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PARRI NEWS

THE PENNSYLVANIA RESTRAINT REDUCTION INITIATIVE

And the Winner Is… Making a Difference in the Lives of the Residents We Care For

THANK YOU TO ALL THE COMMUNITIES WHO SUBMITTED AN ESSAY for September's "making a difference in the lives of the residents you care for" request. Several people wrote about individuals with great energy and spirit including Susan Brown, RN, from Homewood at Plum Creek in Hanover. Susan identified **Angie Cole** as a nurse who makes a difference. "How do you praise an employee who goes above and beyond the job description at all times? An employee who is wise beyond her chronological age...who is compassionate for residents, families, and friends...who makes all the employees feel very special. Her kindness and loving heart are astonishing...." **Esther Scott**, a nursing assistant at Claremont Nursing and Rehabilitation in Carlisle, was recognized by Mary Mentzer, RN, for her recent handling of a resident's fear during a shower. Esther had the insight to stop the bathing and started to sing an old familiar hymn, *Precious Lord, Take My Hand*. Within a few moments, the resident's fear eased and she joined in the singing, along with others in the area. Esther creatively averted a potentially difficult situation with grace and dignity. "Esther is truly one who makes a difference in our residents' lives," wrote Mary.

Several essays were focused on teams. Linda Harmon, RN, from Country Meadows in Bethlehem wrote that she is proud to have "an exceptionally strong TEAM...we have had a dramatic decrease in the number of falls and restraints, and have greatly raised the level of care of all our residents." Nancy Tyrell, RNC, from Good Samaritan Nursing Care Center in Johnstown identified her *"Performance Improvement Team* for their endless hard work to reduce side rail usage and the number of falls occurring at the facility." The team initiated numerous vendor product trials and demonstrations, created an educational brochure, developed a new assessment tool with a heightened focus on new admissions, and compared and communicated fall rates to all staff. The number of falls from January through August, 2004, decreased approximately 60% from the same time period in 2003. "This team has worked unselfishly to improve our residents care and outcomes. I believe they should be recognized," wrote Nancy.

The winning essay came from the Unitarian Universalist House in Philadelphia by way of Beth Proukou, RN. Beth writes:

"**Roberta Weaver**, a Certified Nursing Assistant, has been employed at the Unitarian Universalist House in our skilled unit since 1983. She consistently has been an exemplary employee, was selected by her peers and all departments as our first 'employee of distinction' after the program was initiated in 1998. We have an entire restorative program team and the team merits commendation, but Roberta is the mainstay of the team and is consistently extraordinary. She is bright, calm, and encouraging to residents, and patient and resolute in each resident's restorative program. In addition to the ongoing exercises, Roberta supervises a special 'breakfast club' and monitors a specific group of residents in a community dining setting. In this role she also makes recommendations for advance dining room placement, depending on each resident's progress. She participates on our fall prevention team and in resident care conference, where she makes significant contributions."

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PLEASE ROUTE OR COPY: ☐ DON ☐ RNs/LPNs ☐ Social Service ☐ RNAC
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☐ Other_______________ ☐ Other_______________ ☐ Other_______________

Making a Difference in the Lives of the Residents We Care For

.....continued from page 1

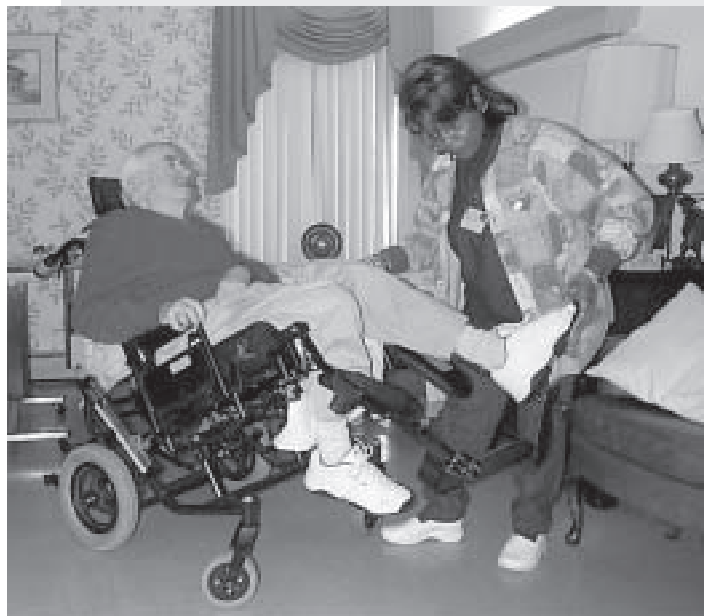
"I am attaching an article published in our *Unitarian Universalist Friends Newsletter*. The article exemplifies the contributions of our restorative program and Roberta in particular. As I said in the article, it would be easy to renege on a portion of the treatment plan when progress seems obscure or slow. But the integrity and perseverance for goal attainment among staff and the residents are great motivators and are instrumental in promoting the ongoing success of the restorative program."

