Sinacore, Nurse Manager.

## Adventures in Pain Management—continued from page 1

### 5 Enhanced pain management protocol and policy

Major changes were undertaken to enhance our pain management policies. Both a pain assessment and a pain control record were used to evaluate the effectiveness of any medication given. We more strongly adopted the philosophy of “pain as the fifth vital sign.” We placed the statement “resident has pain” on every resident’s medication administration record (MAR), with blocks for each shift to initial. During the course of each shift, the charge staff asks the resident if they are having any pain. If the answer is no, they initial and circle their initials. If the answer is yes, the nurse signs her initials and proceeds to give whatever prn medication is ordered. She then assesses success by using the pain control record. Staff is trained to look for patterns or frequency and then to refer the resident back to the physician for a possible standing regimen. If a resident is non-verbal or severely cognitively impaired, the staff has a choice of using the FLACC (Face, Legs, Activity, Cry, Consolability) scale or a simple list of behaviors that can be relayed to the physician as probable indicators of pain.

Over the past two years, the number of orders for standing pain regimens has increased from 42 to 91 (40% of our residents). PRN medications stronger than Tylenol have increased from 15 to 46. Minimally, all residents have a prn Tylenol order written on admission.

One note of caution. Once we accepted the basic premise that “pain is what the resident says it is,” we discovered that our Quality Measure (QM) on pain was higher. As many of

you are aware, the current MDS does not ask the critical question, “is the pain relieved by interventions?” It is indeed because we’re so much better at documenting when a resident is in pain that our QM is higher. We rely on our performance improvement reports to explain our QM on pain to surveyors and customers, and these reports only support that we’re doing our job the way it should be done.

We’re doing other things to help combat pain. We have a massage program in its infancy and a number of staff have been trained in Reiki\*. We are working to improve our therapeutic activities and environment using soothing music and aromatherapy. Physical therapy, occupational therapy, and restorative staff all have a role to play in maintaining residents at their highest level of function. Exercise and strengthening play an important role in maintaining joint function.

If you aren’t working on pain, you should be. If you are working on it, keep on plugging. It’s a long road, but it’s one well worth traveling.

\* Reiki is a powerful, precise system of healing which is believed to have originated in Tibet thousands of years ago. It accesses a universal life force energy. This energy, also known as prana, mana, chi, holy spirit, and source, helps promote healing in all living things on the physical, mental, emotional, and spiritual levels.

Leslie Stickley can be reached at St. John Newman Nursing Home, 215-698-5612. Her facility is one of four psychotropic/medication review training sites for the Pennsylvania Restraint Reduction Initiative.

# Designing End of Life Care in Nursing Homes

by Carol Papst, Assistant Director of Nursing and Risk Manager, Marian Manor, Pittsburgh, Pa.

Marian Manor is a not-for-profit, 194-bed long term care facility located in Pittsburgh. The Sisters of the Holy Spirit have owned and operated the facility since its inception in 1954. The facility is comprised of a personal care unit, an Alzheimer unit, and four skilled nursing units.

In 1995 the facility implemented a physical restraint reduction initiative. At that time approximately 75% of the residents were physically restrained. Marian Manor took a systematic approach to restraint reduction through the development of a strong multi-disciplinary team consisting of nurses, nurse aids, housekeepers, administration, activities, social service, therapies, and, in some cases, family members.

It took three years of hard work for Marian Manor to eliminate the use of physical restraints.\* During those three years a lot was learned. Lesson one was the understanding that the key to excellent care is treating each resident as an individual and acknowledging that each has unique needs, strengths, likes, and dislikes. Another lesson learned, perhaps just as important, was that the input of nursing aides is invaluable in developing effective care plans.

Having done the work of physical restraint elimination, Marian Manor was compelled to continue to improve the quality of life for its residents. The next logical step seemed to be the development of its Palliative Care Program. While Marian Manor honored the service that hospice provided, its staff and administration believed that end-of-life care could be improved. In the year 2000, the comprehensive Palliative Care Program was begun with four primary components:

- Pain assessment and management
- Alternative therapy program
- Bereavement program
- Education programs

## 1 Pain assessment and management

This portion began with the development of a committee comprised of licensed nursing staff. The committee worked to produce a pain assessment tool, policies, and procedures for pain assessment, and protocols for acute and chronic pain. Three years later, there is still work to be done. The committee will be re-grouping to further refine the pain assessment tool and to develop a policy for pain management for our cognitively impaired residents.

