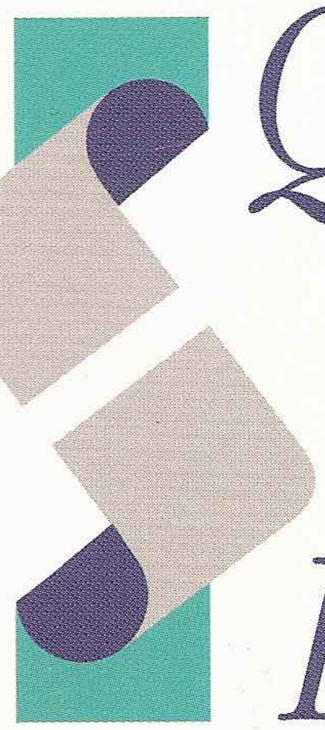
INSERVICE TRAINING MANUAL

Everyone Wins!



Quality Care Without Restraints

RESIDENT CARE LIBRARY

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Everyone Wins! Quality Care Without Restraints *is a project of the Independent Production Fund, New York, New York, in association with Toby Levine Communications, Inc., Bethesda, Maryland. Research for this project was sponsored by Beverly Enterprises, The Commonwealth Fund, Kendal Charitable Funds, and The Retirement Research Foundation. The producers and sponsors cannot be held responsible for decisions made by health care professionals when applying OBRA's principles to any individual resident who is under their care.*

Introduction

Everyone Wins! is a video library about creative ways to provide quality care to nursing home residents without using restraints. It was developed to help staff in all long-term care facilities improve the care they are providing by getting to know their residents better and meeting their unique individual needs. It also seeks to provide individuals who visit nursing homes — for personal or professional reasons — with information on why restraint-free care is important and how they can help it be achieved.

How To Use this Manual

This manual is designed to support the use of the *Everyone Wins!* Resident Care Library for inservice training with a variety of nursing home staff, including nurses, nursing assistants, skilled therapists, social workers, activities coordinators, and support staff. Each video module is self-standing and can be used independently of other modules. Modules also can be used in any order. Depending on your goals, you may choose to spend a half-hour or several weeks on each module.

This manual contains the following elements for each module:

Length of Video

All videos run 10 to 15 minutes to enable you both to show and to discuss the content in a 30-minute training session. Most videos have several short segments or stories, each of which begins with an on-screen title. These titles will help you locate specific segments and facilitate your use of discrete parts of a module in a training session.

Overview

This tells the basic theme and content of the video.

Handouts

Each module contains several handouts that support its content and suggest ways in which the content can be applied locally. These may be duplicated and distributed, used as mini-posters, or converted into overhead masters for use as discussion tools. The handouts themselves are grouped together in the pocket in the back cover of this manual. Each includes the name and number of the module with which it is associated.

Video Places and Faces

This section tells where the video was taped and who is seen.

Objectives

These suggest goals to which you might orient your training. Select

Using Video for Training

If your inservice training time is very limited, consider asking trainees to view the videos independently prior to the day training is scheduled. Previewing the videos yourself will help you compare and contrast the facilities seen in the module with your own, select content on which you would like to focus, and anticipate questions your trainees might raise. It also provides an opportunity to determine which employees should be scheduled for training.

Jot down the counter numbers of those parts of the video on which you would like to focus discussion. While each VCR differs slightly in the accuracy of these counter numbers, your notes will help you find specific segments more quickly than scanning the tape when you are actually in a training session.

Prior to showing the video to your group, tell trainees the basic theme of the module and some specific things to watch for. You might ask different viewers to focus on certain residents, for example, or on specific techniques. You do not need to present a lecture on the content, however. Let the video work for you and draw the content out of the shared viewing experience.

While some viewers will be able to remember a substantial amount of what they saw, others may need some assistance in recall. If your training group contains individuals who have not previously used video as an educational tool, review the content by asking each trainee to tell you one thing he or she remembers from the video. This involves all trainees quickly and provides an opportunity to make notes on a chalkboard, easel

those that meet the needs of your facility and the individuals you are training.

Background
This is a brief essay on the theme of the module.

Before Viewing
In this section you will find suggestions of materials and information that you should gather or think about before using the videos for training purposes. It also suggests activities and discussion areas in which you might engage trainees prior to showing the video.

Discussion
The core of the training is in this section. A thought-provoking question — voiced by the narrator and seen on-screen — ends each video to lead right into a group discussion. This question is highlighted at the beginning of each section. Following it are eight to ten questions designed to engage trainees to discuss further the content of the video. Notes on how the discussion might run are included.

Applications
These activities will help trainees apply the module's concepts to their own work situation. They might form the basis of additional discussion, group work, or homework, depending on how you structure your training.

Using Video for Training *Continued*

board, or overhead projector to which you can refer in the ensuing discussion.

If you have given certain viewing assignments prior to showing the video, be sure to go back over them.

If time permits, show the video a second time. It is extremely difficult for any viewer to catch all the nuances of behavior with only one viewing. While we recommend that you do not interrupt the video with interpretive comments the first time it is shown, use subsequent screenings to point out specific behaviors that trainees might have missed the first time. Also consider reshowing brief segments if your trainees either cannot remember what they saw or disagree about what they saw.

Other Titles in the *Everyone Wins! Quality Care Without Restraints* Video Library

- The Management Perspective (16-minute video and viewing/resource guide)
- Everyone Wins! A Family Guide to Restraint-free Care (12-minute video and pamphlet)
- Surveying the Restraint-free Facility (14-minute video and discussion guide)
- Physicians and Restraint-free Care of the Elderly (30-minute audio cassette on chemical and physical restraints)

For further information, contact the Independent Production Fund, 45 West 45th Street, New York, New York 10036, 1-800-727-2470.