People often ask or worse yet, simply state, "nursing homes are so depressing." I can honestly tell you that day after day we have the good fortune to experience wonderful slices of life that are beautiful and that energize all of us who provide care and service to our residents. A most recent anecdote illustrates life at Unitarian Universalist House.

Mr. L, a delightful 78-year-old man, was admitted to our facility in May of 2003 from a prestigious retirement community in the Philadelphia area. He had been falling frequently and was now confined to a wheelchair, unable to stand or walk. Additionally, he was unable to converse coherently. He is bright-eyed and has a sunny countenance. He was evaluated by physical therapy staff who promptly discontinued therapy because the resident was unable to follow cues. Our nursing staff, and in particular the restorative certified nursing assistant staff, was swiftly and steadfastly undaunted.

Rather than trump with the ace, I'll lead with it and tell you that on March 2, 2004, a full ten months later, with the aid of a walker and his ever-present restorative aides, Mr. L walked. I mean he walked, not just taking a few feeble steps, but walked the length of the corridor to the praise and cheers of all present. Not really knowing how long this great feat would last, we immediately called his son who was able to come and savor the moment. But Mr. L's restored ability has continued, to his understandable glee and that of all of us. To add to the excitement, his ability to speak has improved slowly and remarkably, he can converse, and is able to make fast retorts to our quips.

To be certain, Mr. L always must have had the resolve to achieve these goals. And surely if he were left to languish in his bed and chair, none of this would be possible. Every day since admission, he has participated in his exercises, moving what he can, and allowing passive range of motion exercises by the aides. It could have been easy to renege on at least a portion of the daily regimen. When I interviewed our lead restorative nursing assistant, **Roberta Weaver**, CNA, who is also our first 'Employee of Distinction,' to see what insight she might have on this success story, she said, "He learned to trust us and know that we were there to help him. I always first explained the drill for the day and I always talked to him throughout the therapy session. I said good morning and coached him to say good morning to me. He soon was able to repeat our names back to us. Little by little he began saying more. Some days he seemed clearer and stronger than others, but we always completed his sessions. And he likes women around and there are plenty of us here." If you visit Unitarian Universalist House and see a tall, handsome, bright eyed, gray haired man walking in the corridors, he's not a new face. It's just that his most recent accomplishments were ten months in the making.



Roberta Weaver works on a stretching and strengthening program with a resident at the Unitarian Universalist House, Philadelphia.

Thank you and congratulations to all who wrote to us. Your staff and teams inspire, and remind us that despite the challenges we face in long-term care, there are some who are able to rise above them and truly make a difference.

PA FIRST[1] Fall Management Project Begins Phasing In Additional Facilities

WE ARE DELIGHTED TO ANNOUNCE the kick-off of Phase II of PA FIRST, Pennsylvania's first fall management and prevention project. The three new facilities that will be working towards becoming fall management training sites over the next 12 months include Weatherwood Carbon County Home in Weatherly, Luther Acres Manor in Lititz, and Fulton County Medical Center in McConnellsburg. This will bring the total number of fall management training sites to six.