## 2 Alternative therapy program

The alternative therapy program includes pet therapy, aroma therapy, Reiki, massage, music, and spiritual journeys. Staff has been specifically trained and certified in aroma therapy, Reiki, and massage. These alternatives are used in conjunction with medications in the treatment of pain. On occasion, alternative therapies have been useful in curbing disruptive behaviors. Essential oils are used at the bedside to enhance a peaceful atmosphere at the end of life. A drop of essential lavender oil on the lapel, bed sheet, or pillowcase of an anxious, agitated resident has worked wonders for some! It has provided a calming effect for both the residents and families. Along with the use of essential oils, the Pastoral Care

Department incorporates soft music at the bedside during the dying process. A system for providing the residents' families with "comfort" trays at the end of life is also part of the protocol. Pastoral Care has obtained china that is used specifically to provide families with refreshments and food at the bedside.

The nursing staff is encouraged to teach families how to be involved with direct care at the end of life (i.e., mouth care, moistening lips, ensuring the resident is pain-free, etc.) Education is provided to the nursing staff on respecting and responding to choices at the end of life, even when it goes against their training. An example of this would be a family member who requests that the resident no longer be turned and positioned in the final hours.

Some of the alternative programs have been expanded to meet the needs of all residents. The Activities Department now holds "Spa Night" every Thursday. The residents enjoy hot rock massages, music, and aroma therapy along with manicures and other "beauty treatments."

## 3 Bereavement program

Our bereavement program is in a refinement phase. The nursing and pastoral care staffs work closely with families during the dying process to assist them in their grief. Often, at the request of the family, funeral masses are celebrated at Marian Manor. A memorial service is held after the passing of every resident, and staff is encouraged to attend. This provides support for both the staff and the families. Our administration understands that staff members are not immune to grieving after the loss of a resident.

## 4 Education program

The education program is comprehensive and ongoing. When a facility implements a new program, education is the key to success. Nursing staff were provided 20 educational sessions on pain management alone. The most effective sessions were in small groups of five to eight licensed staff conducted by an expert in geriatric pain management. Staff was also educated in small multi-disciplinary unit meetings on palliative care concepts. The meetings focused on the importance of spirituality versus nursing tasks at end of life. Two libraries were developed as part of the palliative care program. One library offers educational material geared for staff, the other for families. Both contain articles on pain management, artificial nutrition/hydration, advanced directives and stages of death. Staff is encouraged to use articles for their own reference or to share them with families.

\*Marian Manor does not use any physically restraining devices including belts (velcro or other type), trays, lap cushions, or vests. These devices do not exist in the facility.

Carol Papst can be reached at Marian Manor, 412-563-1244. Her facility is one of 21 physical restraint reduction training sites for PARRI.

# A Compendium of FALL Prevention IDEAS

**Editors note: There are extraordinary realities and challenges to resident safety and fall prevention in long term care today. Over the last year the PARRI training team has received an increasing number of requests for support and technical assistance around fall management. To this end, we offer this column on fall prevention ideas as a regular feature of the newsletter. We would be pleased to publish your fall prevention/ safety awareness ideas or programs. Inquiries? Please contact Neil Beresin, PARRI, The Kendal Corporation, P.O. Box 100, Kennett Square, PA 19348 or [nberesin@kcorp.kendal.org](mailto:nberesin@kcorp.kendal.org).**

**The following article was submitted by Pat Hartzell, Director of Nursing at Masonic Eastern Star Home – East in Warminster.**

## “ Help, I’ve Fallen ”

This is a phrase we never want to hear. Yet the elderly population we serve are at high risk for falls for various reasons—from visual impairment, poor cognition, medication use, or trying to make it to the toilet before the Lasix kicks in.

Like most of you, I pine for some magic gold powder to sprinkle on those who threaten to become victims of the pull of gravity. Or, perhaps feather auras to surround vulnerable residents. Until the unlikely advent of such magical measures, we are forced to use our creativity while tap dancing through the shift and coping with medications, treatments, and the rest of our responsibilities.

One of the most critical aspects of fall prevention is thorough risk assessment. There are many fine tools available, not the least of which is the MDS 2.0 Fall Assessment Triggers. Actions which follow proper assessment can lead to treatment of underlying disorders and environmental modifications.

I would like to be able to tell you that if you do a great job of assessment and implement the right strategies, the resident will never fall. But the reality is that resident conditions change and what works at one point may not work later. Further, cognitively impaired residents simply will not remember to ring for help no matter how often we write this

in our follow-up actions and post-fall care plans. When falls occur, despite our best efforts, it is critical to identify why the fall happened; post fall investigation should be immediate and include asking the resident what they were intending to do when they fell. Often, even a cognitively-impaired resident can give you this information if you ask them soon enough after the fall.