Module 1 The New Resident

Length: 12 minutes, 21 seconds

Handouts

- 1A. Four Steps to Restraint-free Care
- 1B. Sample Behavior Mapping Chart
- 1C. Family Interview Check List
- 1D. Restraint-free Interventions for New Residents

Video Places and Faces

Marian Estates at Sublimity, Oregon
Donna Bullick, R.N., *Resident Care Manager*
Joy Keating, R.N., Ph.D., *Nursing Services Director*
Arlene Pickens, *Resident*

Florence Nightingale Nursing Home, New York, New York
Ferlina Baniqued, R.N., *Charge Nurse*
Victoria Calderon, *Resident*
Gwen Desuza, M.S.W., *Social Worker*
Rose Dorsey, *Resident*
Judy Ginsburg, O.T.R., *Occupational Therapist*
Florencia Guerzon, R.N.S., *Rehabilitation Nursing Coordinator*
Onuachu Ngozi, R.N., *Charge Nurse*
Robin Wolff, *Director of Rehabilitation*

Overview

Staff at Marian Estates at Sublimity, Oregon, and Florence Nightingale Nursing Home in New York, New York, show how they kept three new residents restraint free from admission using a conscious process of assessment, planning, implementation, and monitoring. Residents' admitting problems included blindness, language differences, confusion, agitation, disorientation, total dependence for activities of daily living, unsteady ambulation, and a prior history of falls. Joy Keating demonstrates the assessment technique of behavior mapping as one means of getting to know residents better.

The following residents are featured:
- Arlene Pickens, admitted 9 days ago
- Rose Dorsey, admitted 11 days ago
- Victoria Calderon, admitted 21 days ago

Objectives

Conduct an initial assessment of a resident's medical, psychological, and social needs.

Meet with the family to identify the resident's life and behavior patterns prior to admission.

Differentiate between a new resident's immediate needs and long-term needs.

Devise a behavior mapping plan to observe and assess a resident over a multi-week period.

Develop facility guidelines for admissions procedures that emphasize resident safety in the context of a restraint-free environment.

Background

The day an individual first enters a nursing home is likely to be one of the most difficult days of his or her life. The new resident may be in a particularly weakened condition due to recent surgery or illness and is likely to be at least a little disoriented. Family members are likely to be more than a little anxious. How the facility treats the resident and his or her family during this period may set the tone for the rest of the resident's stay in the nursing home.

Because some residents arrive at nursing homes either already restrained or with orders to apply restraints as needed, it is important to have a clear policy and specific procedures that enable residents to safely become or remain restraint free from the very beginning. Assessment is a very important part of this process. While the law stipulates that a certain amount of data must be collected about a resident in a given period of time — the Minimum Data Set or MDS — this assessment is only the first step in developing a resident's care plan.

A complete assessment is the single best tool you have to avoid the use of restraints from the start. The Resident Assessment Protocols (RAPS), which follow the MDS, provide a framework for conducting a more comprehensive assessment and obtaining additional background information on residents' strengths, preferences, and needs. RAPS cover the following areas: 1. delirium/cognitive loss/ dementia, 2. visual function, 3. communication, 4. daily living function/rehabilitation potential, 5. urinary incontinence/ in-dwelling catheter, 6. psychosocial well-being, 7. mood state, 8. behavioral problems, 9. activities, 10. falls, 11. nutritional status, 12. feeding tubes, 13. dehydration/fluid maintenance, 14. dental care, 15. pressure ulcers, 16. psychotropic drug use, and 17. physical restraints.

When the MDS and the RAPS are used together, a more thorough picture emerges to guide resident care planning than any single assessment would provide.

Such an integrated assessment can identify situations that traditionally have led to restraint use. Once these needs and behaviors are identified, they can be anticipated and a care plan can be developed to assist the individual without using restraints.

Behavior mapping can provide even more specific information about when behavioral symptoms are most likely to be evident and how severe they are likely to be. When the frequency and severity of a particular behavior are mapped periodically, changes in the resident's behavior can be easily identified and documented.

The development of an initial care plan is only a first step, however. The plan must be implemented carefully and the resident regularly reassessed. Frequent monitoring and reassessment are particularly important with regard to a new resident, as his or her needs may well change radically within a few weeks. Bear in mind that this initial adjustment period may last up to 12 weeks.

Before Viewing

■ Review your facility's admission policy concerning restraint use, and also the extent to which it is followed.

■ Have available any tools regularly used for assessment of new residents.

■ Determine the percentage of new admissions who arrive at your facility in restraints.

■ Have trainees discuss how they usually assess a new resident's need for a restraint and how they feel when they need to apply a restraint.

■ Some trainers have found that the use of a role-playing exercise in which learners are restrained for a period of time is a very effective technique with those who are new to the concept of restraint-free care. You will see this technique used in the video. Trainees drink fluids prior to the session in which they are restrained to create the need to go to the bathroom while restrained. Vision is blurred by rubbing petroleum jelly on eyeglass lenses. Hearing is modified with cotton balls. If you choose this technique, trainees should be given the choice of whether or not to participate. Those who do not wish to be restrained may be assigned the task of applying restraints to those who do. Once the conditions have been set, do not refer to the restraints again during the set period of time you select. Conduct all other activities — including some that require moving around — as if all trainees could move about at will. At the end of the set period of time, it is most important that you provide ample opportunity for participants to talk about the experience and to express their feelings. Include in this discussion both those who applied the restraints and those who were restrained. Ask participants also to discuss how they think their own feelings might compare to those of residents.

■ Ask trainees: *If you spent one hour simply observing a new resident, what do you think you would learn?*

Discussion

What could you do to promote a new resident's independence and adjustment to your facility?

1. How are the new residents' needs assessed in the cases you saw in the video?
Observation of a resident's strengths and weaknesses is used to assess all three cases in the video. The staff had visited Arlene Pickens' home prior to admission and thus were aware of her lifestyle and the things that were important to her. After admission, they utilized behavior mapping to identify what times of day and what events precipitated her crying and asking to go home. They responded by taking her outdoors — which they knew she enjoyed — to help her adjust to a new environment.

In Rose Dorsey's case, staff quickly realized that although she was blind, she also was independent and could verbalize her needs. After giving her a call light to notify staff when she needs assistance, staff members realized that a side rail for her bed was not needed.

In Victoria Calderon's case, the nursing staff observed that she became agitated when people did

not understand her and calmed down when someone interpreted for her. To alleviate her anxiety, Spanish-speaking staff was assigned to assist Mrs. Calderon, and she was placed with a Spanish-speaking roommate.