Weatherwood-Carbon County Home Fall Management Team. *Front, left to right: Joanne Peters, Susan Hydro, Janis Billig, Donna Maleski, Sharon Benack, Betty Smith. Back, left to right: Barbara Nocchi, Catherine Fikentscher, Susan Blackwell, Susan Hamm, Betsy Dotter, Fay Hunsicker, Nancy Markovchick, Sandra Shemonsky, Donna Stone, Sally Mitchell, Charon Gimbi.*

Fulton County Medical Center Fall Management Team. *Front, left to right: Melissa Randler, Lynn Miller, Tracy Everhart. Middle, left to right: Ann Smith, Paula McFadden, Lori Lupey, Wendy Mumma. Back, left to right: Jeffrey Thomas, Teresa DeShang, Donna Carbaugh, Dawn Baughman, Kim Slee.*

RIGHT: Luther Acres Manor Fall Management Team. *Front, left to right: Susan Heilman, Judy Henninger, and Melissa Boas. Back, left to right: Joseph Mraz, Marvis Hambleton, Carla Palm, Nancy Kieffer, Paula Palm, and Tamara Dunlap.*

Through the first eight months of the PA FIRST project, much has been learned and accomplished. Weekly meetings with fall teams from each of the Phase I sites, teleconferences, and a half-day seminar in Lewisburg have facilitated a more comprehensive approach to fall management. In addition, all Phase I sites completed a mid-term project evaluation. Below are some staff responses to the question, "What have you found most helpful in the PA FIRST project?"

- Since our staff need more education, the programs PARRI has offered will be very useful in helping us to deliver the "critical thinking" piece to facility staff. Many of our staff come from an acute care background and they are not used to giving care in this way.
- Doing in-depth chart reviews related to resident falls and really looking for things we may have missed.
- "Trickle-up," everyone should be involved.
- Identify communication breakdown. We created a simple sheet that captures recent falls and new behaviors.
- Increasing the awareness by all staff of those residents who are at risk.

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[1] *FIRST is an acronym for **F**all **I**nterventions, **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.*

Dementia
More Than Just a Memory Problem

COGNITION, the mental process through which we obtain and retain knowledge, is not exempt from age-related changes. Involved and difficult tasks that we learned when younger, e.g. gapping spark plugs, adjusting the carburetor and engine belts to keep a car running smoothly, may remain with us for years to come. However, trying to learn how to program a cellular phone for speed dialing or using a computer may prove to be more difficult to learn when we are in our 70s, 80s or 90s. That's not to say the elderly we care for cannot learn new skills or gain knowledge. The rate or speed at which they learn, along with the components used to obtain new knowledge, will most likely change. Studies have shown that reading, vocabulary, and long-term factual memory components are areas least affected by the aging process. Those areas most affected include visuo-motor skills, delayed recall, and serial learning processes.

Unlike the "normal," or expected, changes in cognition that occur with growing old, dementia is a specific condition or syndrome that can cause a much greater decline in cognitive abilities. According to Kawas, the syndrome of dementia "has over a hundred potential causes."[1] The effects of dementia go beyond simple "forgetfulness" or memory impairment. A person's language or ability to communicate and understand language, to reason or make judgments, to grasp abstract ideas and concepts, and to make visual "sense" of the self in relation to the surrounding environment must all be evaluated when considering a diagnosis of dementia. By the time an elder with a dementia syndrome is admitted to a long-term care facility, the diagnosis is usually well established and the diagnostic process is rarely the focus of care for the frontline staff including nurses, nursing assistants, therapists, and social workers. What may be more helpful to the various care team members is to determine *how* the diagnosis of dementia has affected that *individual resident*.

Each individual has the potential to demonstrate *hundreds* of different ways or reactions that reflect the presence of a significant cognitive impairment. Educating staff about some general indicators or behaviors associated with the more common dementia syndromes seen in nursing home residents may improve care outcomes by helping to identify more focused care plan interventions. The areas of the brain most affected by the dementia frequently determine what signs or behaviors we will see. The accompanying table outlines some of the general changes or cognitive areas that may be affected by the cortical, sub-cortical, and vascular types of dementia, along with potential signs and behaviors that may be observed. Actual care plan interventions must continue to address the individual's presenting care needs whatever may be the cause of the underlying dementia.

Sara Wright, MSN, CRNP
Nurse Practitioner/Consultant, PARRI

TYPE OF DEMENTIA
Cortical (cerebral cortex): Alzheimer's Disease · Frontal lobe dementia · Lewy Body dementia
Sub-cortical (basal ganglia & brainstem): *Parkinson's Disease* · *Huntington's Disease* · Progressive Supranuclear Palsy (PSP)
Vascular (ischemic, infarction, hemorrhagic)

1 Hazzard, WR et al (ed.): Principles of Geriatric Medicine and Gerontology, 4th ed. (Chapters 92, 95, 97) NY, McGraw-Hill, 1999.