We have found one strategy that seems to work for us when all else fails. We design a one-to-one schedule for the individual. I hear you now: “We could never do that!” or even better, “She must be staffed at 6.0!” In fact, we have succeeded in implementing this type of schedule even though our staff felt it could never be done and our staffing level is presently about 3.5. It worked because all staff was involved and no staff member had 1:1 for more than 30-45 minutes at a time. It worked so well that when one of our residents died (not fall-related) who had been on a one-to-one schedule, and we had problems with other residents, the staff ASKED for help to develop a one-to-one schedule for this new resident. A side benefit of the schedule has been increased alertness and happiness of the targeted residents, as well as some beautiful drawings and even journal writing by other cognitively-impaired residents.

Sometimes, giving a resident a task can help divert them. One evening I brought our cockatiel to the unit with his cage. I fixed the door to the cage so he could open it and asked one of the frequent fallers to watch the bird and call me if he got out. I was able to distribute medications to the unit while the resident periodically called out, “He’s out again.” The interruption to replace the bird in the cage took much less time than all the paperwork I would have had if the resident had not been happily helpful.

Of course, this could have backfired if the resident tried to get up to assist the bird instead of calling me. But, like any intervention, you need to know your resident and how they may react. Other interventions can include taking the resident with you and asking them to “watch my cart” (keeping it locked of course) or asking them to tell you if the phone rings. Sometimes other residents like to get involved and will sit with their peers and read to them or just hold their hands.

Sharing our experiences and ideas is essential to help us fill our creativity vault with interventions that we can try. Most essential is to keep trying, at least until the gold powder or feathers or...wait... maybe helium balloons tied to the waist might work. Best of luck with your fall prevention work.

*Pat Hartzell, can be reached at Masonic Eastern Star Home—East in Warminster, 215-672-2500. Her facility is one of 21 physical restraint reduction training sites for PARRI.*

# Web Site Resources

## • Palliative Care •

In each edition of the newsletter, we offer a list of web-based resources addressing specific diseases, care, or organizational issues. It is hoped the resources promote new approaches and strategies in the spirit of providing individualized resident-centered care without the use of physical restraints. Please note that being listed here does not constitute an endorsement or recommendation by PARRI. If you have a specific web site that you have found valuable to your daily work, or, if you have a specific topic you would like to see addressed, contact Janet Davis. (See last page for information.)

In its simplest form, palliative medicine is an interdisciplinary model of pain and symptom management. It encompasses a commitment to care wrapped around a patient's physical comfort and emotional and spiritual well-being. It focuses on enhancement of the quality of life for the resident, support for the family, and includes the management of distressing symptoms, provision of respite, and care through death and bereavement.<sup>1</sup> Toward this end, we hope the following resources are helpful to you.

1. World Health Organization. *Cancer Pain Relief and Palliative Care in Children*. Geneva, Switzerland, 1998.



**The Pennsylvania Restraint Reduction Initiative thanks all caregivers and providers for the meaningful work that you do, and extends best wishes for a happy and healthy holiday season. May the coming year be full of blessings for you, your loved ones, and the residents for whom you care.**

### <http://www.nhpco.org>

The National Hospice and Palliative Care Organization (NHPCO) is the largest nonprofit membership organization representing hospice and palliative care programs and professionals in the United States. The organization is committed to improving end of life care and expanding access to hospice care with the goal of profoundly enhancing quality of life for people dying in America and their loved ones.

### <http://www.hospicecarecenter.org>

Hospice and Palliative Care Center (HPCC) is guided by the principles of raising public expectations and improving the quality of end-of-life care as it seeks new and creative ways to increase understanding and improve the delivery of care near the end of life. To achieve these goals, HPCC has developed close relationships with a wide range of health care providers in medical centers, long-term care facilities, and community organizations in order to improve professional and public education about end-of-life and palliative care and deliver home and hospice care to diverse populations, including people with chronic, life-threatening conditions, and nursing home residents.

### <http://www.medicaring.org>

Center for Palliative Care Studies (CPCS) offers expert support to hospitals, nursing homes, health systems, hospices, and other organizations that serve individuals nearing the end of life. It seeks to help make breakthrough change happen in areas that matter to patients and families. A key goal is to gather information and create a common database that can help improve the experience of dying patients and their families everywhere. CPCS was formerly known as the *Center to Improve Care of the Dying (CICD)*.