2. Why is an interdisciplinary approach so vital to the adjustment and safety of a new resident?

Because every discipline has a particular area of expertise, each team member will have different suggestions and insights into a resident's needs. This is very valuable in establishing a care plan and assisting a resident to be safe in the least restrictive environment. A physical therapist, social worker, occupational therapist, rehabilitation specialist, activities specialist, and charge nurses should all be part of the facility-wide team to keep new residents restraint free. You might also point out that family members and nurses' aides can play very important roles as well.

3. In the video, the narrator refers to restorative care as a means of avoiding restraints. What is meant by restorative care?

Restorative care focuses on what a resident **can** do. It works to improve and maintain a resident's abilities. This approach shifts the emphasis from maintaining safety to promoting function. The goal is for the resident to function at his or her highest level of ability.

4. How was the staff's visit to Arlene Pickens' home helpful in facilitating her adjustment as a new resident of the nursing home? How would you go about meeting Mrs. Pickens' needs as a new resident if you had knowledge of her life patterns prior to admission?

Donna knew that Arlene Pickens liked to be outdoors, and that it had a calming effect on her. She was able to share this information with the staff, and it was incorporated into Mrs. Pickens' care plan. It became an intervention used for agitated behavior and assisted Mrs. Pickens in becoming secure in her new environment. Had this intervention not been used, it is possible that Mrs. Pickens' agitation would have escalated to a point where she could have been a danger to herself or to others.

If Arlene Pickens were admitted to a nursing home where none of the staff knew her previously, it would be very important to talk with family, friends, and/or significant others to learn more about her past. Questions would focus on how she typically spent her days. What kind of schedule did she follow? What time did she get up in the morning and go to bed at night? What were her interests? Such knowledge can help the team help a new resident have a smoother transition to the nursing home.

5. Why are nursing interventions that anticipate a resident's needs particularly important in the period just after admission?

During this period, a new resident may not be able to express the need to go to the bathroom or may feel a strong need to walk or pace in order to find his or her way around the new environment. Offering assistance in meeting such needs is very important in avoiding the use of restraints.

6. How do physical therapy and occupational therapy contribute to restorative care?

The physical therapy department may work on muscle strengthening, gait training, and assessing the appropriateness of seating and mobility devices, for example, while the nursing staff offers assisted ambulation or range-of-motion exercises. Assisting the resident to walk to the dining room, the bathroom, or activities not only improves a resident's ability to walk, but also promotes function for other activities of daily living. Other staff should also be involved in this goal. The activities staff, for example, could encourage the resident to attend an exercise group, providing opportunities for both socializing

and muscle strengthening. It is important for all staff to understand that restorative care and keeping residents restraint free are everyone's responsibility.

7. How would the use of a restraint cause Rose Dorsey to regress both physically and mentally?

Restraints do not promote function; they reduce function. Rose Dorsey is able to walk. If she were restrained, she would not be able to learn her way about, and it is likely that she would become frustrated and agitated. Over time, her leg muscles would weaken, reducing her ability to walk. It is also important to note that Mrs. Dorsey wants to be restraint free and has specifically said she does not want the bed rail to be raised. We could reasonably expect her to be angry and combative at such a restriction of her freedom against her will.

8. While the occupational therapist teaches Rose Dorsey how to get around her environment independently, what other interventions could contribute to her restorative care plan?

It is important to stress that restorative care does not begin and end with skilled therapies. Residents are in skilled therapy only a short time each day. The rest of the time they are on the nursing units, where the staff must encourage them to use what they have learned in therapy to function at their highest level of independence. In Rose Dorsey's case, all members of the staff can use verbal cuing to help Mrs. Dorsey learn her environment and can provide assisted ambulation rather than using a wheelchair to take her to activities. While a wheelchair may be faster and may give the perception of being safer, it does little to promote the restorative care plan. In addition, placing Mrs. Dorsey where she is visible to the staff and anticipating her needs will make her less likely to try to walk alone when it is not yet safe for her to do so. Social services can assist Mrs. Dorsey to work through her feelings of relocation. They also can keep her family apprised of her progress so that when they visit, they, too, follow a care plan that promotes function. Therapeutic activities can help prevent Mrs. Dorsey from feeling isolated from the other residents and meet her need for social contact.

9. How would you use behavior mapping to assist Victoria Calderon to adjust as a new resident in the nursing home?

You might begin by tracking the times of day when Mrs. Calderon gets particularly upset. Is it after meals or late in the day, in response to a specific activity such as morning care, or with certain people? By determining under what conditions a particular behavior is most likely to happen, staff can speculate on what the behavior communicates. They can then anticipate the resident's needs and/or brainstorm interventions that might be used to modify the situation so the behavior is less likely to occur. If the behavior occurs after meals, for example, it may mean that Mrs. Calderon needs to go to the bathroom but is unable to communicate her need due to the absence of Spanish-speaking personnel. Late afternoon agitation may signal a need for a nap at that time. It is important to remember that Mrs. Calderon was living alone and is not used to having so many people around her. By late afternoon she may be overstimulated and in need of some quiet time. If agitated behavior occurs only in the presence of individuals who speak English, it may be that a caregiver's inability to speak Spanish makes Mrs. Calderon feel anxious about being understood. During specific care activities, she may need the presence of a Spanish-speaking staff member to explain what is being done. Overall, it is important that staff see behavior mapping as a tool that will help them provide better care.

10. How could restorative care interventions be used with each of the residents in the

video to help the staff avoid the use of restraints?

Arlene Pickens: By assessing her behavior and trying to understand the meaning behind it, the staff might plan to take her outdoors daily and increase activities to help her fill her day with time spent doing things she finds pleasurable. Further, if the same staff were involved in her care every day, she could begin to develop relationships and feel more secure.

Rose Dorsey: Both occupational therapy and frequent reminders to use the call light to summon help would teach her how to maneuver independently and safely in her environment while reducing her risk of falling. Assisting her to explore her environment would augment the skills she learns in therapy, increase her confidence, and decrease her anxiety. Removing the siderail from the bed would allow Mrs. Dorsey to exit the bed safely and independently.