COMMON CHARACTERISTICS	CARE CONSIDERATIONS
Inability to remember or retain information; gets “lost” in everyday surroundings; unable to identify common objects or their use; can’t find the right word or substitutes/makes up words→difficult to understand what they are telling us; appear unconcerned or impulsive, irritable, suspicious or uninhibited→hitting, yelling. Lewy body type—more likely to demonstrate associated gait/motor changes of the sub-cortical dementias and have more marked fluctuations in day-to-day cognitive/functional ability; may have higher degree of “confusion” on some days more than others; may experience episodes of loss of consciousness; visual and/or auditory hallucinations are common.	Avoid using the word “remember” and don’t expect the person to be able to; try verbal, visual & tactile cues, i.e. “brush your teeth” while placing toothbrush in resident’s hand & gently guiding their hand to their mouth; post object or photo at resident’s room that they recognize; pay attention to resident’s tone of voice and non-verbal body language to identify if communicating happiness, anger, or anxiety regardless of what words they are using; recognize that if something we do during care unintentionally is uncomfortable or hurts them, they are likely to hit/strike out at us
Slowed, monotonous or whispered speech; little motivation or energy to initiate/start an activity or task; flat, depressed or apathetic mood; marked changes in motor skills→stooped posture or rigidity/hyperextensions, slowed or “frozen” movements, tremors, gait changes/instability.	Avoid rushing resident through care tasks/routines; although “forgetful,” they may be able to recall if given time & verbal/visual cues; recognize that they will have more frequent changes between “good” days and “not-so-good” days with both ADL and ambulatory/transfer abilities.
Depend on areas of the brain that are affected: **Lacunar:** sub-cortical characteristics **Anterior, middle, posterior cerebral arteries:** cortical characteristics **Carotid arteries:** cortical characteristics **Small vessel disease:** cortical characteristics **Combination deep and superficial infarctions/insults:** cortical & sub-cortical characteristics* **Adapted from Cummings, JL and Benson, DF.* Dementia: A Clinical Approach, 2nd ed., Boston, Butterworth-Heinemann, 1992.	Usually have a left or right-sided body weakness/paralysis or other physical/functional problems from the original vascular event/accident (stroke, brain injury) that led to the dementia; physical changes may include pain, numbness or overly sensitive areas of the body→hitting/striking out during certain care tasks; depression is common as are rapid changes in emotions e.g. crying one moment, laughing the next ; confusion may be worse at night; residents may use short, simple sentences and may better understand short simple directions/explanations; impulsive behaviors or neglectful/denial tendencies→safety concerns; may get frustrated over their inability to express themselves or their inability to understand what we are telling them; focus on maintaining current physical abilities and using/exercising remaining cognitive/thinking skills to ↓ frustration and feelings of helplessness. *Sara Wright, PARRI*

PA FIRST[1] Fall Management .....*continued from page 3*

When staff was asked, “What changes to your fall management protocol would you highlight in a training program,” their responses included:

- Being proactive on review of new admission history, doing immediate investigation of falls, and making immediate changes to care plans.
- The importance of addressing policy and procedure at the beginning—this is the foundation from which you work.
- Taking baby steps—this does not happen over night. Allow staff to have educational opportunities to develop the skills for critical thinking.
- Find ways to easily audit for interventions to make sure there is compliance.

Phase I sites are currently working on final revisions to their fall policies and procedures, as well as preparing a comprehensive fall management education plan for their staff. By spring of 2005, Phase I sites will begin to develop a training program for neighboring facilities that highlights their accomplishments, critical changes to their fall management process, and continuing challenges. By June, 2005, it is anticipated that the facility training teams will begin to offer training programs to area facilities. We look forward to our continuing partnership.

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 sites 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 occuring sounds recorded in six long-term care facilities.

TABLE I. 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	

Another study by researchers at the Georgia Institute of Technology of 92 metro Altanta 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 to not awaken 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 home" or are awakened.
- Develop a cleaning schedule that is sensitive to residents, especially during vacuuming and other loud cleaning activities. Perhaps more residents can be off the unit or further away from the cleaning activity. Scheduling activity programming off the unit at times when housekeeping is using loud pieces of cleaning equipment may help.

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1 Kovach, C.R. (2000). Sensoristasis and imbalance in person with dementia. *Journal of Nursing Scholarship*, Fourth Quarter, 379-384.