### <http://www2.edc.org/lastacts/>

This is an international, online journal featuring peer-reviewed promising practices in end-of-life care, useful tools, selected bibliographies, and other resources.

### <http://www.stoppain.org>

A project of the Department of Pain Management and Palliative Care at Beth Israel Medical Center, this website has won numerous awards for its content.

### <http://www.growthhouse.org/palliat.htm>

Growth House, Inc., provides resources for life-threatening illness and end-of-life care. Their primary mission is to improve the quality of compassionate care of the dying through public education and global professional collaboration. They offer professional forums, "find" palliative care instruments, check fast fact tutorials, help for quality improvement projects, and a free newsletter subscription.

# Three New Training Site Partners

Lutheran Home at Johnstown, The Rouse Home in Youngsville, and Little Flower Manor in Wilkes Barre are the newest Pennsylvania Restraint Reduction Initiative physical restraint reduction training site partners. They bring the number of training sites to 25.

The team at Lutheran Home at Johnstown (LHJ), under the direction of Patricia Konhaus, NHA, and Melanie Grecek, RN, BSN, has worked aggressively on restraint reduction since 2000. The team members agree that even though there were plenty of ups and downs during the process, the effort to create a safer environment without the use of restraining devices for their residents has been meaningful. LHJ has done extensive work to improve the monitoring of individuals at risk for injury including the development of the “pampered chef technique.” The pampered chef technique utilizes a cooking timer that is set to ring at 15-30 minute intervals to remind the staff to check on a particular resident. The staff at LHJ share this responsibility, passing the timer off to someone else working on the unit so as not to overwhelm one person with the frequent safety checks. In addition, the staff has been very aggressive regarding bed safety and side rail reduction. “It has been a joint effort,” explained Melanie Grecek. “We are a small facility so every person’s input counts. Creative thinking and willingness to try new ideas have allowed us to be successful.”

The Restraint Reduction/Fall Prevention Team at The Rouse Home (TRH) has also experienced the rewards and challenges of restraint reduction since 2000. Cindy Walters, DON, and Carrie Sauers, RN, have led the team in its effort to eliminate physical restraint use. Throughout their process, falls and risk of injury from falls were their greatest concern. That led to the creation of a very proactive fall prevention program. “The only way to maintain the safest possible environment for each resident is through constant education,” commented Carrie. “We still have some staff who struggle with our philosophy, so it’s up to us to see that they have a good understanding of why we want it that way. If that process stops, we would probably see old habits reappear.”

Little Flower Manor (LFM) in Wilkes Barre accepted the role of a physical restraint reduction training site in the spring of 2003. Lisa Marcincavagae, CRNAC, led the team and has felt from the beginning “that this was something so important to us in being able to provide a high level of autonomy and dignity to our residents. Looking back at what we’ve accomplished, we’ve learned that we could eliminate physical restraints, work together effectively as a team, and do all of this without compromising resident safety or quality of life. We are thrilled to be a partner with the Pennsylvania Restraint Reduction Initiative.”

Help is available from these three facilities or the 22 other training sites. If you would like to attend a training program facilitated by one of the training site partners, contact Mary Scharf. (See last page for contact information.)



Lutheran Home at Johnstown Restraint Reduction Team, back row from left to right: Patricia Konhaus, NHA; Melanie Grecek, QA Coordinator. Front row, left to right: Mark Adams and Paul Grela, Maintenance; Patricia Burns RN; Christine Cramer, Housekeeping; Amber Baker, Social Services. Absent from photo: Linda Pattison, Activities; Darlene Jones, DON; and Judy Fornwalt, RNAC.



The Rouse Home Restraint Reduction Team, from left to right: Mike Forslund, Rehabilitation Director; Carrie Sauers, Risk Manager; Marjorie Reinard, Social Services; Amy Trask, Unit Director; Cindy Walters, DON; Barb Toner, RNAC; Kathy Hawk, Restorative Nursing Coordinator; Jeff Ondrey, Administrator.



Little Flower Manor’s Restraint Reduction Team, left to right: Michael Semian, Assistant NHA; Cindi Henessi, Unit Manager; Lisa Marcincavagae, CRNAC; Rebecca Dominick, CNA; Sister Catherine Leighton, Director of Mission Effectiveness; Michele Boucher, PTA. Absent from photo: Barbara Maxwell, LPN.