Victoria Calderon: Providing a Spanish-speaking caregiver and placing her with a Spanish-speaking roommate would enable her to communicate her needs and decrease her anxiety. Involving her in activities, some of which include other residents from her cultural background, could reduce her sense of isolation. Interviewing family members about her background and preferences would enable the staff to develop a care plan that is individualized and better meets her needs. Placing her near the nurses' station would enable staff to see when she is getting agitated so they can offer reassurance. It would also facilitate behavior mapping so that they can anticipate when specific interventions may be needed. Physical therapy to reverse contractures of her lower extremities could help her sit in a chair more comfortably and may lead to her ability to stand or take some steps independently.

Applications

■ Use Handout 1A entitled "Four Steps to Restraint-free Care" to review this care plan procedure. Discuss how it could be applied at your facility.

■ Select a resident in your facility that all trainees are likely to know. Invite trainees to share examples of how they modified the care they were providing on the basis of what they observed about that resident's behavior. More specifically, ask them to discuss what the behavior communicated about the resident's needs. Design a behavior mapping strategy to get to know the resident's needs even better (see Handout 1B entitled "Sample Behavior Mapping Chart"). Discuss: On what behaviors will you focus? Over how long a period of time will you observe and collect data? How will you differentiate among different levels of severity of the same basic behavior? At the next inservice meeting, review what staff have learned about the resident through the use of behavior mapping and what changes they might recommend in the resident's care plan as a result.

■ Discuss the ways in which the residents you saw in the video are similar to or different from those in your own facility. In what ways do you think you could adapt some of the interventions you saw to the needs of the residents where you work?

■ Review your facility's guidelines regarding the use of restraints with new residents. If needed, suggest a revised policy that enables residents to remain restraint free. Include a discussion of what actions would be needed to put a new policy into effect, e.g., what precautions will be taken with residents who are at

risk of falling, how will such residents be identified, and how will family members be notified. Devise a plan for communicating to local hospitals and doctors that you have a commitment to restraint-free care.

■ Consider the underlying assumptions of each of the following statements and discuss which is more likely to result in a restraint-free environment:
1. No restraints will be used unless a full assessment indicates their need.
2. If an individual is admitted in restraints or with orders for restraints, these will be maintained for no more than 72 hours until a full assessment can be completed and a care plan developed.

■ Use Handout 1C, "Family Interview Check List," to learn about a particular new resident and present what is learned to the group.

■ Review Handout 1D, "Restraint-free Interventions for New Residents," and challenge trainees to add to the list. Continue this assignment throughout your use of the Resident Care Library.

Module 2

Length: 14 minutes, 44 seconds

Up and About: Minimizing the Risk of Fall Injuries

Handouts

- 2A. Checklist for Minimizing the Risk of Fall Injuries
- 2B. Fall Assessment

Video Places and Faces

Hebrew Home of Greater Washington, Rockville, Maryland
Claire Bloom, R.N.C., *Nurse Manager*
Sarah Greenberg, *Resident*
Dora Jabes, *Resident*
Vivian Koroknay, R.N., C.R.R.N., M.S., *Gerontological Clinical Nurse Specialist*
Kathy Taylor, *Restorative Care Nurse*
Abraham Wolf, *Resident*

Lakeside Plantation, Naples, Florida
Alma Bossle, *Resident*
Audrey Pogue, *Resident*
Lisa Rose, R.N., *Unit Manager*

Three Fountains Nursing and Rehabilitation Center, Medford, Oregon
Cheryl Battazzo, R.N., *Director of Nursing Services*
Molly Reddin, *Resident*

Westminster Canterbury, Richmond, Virginia
Jennifer Ferris, R.N.C., *Head Charge Nurse*
Phyllis A. Moore, R.N.C., *Director of Health Services*
Lucy Wright, R.N.C., *Head Nurse*

The Benedictine Institute for Long Term Care, Mt. Angel, Oregon
Joanne Rader, R.N., M.N., F.A.A.N., *Clinical Research Fellow*

Overview

All of us fall occasionally. That is a fact of life. Though older people are at greater risk for falls, most falls do not result in serious injury. In this video, caregivers explain various causes of falls in nursing homes, including relocation stress, partial incontinence, medications, poor vision, and unsteady gait. They also demonstrate how assessment can help staff members plan and implement individualized restraint-free strategies that help residents move about safely. The video has three segments:

- Why Residents Fall
- A Fall Assessment
- Minimizing the Risk of Fall Injuries

Objectives

Identify factors that make older people more prone to falls than younger people.

Determine if a pattern exists regarding where, when, and why falls occur.

Describe specific environmental interventions that can prevent falls and/or reduce their severity.

Demonstrate the use of assessment tools that can help determine an individual's risk of falling.

Identify medications that place residents at risk of falling.

Show interdisciplinary involvement in fall prevention programs.

Background

Falling is a part of life, whether a person is a toddler or an adult. The use of restraints with the elderly is not an effective method of preventing falls. In fact, a 1992 study (Tinetti, Liu, and Ginter) indicates that restraints may actually cause some falls and lead to more serious injury than would occur if an unrestrained individual fell. To determine how to prevent falls and related injuries without the use of restraints, it is necessary to understand why people fall.

Several age-related factors contribute to the frequency of falling:

- vision deterioration
- decreased ability to maintain balance
- changes in gait
- slower reaction times
- diminished muscular strength and endurance
- partial incontinence

In addition, such environmental conditions as poor lighting, loose rugs, and clutter contribute to falls. Nursing home residents who are unfamiliar with their surroundings, who have chronic physical or psychological illnesses, and/or who take certain medications (sedatives, hypnotics, tranquilizers, and antihypertensive drugs) also are at a higher risk of falling than others.

Assessment is the key to prevention.
If caregivers can identify residents at risk of falling and pinpoint the specific factors that create the risk, appropriate prevention measures can be taken.

A fall assessment begins with knowledge of a resident's medical history, daily living pattern, behavior, and preferences. Gait can then be examined with an assessment tool like the following:

- *Tinetti's Balance and Gait Evaluation Index*. This is a baseline assessment of gait and balance, mental status, and physical health. The test tries to simulate situations in which falls occur by asking participants to walk at normal and accelerated rates, bend down, turn, and rise from a sitting position. The number of assessments (22 items) and the requirement to walk 50-100 feet at a relatively rapid pace make the use of this scale impractical with some. (Tinetti, M.E. "Performance-oriented Assessment of Mobility Problems in Elderly Patients." *Journal of the American Geriatric Society* 34 (1986): 119-126.)