2 The Sound of Music? American Society of Consultant Pharmacists, 1998 (online publication)

3 Georgia Research Tech News. Quiet on the Hall: Researchers Search for Ways to Reduce Noise and Improve Sleep in Nursing Homes. October, 2002 (online resource)

Where Did That Come From? When Restraints Suddenly Appear**

IN MY ROLE AS REGIONAL DIRECTOR with the Pennsylvania Restraint Reduction Initiative (PARRI), I am in nursing facilities on a daily basis and have the opportunity to get involved in all aspects of the restraint reduction process. One situation that is particularly troubling is the growing trend of physical restraints that seem to be appearing from nowhere. I am referring to the use of devices on residents for which there is no physician's order, nor is there any evidence on the resident's chart that a process was followed to determine appropriate use of the device. Some of the most common examples include side rails, lap cushions, lap trays, and seatbelts. Recently, one of the staff members at a facility I visited was asked why a particular resident had the seatbelt on. She responded, "It came with the chair so I put it on her." Other devices observed are more "innovative" designs such as: the use of a gait belt or clothing belt wrapped around the front of the resident and secured behind the back of the chair; the use of folded wheelchairs along both sides of a bed for a resident who was not issued side rails; and, a resident's sweater put on backwards and then buttoned behind the back of her dining chair, essentially rendering her a prisoner in her chair while eating.

Whether it is a device specifically manufactured to restrain or a common article "creatively" applied by staff that restrains or restricts movement, the act of placing it on the resident without evidence that a process was followed is categorically wrong!

Whether it is a device specifically manufactured to restrain or a common article "creatively" applied by staff that restrains or restricts movement, the act of placing it on the resident without evidence that a process was followed is categorically wrong! Why are staff members intervening in this way? Some reasons may include:

1. Lack of understanding or knowledge on the part of the direct care staff. This includes all disciplines involved in the care of the resident. Staff may not be aware of the regulatory issues related to restraining a resident. The regulations on restraint use are crystal clear and include the necessity of an assessment by an interdisciplinary team, a physicians order, and informed consent. (There are additional criteria as well.) The decision to restrain is a serious one and should never be made by one person. (Perhaps with the exception of an "emergency," and only by an RN supervisor.) The simple action of pulling up a side rail without an order, for example, may seriously jeopardize the safety of the resident involved. In addition, the staff member who elevates the rail without an order may be held personally responsible for an adverse event, and place him/herself and the facility in a position of heightened liability.

2. Family members may also be a source for restraint use. Rarely do they ever put the devices on, but in many cases family members may pressure staff to comply by way of veiled threats including litigation. Often, family members who do this are motivated by a genuine concern and fear that something very bad is going to happen to their loved one if there is no restraint in place. However, staff and families must be made aware that a restraint is *never* to be initiated solely on the basis of a family request.

3. Confusing communication process in the facility. There must be mechanisms in place so that staff has the opportunity to be heard. It is not uncommon for a caregiver to take matters in his/her own hands, especially if s/he thinks s/he is doing something that will keep the resident from getting hurt. If the staff person is reporting unsafe resident behaviors on a number of occasions, and it seems no one is stepping up to suggest new "safety" interventions, the caregiver's frustration and concern may motivate her to put a restraint on. Every facility has an obligation to ensure that each resident has a plan of care that is appropriate in meeting the goals for safety. No staff member likes the feeling of being between "a rock and a hard place." When you have many residents to care for and many of them requesting help, it is often hard to prioritize. Do I take Mrs. S to the bathroom or continue to stay with Mr. D who keeps trying to stand from his chair? Is there a process for communication in the facility that will allow the situation to be addressed in a timely manner? Nurture staff creativity and care to develop more appropriate safety plans for residents. To summarize, facilities should:

- Make sure staff has the opportunity for ongoing education and training on the subject of physical restraint and bed and side rail use and safety. Call the Pennsylvania Restraint Reduction Initiative (PARRI) if you need help. (See back page of newsletter for contact information.)
- Be alert for devices that appear from nowhere. Random audits may be one way to monitor this. The most likely time for restraints to appear is during the 11-7 shift, when rails may be pulled up without orders.
- Ensure that there is a process in place that allows staff concerns to be heard and addressed in a timely manner.