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

- Karen Russell and Sara Wright of the PARRI training team joined staff from Windy Hill Village (WHV) of the Presbyterian Homes to present *Kaleidoscope Initiative: Chemical and Physical Restraints* at the Pennsylvania Culture Change Coalition Conference on August 20 in Harrisburg. The presentation highlighted the process that WHV staff applied to eliminate physical restraints and review/reduce unnecessary medications. These processes, part of their Kaleidoscope Initiative, have contributed significantly to a better quality of care for their residents. Kudos to Anne Ferguson, Laura Hamm, Jackie Soltis, Marcella Wood, and all WHV staff.
- A full-day workshop entitled *Moods, Behaviors, and Psychotropic Medications: Building a Balanced Review Process* was presented by Coleen Kayden, RPh, of Williams Apothecary and Sara Wright on September 9 in Greensburg. Participants reviewed the basic steps in developing an effective behavioral medication review procedure within their facilities. Medications commonly used for behavior challenges and the effects of aging changes on medications were discussed. The program was praised by participants and will be offered again in 2004. Thanks to all participants who made the 2003 programs a success!
- Neil Beresin of the PARRI training team participated on a panel for the conference *New Directions in Geriatric Behavioral Health for Long-term Care*. It was sponsored by the Mental Health/Aging Advocacy Project of the Mental Health Association of Southeastern Pennsylvania on October 16 in Philadelphia.
- PARRI's latest bed and side rail programs have been well received by providers. If you are interested in hosting one



Neil Beresin, Janet Davis, Karen Russell, and Sara Wright presented a session at the annual conference of the American Association of Homes and Services for the Aging.

of these inservices at your facility, contact Mary Scharf. (See last page for contact information.)

- The PARRI training team presented *Falls Got You Down? Building an Effective Fall Management Process in Long Term Care* at the American Association of Homes and Services for the Aging (AAHSA) 2003 Annual Meeting and Exposition in Denver on October 26.
- The PARRI training team facilitates a comprehensive on-site fall and safety evaluation for Pennsylvania long term care facilities. The process involves meeting with the "falls" team; reviewing facility forms, procedures, and policies; and evaluating current fall protocol systems. If you are interested in discussing this type of program review, contact Sara Wright. (See last page for contact information.)

## Educational Materials Available

- The PARRI training team, with *Untie the Elderly*<sup>®</sup>, has compiled a resource guidebook, *Assessment Tools and Guidelines for Nurses and Caregivers*. Sections include: Bed Safety/Rails, Behavior Management, Environmental Safety, Fall Prevention, General Nursing, Medication Monitoring, Monitoring Devices, Pain, Restorative Nursing, Restraint Elimination, and Seating. Cost is \$25 to Pennsylvania providers; \$40 to others.
- A new video is now available on bed and side rail safety called *Do No Harm!* 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 video helps the viewer understand the importance of individualizing the bed system for each person, regardless of the health care setting. Cost is \$45.
- *Quality Care: Resource Catalogue for Health Care Providers and Caregivers* is a new 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.

# • Upcoming Activities •

## **TELECONFERENCING SERIES FOR 2004 to be launched in January**

Based on the successful bed and side rail safety teleconferences offered this past year, the new series is designed to provide more accessible educational opportunities and support to long term care facilities. The four topics chosen for 2004 include: 1) bed and side rail safety, 2) falls, 3) pain/behavior management, and 4) activity interventions. For more information, contact Mary Scharf.

## **POPULAR FALLS PROGRAM continues in 2004**

This comprehensive full-day program addresses strategies for developing successful fall prevention and safety management practices. The program will be offered in the Philadelphia, Lancaster, Scranton, and Pittsburgh areas in March and April, 2004.

## **FALL PREVENTION INITIATIVE to be launched in Spring, 2004**

Based on the response to a survey sent to all nursing facilities, the Pennsylvania Restraint Reduction Initiative will be launching a fall prevention initiative in May. While most facilities have a process for fall review, many struggle with fall risk assessment, intervention strategies, and developing comprehensive policy and protocol. PARRI will select a small number of homes to pilot the development of a comprehensive fall management system. Applications will be sent to all nursing facilities in January, 2004. Please watch your mail!

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The Pennsylvania Restraint Reduction Initiative training team provides support and technical assistance to all Pennsylvania nursing facilities striving to deliver quality care to their residents. Consultation and on-site visits addressing the following areas is offered: physical restraint reduction, bed and side rail safety/reduction, fall prevention, psychoactive medication reduction, behavior management, and individualized assessment. 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)

All general or product inquiries, contact Mary Scharf at 610-388-5580 or by e-mail, [mscharf@kcorp.kendal.org](mailto:mscharf@kcorp.kendal.org)

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