- *The "Get Up and Go" Test*. In this simple but useful assessment of gait and balance, the individual is told to rise from a straight chair, walk ten yards, turn around, return to the chair, and sit down. (Mathias, S., U.S. Nayak, and B. Isaacs. "Balance in Elderly Patients: The Get Up and Go." *Archives of Physical Medicine and Rehabilitation* 67 (1986): 387-389.)

- *Morse Fall Scale*. This assessment assigns a numerical value to such criteria as history of falling, gait, debilitating illness or disability, mental status, whether the resident uses an aid like a cane or a walker, and whether he/she receives intravenous therapy. (Morse, J.M., R.M. Morse, and S.J. Tylko. "Development of a Scale to Identify the Fall-prone Patient." *Canadian Journal on Aging* 8, no. 4 (1989): 366-377.)

The person conducting the functional gait assessment should particularly note the following factors: the resident's ability to stand up independently; a loss of balance while standing; the need for hands-on assistance when walking; the ability to walk a straight path; the presence of short, discontinuous, or shuffling steps; the ability to navigate around obstacles in the walking area; and the proper use of assistive devices.

The best interventions consider the various causes of falls.

The knowledge about an individual's needs that is learned from an assessment can help staff to plan and implement strategies that address an individual's specific risk factors and their interrelatedness.

Environmental interventions: Provide appropriate lighting, beds with lower heights, handrails, non-skid floor surfaces, chairs that support and stabilize, and easy access to necessary items.

Physical interventions: Encourage residents to minimize their risk of injury by participating in activities that strengthen their balance, gait, endurance, muscle strength, and muscle tone. Equip residents with appropriate shoes, canes or walkers with rubber tips, and/or protective pads to prevent injuries. Reduce discomfort from skin pressure or joint stiffness by adjusting a resident's sitting position, using different chairs during the day, or scheduling a nap. Adjust medications that may cause dizziness or confusion. Treat causes of restlessness, such as bladder or bowel urgency, discomfort, hunger, or thirst.

Social and psychological interventions: Look for such factors as depression and anger that may distress or preoccupy residents and lead to falls. Have family and social work staff talk with residents about psychological concerns.

All staff members can contribute to the success of these interventions by carefully documenting incidents of falls, including information on the location and context of the fall, time of day, and any resulting injuries. Tracking such records can uncover falling patterns, point to specific causes of falls and their associated risk factors, and document improvements that result from applied interventions.

Before Viewing

- Have trainees think about an experience when they witnessed a resident fall. If a restraint was in use, what effect did the restraint have on the fall? If no restraints were present, ask trainees to speculate on what effect the presence of a restraint might have had.
- Gather any fall assessment tools or data collection forms for falls used by your facility.

Discussion

What conditions in your facility could you improve to minimize the risk of fall injuries without using restraints?

1. This video shows how various nursing homes limited the number of serious injuries that result from falls without using restraints. Discuss some of the situations you saw and the interventions that helped keep residents restraint free.

With Molly Reddin, the staff utilized a "skid lid" or bike helmet. Mrs. Reddin also was given physical therapy to strengthen her muscles so that she could walk more safely, and occupational therapy to improve her ability to perform activities of daily living. The staff worked with the doctor to develop a plan of care that would meet Mrs. Reddin's need for safety without restraints.

In the case of Abraham Wolf, the nurse evaluated his medications and their effect on his blood

pressure. Because she found that his blood pressure dropped when he stood up (orthostatic hypotension), she requested that the physician change his medication. This change eliminated his orthostatic hypotension and thus the need to restrain him from getting out of a chair independently.

Because Dora Jabes' assessment indicated she was at risk of falling, the Hebrew Home placed her on their "Falling Star" program. The pin and the sign outside her door alerted all staff to provide assistance to Mrs. Jabes anytime she was observed wanting to move around. Her care plan included physical therapy to increase her strength, and recommended she wear safer shoes. The staff also planned to encourage Mrs. Jabes to participate in activities, with the goals of improving her strength and endurance and of decreasing her isolation.

Many of the nursing homes also implemented such nursing interventions as taking residents to the bathroom on schedules designed to meet each individual's unique needs, observing residents often, assisting residents to walk, and encouraging residents to participate in activities.

2. Many of us have been in situations with residents like Molly Reddin. How do you feel when you are caring for a resident who has expressed a clear desire not to be restrained even though the resident is at risk of falling?
Long-held beliefs about keeping residents safe are difficult to change. Nurses are trained to protect residents from harm. Historically, restraints have been perceived in the nursing and medical communities as the appropriate intervention to prevent falls. As with many areas of health care, however, research has uncovered better and different methods of providing care, and nursing staff need to change and implement new standards that will afford the nursing home's residents a better quality of life. Although the belief that restraints are used for the safety of the resident has been rebuked, many health care providers may feel confused regarding the issue. Some of the feelings that nursing staff may have are:

- *Anxiety*: If the resident falls, will I be blamed for it?

- *Frustration*: We don't have enough staff to keep the residents from falling without using restraints.

- *Hopelessness*: This is the way I have always taken care of residents. I don't know any other way to keep them safe.

- *Guilt:* I don't like restraining residents but I thought it was what I was supposed to do.

Before a change in the philosophy regarding resident rights and the avoidance of restraints can occur, individual staff members must have the opportunity to express their feelings. An open discussion may facilitate acceptance of a restraint-free approach to safety. Anxiety regarding liability issues, for example, can be allayed if staff conduct detailed assessments and carefully document the case for removing restraints. Regular monitoring and reassessment are an important part of this process. Above all, staff need to be told that they are not bad caregivers because they used restraints in the past when it was the accepted standard of care.