Karen Russell, LPN
Regional Director, Western Division, PARRI

**Physical restraints have been shown, in most circumstances, to decrease safety and damage residents self-esteem and self-regard. In addition, physical restraint use has led to a decline in health care outcomes including, but not limited to, increased incontinence, anxiety, depression, anger, skin breakdown, and infection in the residents they were intended to help.

Is It Time for You to Join the PARRI Effort?

Sara Wright (standing), facilitates the session, "Falls, Behaviors, and Medications: An Ounce of Preventative Assessment" for ***PA FIRST*** *training site staff, December 2, 2004.*

It's Important Work. Let's Do It Together.

See the back page of this newsletter for complete contact information.

Improving the Nursing Home Environment.....continued from page 6

- 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.

- Be aware of increased 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.

Janet Davis, BA, ACC
Regional Director, Central Division, PARRI

N • E • W • S N • O • T • E • S

- The PARRI training team presented *Developing Medication Review and Fall Prevention Programs: Lessons Learned from a Statewide Initiative* at the American Association of Homes and Services for the Aging (AAHSA) in Nashville, Tennessee in October.

- Neil Beresin, PARRI Regional Director presented *Realigning Your Bed and Side Rail Safety Program for Success* at the conference, "Strategies: Educational Excellence for Health Care Providers" at Pennsylvania State University in November. The conference targeted nurse managers, and nurse inservice trainers, as well as health occupations/allied health instructors.

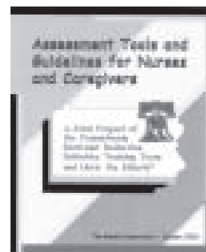
- PARRI's teleconference series for 2004 demonstrated that Pennsylvania providers continue to need innovative and cost effective ways to educate their staff. Fourteen teleconference training programs on falls, behavior and medications, activities, and bed and side rail safety were held in 2004. During the year, 137 facilities and 705 staff participated in this training opportunity.

- The PARRI training team will be offering 11 teleconference trainings in 2005 on topics including family friction, falls from an f-tag perspective, and bed and side rail safety, To register for any of these free programs online, go to parri.kendal.org, click on the Consultation, Education and Resources tab, then click on the Teleconference Trainings tab.

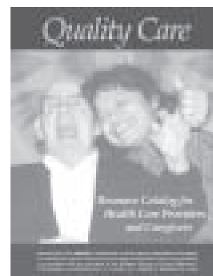
- The PARRI training team will be doing some work for the Quality Insights of Pennsylvania (QIP) in 2005: a teleconference on March 16 and three training sessions in May. For program dates and locations, check the QIP and PARRI websites.

Educational Materials Available

• A video, ***Do No Harm***, is now available on bed and side rail safety. 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.



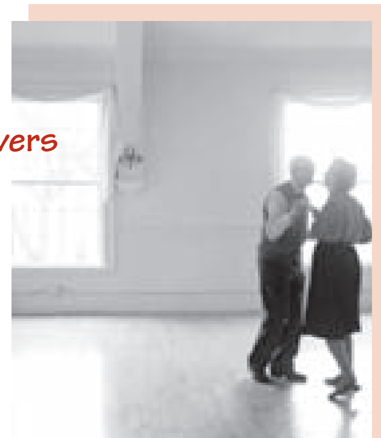
•The PARRI training team, with *Untie the Elderly®*, has compiled a resource guidebook, ***Assessment Tools and Guidelines for Nurses and Caregivers***. Sections include: Bed Safety/Rails, Behavior Management, Environmental Safety, Fall Prevention, General Nursing, Medication Monitoring, Monitoring Devices, Pain, Restorative Nursing, Restraint Elimination, and Seating. Cost is $25 to Pennsylvania providers; $40 to others.



•***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.

New web presence: The Pennsylvania Restraint Reduction Initiative has an exciting new presence on the world wide web. Informative, interesting, interconnected with all Kendal communities and services. Please visit parri.kendaloutreach.org

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 new year. May the coming year be full of blessings for you, your loved ones, and the residents for whom you care.



Did you know that the Pennsylvania Restraint Reduction Initiative is a grant-funded project available as a resource to all long term care providers in Pennsylvania as they work to create quality care practices for their residents? The nature of our work may range from facilitating staff educational programs to working with interdisciplinary teams. If requested, we will review residents who may be falling frequently, who are currently physically restrained, or who exhibit increasingly challenging behaviors. Do not hesitate to contact any member of the training team for assistance.

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

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

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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.