3. The video reminds us that "all of us fall . . . it's a fact of life." At one time restraints were used to prevent falls. What has changed?
In actuality, research has not found that the use of restraints significantly reduces falls. Many residents have fallen while restrained, sometimes resulting in more serious injuries than an unrestrained fall might have caused. Individuals have been known to pull wheelchairs over on top of themselves while restrained, to experience skin tears and lacerations from the restraints, and even to strangle to death.

In addition, restraints have been shown to cause such long-term effects as contractures, muscle atrophy, the breakdown of bones, pressure ulcers, incontinence, and respiratory complications. Long-term psychological effects of restraint use include depression, loss of self-esteem, agitation, confusion, and withdrawal.

Recent research at facilities that do not use restraints indicates that the number of falls may increase when restraints are no longer used, but the serious injury rate does not. Nursing staff need to understand that without the use of restraints, more residents will be up and about and a higher number of people will be at risk for falling. It is important to remember, however, that because these individuals are up and about, they tend to be in better health and experience less severe effects from a fall.

4. What other risk factors for falls are mentioned in the video?

■ *Relocation*: Moving to a new environment may cause agitation and disorientation. This may cause an individual to move about in an unsafe manner or to forget to call for help when needed. Confusion and disorientation may decrease as the person's health improves and as he/she settles into the new environment.

■ *Medications*: Medications can cause a variety of symptoms that may increase a person's risk for falls, including fluctuations in blood pressure, changes in the resident's mental status, and changes in gait or the ability to walk safely.

■ *Toileting needs*: Many falls occur when individuals who are weak or ill attempt to go to the bathroom without assistance.

■ *Poor vision*: Poor vision makes it difficult to see obstacles. Glare and poor lighting worsen the situation, making it difficult for residents to get around safely.

■ *Cognitive impairment*: Residents who lack insight into their abilities due to impaired cognition will not remember to call for help when getting up or may forget to use such assistive devices as walkers. Impaired cognition also may lead to agitation and restlessness.

■ *Unstable gait*: Many changes in the way people walk occur as they age, making the older person's gait less efficient and less safe. If a resident has an underlying illness such as a history of a stroke, or is on a medicine that causes dizziness, then the risk for falling becomes more serious.

5. In what ways can an interdisciplinary care plan reduce the risk of fall injuries?

All disciplines play a role in fall prevention. Residents may go to physical therapy for muscle strengthening and gait training, and nursing may augment the therapy by providing assisted walking on the unit. The activities director may include the resident in exercise groups that will strengthen muscles and provide the resident with safe diversionary activities to decrease agitation and make it less likely that the individual will attempt to get up unassisted. Physicians need to assess residents' use of medications and make adjustments as needed. Even the administration and building maintenance staff have a role in fall prevention by maintaining a safe environment and seeking help when a resident is observed behaving in an unsafe manner.

6. Select several risk-reduction interventions and discuss the ways in which they minimize risks.

A bike helmet, for example, does not prevent a fall, but protects the resident from head injury if a fall occurs. Similarly, lowering a bed and placing a gym mat next to it may not prevent the resident from falling from the bed, but it will decrease the likelihood of an injury if the resident does get out of bed. Observing residents near the nurses' station not only enables the staff to intervene when a resident attempts to get up independently, but also reassures the resident that people are nearby to help if

needed. Toileting schedules geared to each resident's unique pattern and needs help to prevent falls because they enable the staff to anticipate and meet such needs before a risk develops.

7. The nursing staff in the video used staff meetings to examine safety issues and specifically to analyze the causes of falls within the facility. Why is it important to do this?
Tracking falls enables the unit to improve their fall prevention interventions by identifying patterns and then implementing actions that will correct or reverse those patterns. For instance, tracking where falls occur may indicate that most falls happen in the day room. If this is the case, then the unit may decide to assign a staff member to the day room to monitor residents' safety and intervene as needed. If a unit were to find that most falls occurred in the bathroom, this may indicate either an unsafe bathroom environment (such as inadequate grab bars) or nonadherence to individual toileting needs by the staff.

In addition to tracking where falls occur, staff should note the time of day most falls occur, what day of the week most falls occur (do falls increase on the weekend because of less staff or the assignment of floating staff?), and sudden fluctuations in the number of falls. In reviewing and evaluating falls, consider whether the person's risk for falls had been identified, whether injuries resulted from the fall, whether physical hazards may have contributed to the fall, and ways in which such falls might be prevented or their harmful effects minimized. Because the collection of this data may have important legal implications for the nursing facility, you should discuss with your legal counsel appropriate methods for retaining it.

Applications

- Review Handout 2A, "Checklist for Minimizing the Risk of Fall Injuries." Discuss how staff members at all levels could contribute at each stage of the process.

- Evaluate your nursing home's current forms and procedures for recording and retaining data on falls and their causes.

- Walk through the nursing home with the trainees to observe any environmental safety features that may prevent residents from falling and make a list of any hazards or conditions that may need attention.

- Discuss the procedures in Handout 2B, "Fall Assessment." Ask a staff member who regularly conducts gait assessments to explain which observable characteristics indicate the greatest risk for falls.

- Physicians and families can be very resistant to allowing a resident to be free from restraints. Role play how staff would approach a resistant physician or family member. Note that even when a clear restraint-free policy exists, physicians and family members need to be reassured that the staff is not just removing the restraint but rather implementing an alternate plan of care. Families and physicians will want to know what specific interventions the team will use to keep the resident safe. It may be helpful to ask staff, "If your mother/father were the resident, what would you want to know before allowing a restraint to be removed?" Role playing will enable staff members to become comfortable with their responses and even to begin to formulate some new fall prevention care plans.

■ Pick a resident well known to the staff and discuss as a group possible restraint-free interventions that will decrease the likelihood of falls and decrease the risk of serious injury should a fall occur. Set ground rules for the discussion prior to its occurrence. Start by identifying all that is known about the person. What does he or she like and dislike? How does he or she typically behave? What is his or her daily pattern? What is known about his or her prior life? Then focus discussion on interventions that respond to the individual's needs and patterns. Write on a board any ideas that the group provides and underscore that **all** ideas have merit. This strategy encourages the staff to be creative and allows them to feel safe in expressing their ideas. After the group has identified a number of interventions, begin to develop a care plan by selecting the interventions that are most appropriate to the resident's particular needs.

Module 3

Length: 13 minutes

Working with Residents Who Wander

Handouts

- 3A. How and Why People Wander
- 3B. Making It Safe for People Who Wander

Video Places and Faces

Cobble Hill Nursing Home, Brooklyn, New York
Catherine Horn, *Resident*
Robert Levey, M.D., *Attending Physician, Alzheimer's Program*
Mary Morrisey, *Resident*
Tony Yang-Lewis, C.Q.S.W., *Director, Alzheimer's Program*

Florence Nightingale Nursing Home, New York, New York
Gloria A. Kelly, R.N., *Registered Nurse Supervisor*
Regina Schwartz, *Resident*

Gracy Woods Nursing Home, Austin, Texas
Sue Biddle, *Activity Director*
Lynda B. Hester, B.S.W., *Social Worker*
Lena Lankford, *Resident*
Maria Soto, *Certified Nursing Assistant*
Christine M. Tonche, *Physical Therapy Assistant*
Phyllis Trotter, *Resident*

Jewish Home of Rochester, Rochester, New York
Carol Maskiell, *Director of Social Work*

Overview

Staff at several nursing homes discuss how they keep residents who walk around and wander restraint free and share tips on how to keep everyone and everything safe. The video has four primary segments:

- Residents Who Keep Leaving the Building
- Residents Who Get Into Things
- Residents Who Wander at Night
- Residents Who Won't Stop Walking to Eat

Objectives

Recognize and describe the pattern and behavior of residents who wander.

Identify the possible causes of wandering, considering medical, psychological, and social/environmental factors.

Discuss positive and negative outcomes of wandering and assess what impact these would have for a particular individual.

Suggest a variety of strategies to minimize the negative outcomes and maximize the positive outcomes of wandering with reference to a specific individual.

Devise a plan of care that maximizes resident freedom and safety and that provides for ongoing monitoring and reassessment.

Background

The resident who wanders moves about in a seemingly aimless fashion. This is not a resident who is simply taking a walk or getting some exercise. He or she may be disoriented and disregard environmental constraints or hazards. Such residents may walk for hours, without sensing fatigue and without being able to identify a destination. They may have good social skills, but are likely to experience memory loss.

At one time, long-term care facilities routinely restrained such individuals. They did so for several reasons: to safeguard residents who wandered, to protect the rights of other residents whose privacy might be invaded by those who wandered, to make it easier for staff to know where everyone was, and to limit the facilities' liability should the resident who wandered become injured.

It is no longer legal to routinely restrain such residents. Since the enactment of OBRA '87 — the Omnibus Budget Reconciliation Act of 1987 — long-term care facilities are using systematic approaches to determine why residents wander, are altering the environment and care plans to protect both residents and management, are training staff to behave differently, and are finding they can provide restraint-free care to residents who wander.

They also are finding that the physical activity in which people who wander engage often has important positive consequences. It stimulates circulation, channels excess energy and anxiety, may relieve stress, and reduces the risk of osteoporosis and cardiovascular problems. Being able to walk around at will also gives residents the chance to determine their own activity, results in less agitation, and provides a sense of self-worth and empowerment.

Long-term care facilities find that they can provide dignity and freedom to residents who wander by analyzing each resident's behavior and the needs it expresses, by devising creative ways of meeting such needs, and by eliminating potential environmental hazards.

Before Viewing

- Identify the residents in your facility who wander and determine how your facility commonly responds to such behavior.
- Have trainees think about the residents in their care who wander. Discuss the possible reasons for their behavior.
- Ask trainees to point out possible hazards associated with wandering.

Discussion

What could you do to maximize a resident's freedom and safety should they wish to wander?

1. What forms of wandering behavior are shown in the video?
Phyllis Trotter wanders directly from one place to another. She leaves the building and looks for her car, or she roams the hallways as she does her "shopping" and looks for her daughter. Lena Lankford likes to eat off other people's trays and get into things. Such behavior could include wandering into other people's rooms and looking through the person's belongings. Mary Morrisey walks constantly, with a determination to keep moving. Some people might walk in large repetitive circles or random patterns.

2. Why do people wander?
Wandering usually indicates that a person has a need that is not being met. For some, wandering may be the activity that helps meet the need. A resident may be physically uncomfortable due to hunger, thirst, unfamiliar surroundings, or a need to use the bathroom. Wandering also may result from unfulfilled psychological and social needs such as loneliness, boredom, or agitation. A resident may habitually wander about at a time when he or she typically used to go home from work. Residents who are understimulated or disoriented may wander due to unfulfilled cognitive needs.

3. Phyllis Trotter is a new resident who frequently attempts to exit the building. How does knowing Mrs. Trotter's history help staff members keep her safe without restraints?
Staff members learned that Phyllis Trotter was a very active person who went out frequently. Because of her dementia, she still believes that she has places to go. Knowledge of her past activity patterns can alert staff members to the times when she may want to leave the building and needs closer observation. To meet her need to be out and about, staff can arrange outings or daily walks during those time periods.

Knowledge of a resident's past also can provide clues as to why a person wanders at night. For example, residents who have historically tended to be "night people" may wander in the evening hours because they have difficulty adjusting to a nursing home schedule of going to bed around 9 p.m. By providing a choice of bedtimes and by asking family members about previous activity patterns, staff members will better understand resident behavior and be able to personalize care plans accordingly.

4. How can one-to-one care help to limit wandering by newly admitted residents like Phyllis Trotter?
New residents may get restless

and try to leave the building because relocation triggers feelings of confusion, anxiety, and disorientation. One-to-one care can comfort new residents and make them less likely to wander. A familiar picture or object can help a new resident identify his or her room. Similarly, showing new residents around the facility several times can help them adjust to their new surroundings. As staff members give new residents a tour of the facility, they should point out navigational landmarks, such as, "Your room is two doors down from this picture with the yellow flowers." Comments like these may need to be stated over and over again until residents can recognize the landmark on their own. (Some residents may never remember, but most will eventually learn their way around their unit and be able to find their own rooms). It also is helpful to have the same nursing staff consistently assigned to the same residents to facilitate the establishment of relationships. These staff members can then provide the security of a familiar face or voice if residents try to leave the building independently.

5. How can "tracking" be used to help a resident who wanders?
Tracking is the process of noting a resident's specific whereabouts at fixed intervals throughout the day. Some facilities note the location of the resident every half-hour on a specific tracking form. This procedure helps staff members ensure that the resident is safe and may help identify a pattern in the resident's behavior. Understanding such patterns will help staff members provide more individualized care.

6. In the video, Mary Morrisey paces constantly. What are the positive and negative aspects of pacing?
Pacing provides the resident with exercise; visual, auditory, and tactile stimulation; and interaction with staff and other residents. Most often, pacing indicates that a resident is bored and needs some form of stimulation. But for Mary Morrisey, wandering is her stimulation. Pacing could be a warning sign of depression, however, and may result in weight loss or inadequate nutritional intake due to the constant expenditure of energy and the unwillingness to sit for a meal. As seen in the video, some dementia units have successfully addressed the nutritional problem by offering residents a liquid form of nutrition such as Ensure, or a finger-food that can be eaten on the move. Another concern is that residents can pace to the point of exhaustion and not recognize their body's need to rest. This places the resident at risk of falling. During the day, staff members should try to get such residents to take short rest breaks. One way to do this is to engage the resident in conversation and use touch and eye contact to keep the resident at rest and involved in the conversation. The goal is not so much to have meaningful conversation but to get the resident to rest, if only for a few minutes.

7. Mary Morrisey talks about her father and mother while pacing. What is validation therapy and how could staff members respond to this behavior using it?
When a resident is confused or disoriented and is talking about people or events of the past, he or she has withdrawn into an inner world that is not part of the present. Validation therapy is an approach that accepts and validates the feelings of the resident. For example, one could respond to Mary Morrisey by saying, "You must miss your mother. What did she look like?" This response may engage her in a conversation that could have a calming effect and evoke pleasant feelings for her. Using gentle touch and quiet conver-

sation is an integral part of validation therapy.

8. The video shows another resident, Lena Lankford, "getting into things." Staff members believe her behavior relates to her need for neatness and realize that it is not always possible to stop her. What are some ways to respond to such behavior?
Asking a resident who "gets into things" (rummaging, going into other residents' rooms, hoarding, eating from other residents' trays) to stop the behavior is usually ineffective because the resident believes there is a real and valid purpose for the activity. Staff members may have more success by helping the resident replace the behavior with a more acceptable activity. If the resident takes items off the linen cart, for example, give the person some linen to fold and "put away." (One can always retrieve the linen later.) If the resident is getting into papers at the nurses' station or in another resident's room, ask the resident to sort a stack of less valuable papers and place them so that they are always available in the same place. Eating from another resident's tray is especially troublesome for both staff and other residents. It may indicate that the resident is hungry and needs larger portions or that he or she may need to eat in a less stimulating environment. Some facilities will serve meals to these residents in their own rooms or in a smaller dining room where fewer residents are eating. Feeding such a resident alone and/or at a later time than the other residents also may be effective.

9. What is meant by the least restrictive environment? What are some environmental interventions that can help wandering residents live in the least restrictive environment?
The least restrictive environment is one in which a resident can wander or pace without restrictions unless his or her safety is at risk. If a restriction is necessary to protect the resident, then the least restrictive intervention is the first implemented. A wandering alert alarm would be used, for example, before placing a resident on a secure unit. Other environmental interventions for wandering residents include the following:

- Provide adequate light.

- Maintain clutter-free hallways and floors with good traction.

- Alert staff members to residents who may try to leave the building or wander somewhere dangerous.

- Equip lobby staff with resident photographs that include room and unit numbers so they can identify residents who may not be able to safely exit the building independently.

- Camouflage doors to discourage residents from entering rooms that are off-limits: place Velcro strips across the opening, hang a towel rack with towels on a door so that it does not appear to be a door, drape a strip of fabric across the doorway, or paint the doors the same color as the walls.

- Install an alarm system that sounds when a resident attempts to exit the facility or a unit. Use wrist and ankle alarms as well to alert staff that frail residents are restless or beginning to walk around.

- Move a resident to a locked unit if he or she consistently attempts to exit the facility and wander off the premises. A secure unit will enable the resident to pace within the boundaries of a safe area.

Applications

■ Select one resident in your facility who wanders. Use Handout 3A, "How and Why People Wander," to describe and analyze the individual's behavior. Examine what the trainees know about this person's background that might explain his or her behavior. Then have them suggest possible ways to respond to the individual's wandering without the use of restraints.

■ Create a list of factors you would need to observe if you were caring for a resident who stays in motion for hours at a time.

■ Devise a specific procedure for notifying neighbors, local businesses, and local police that a resident has wandered off the grounds.

■ The video features four different facilities, only one of which has a special unit for people with Alzheimer's. Explain how your approach to providing restraint-free care to residents who wander might differ between a facility with a special Alzheimer's unit and one in which residents who wander are found in all units.

■ In the video, Dr. Levey suggests that trying to sedate a resident who wanders might put the person at greater risk. Discuss why this would be so.

■ Brainstorm a list of strategies your facility might use to accommodate residents who regularly want to be up and about at night. Be sure that each person has an opportunity to talk before any ideas are evaluated. One suggestion might be to keep some snacks and easy-to-read books and magazines near the nurse's station. Another might be to keep juice or warm soup at the nurse's station and have aspirin handy for residents who can't sleep because of pain.

■ Create a simple graph paper chart to help track a specific resident's behavior. Use a different chart for each day. Leave a wide column on the left where you can write down the specific wandering behavior you observe. Note the hours of your shift across the top so you can easily check off the time of day the wandering occurred. Keep the chart for one week to see if any patterns emerge. Look especially for relationships between wandering and what occurs around it. Does the resident always seek a specific location or always follow a specific path? How does the resident move? Is the wandering haphazard or purposeful? Is the resident likely to wander over a large area or a limited area? Does the resident wander only at specific times of the day? Answers to such questions could provide significant clues about how best to provide quality care for the resident.

■ Survey your facility to determine how safe the environment is for people who wander. See how many of the suggestions on Handout 3B, "Making It Safe for People Who Wander," are already in place and which merit consideration for future implementation.