MDS Alert

In The Spotlight: Maintaining Safety In A Restraint-Free Environment

This facility pulls it off by using the MDS and managing key risks.

If you don't score, you're out of the game in most cases, but not when surveyors and consumers are checking out your prevalence of residents in physical restraints.

And **Kendal-at-Longwood** in Kennett Square, PA, has "no scores" on that quality measure because the facility doesn't use restraints at all - period, emphasizes **DON Celia Agustin, RN**.

Yet that's just the beginning in finding other ways to keep residents safe who are at risk for falls, elopements and other accidents. And part of that quest involves letting go of the idea that restraints keep residents as safe as people used to believe they did. Out of the **Centers of Medicare & Medicaid Services'** own mouth: "Research and standards of practice show that the belief that restraints ensure safety is often unfounded" (p. 3-201, RAI user's manual).

Look at the Big Picture

The MDS helps Kendal-at-Longwood identify residents who have behaviors and conditions that put them at risk for accidents and elopement. "The MDS staff look closely at Section E (mood and behavior) and Section J which asks about accidents and pain, as pain can affect behaviors," Agustin notes.

They also comb through Section C (communication/hearing patterns) to identify and address any problems, which can cause safety risks and contribute to fall risk and behavioral issues. In Section P2 (intervention programs for mood, behavior, cognitive loss), they code whether the resident has a behavioral management program and other interventions, including a mental health consult in the previous 90 days.

Staff also does a comprehensive fall assessment upon admission that looks at the resident's fall history, gait and balance, cognitive function and any environmental issues. To augment the MDS, they administer the Briggs fall assessment form.

Any resident identified as being at risk for falls receives precautionary measures and environmental interventions, reports **Patricia Wilder, RN**, nursing supervisor in charge of fall reduction. "We do reviews of the resident's fall risk again quarterly and any time the resident falls or has a significant change in status," she adds.

The facility implemented an activity program to prevent falls, which a root-cause analysis showed were occurring most frequently after meals, reports activities director **Jan Clodius**. A day activities program runs from 10 a.m. until 1:45 p.m., and an evening program resumes at 4:15 through 7 p.m., and includes dinner with staff. Residents with cognitive impairment and/or behavioral issues are especially encouraged to participate in the program.

Read the Behavior

Kendal-at-Longwood staff has also figured out that "wandering" behavior may not be as aimless as it appears. "For example, a cognitively impaired resident might be hungry, so he starts wandering around or he becomes agitated," says Wilder. "If the person's typical pattern is to eat snacks throughout the day, then we care plan that intervention and make sure to give the person a little snack [when he begins to wander] and then divert him with an activity," she adds.

Sometimes residents wander, pace or become frantic because they can't find a lost parent, child or spouse, Wilder notes. "In that case, we communicate to the person that we recognize he or she has a sense of loss or needs comforting, and

then redirect him/her to a safer location or into an activity - something to redirect their thoughts," she says.

Residents who develop acute delirium or who become very agitated receive one-on-one care by a member of the interdisciplinary staff. "Staff rotate every 30 minutes" in providing continuous monitoring of the resident, Agustin reports.

The facility also sometimes enlists family members to help and has hired companions to be with the resident during the most critical times, she adds.

The staff also assesses the resident to determine a pattern to his behaviors (agitation, pacing, restlessness) so they can care plan to have a companion or other interventions in place when the behaviors are most prominent, Agustin says.

Key to success: Residents' behavioral issues aren't viewed as a "nursing only" problem, so everyone on the interdisciplinary staff works with the resident to meet his needs and keep him safe. In fact, all of the staff in the facility, including the receptionist, housekeeping, dietary, nursing, etc., have attended a six-to-eight week behavioral training program one half day a week provided through a state-funded initiative.

Assess for Chemical Restraints

The facility does give residents antipsychotic and other psychoactive medications when clinically indicated. "Our quality indicator for antipsychotic drugs runs low at the 25th percentile, however," comments **Doug Neil**, director of social services.

To assess whether a psychoactive drug may be "restraining" a person, staff watches for signs of sedation to report to the physician, explains Neil. "For example, if the resident shows a decreasing level of engagement, we would assess the reason and report that as a potential effect of the psychoactive medication," Neil explains.

Get Families on Board

Residents and families know the facility has a "no restraint" policy when the resident is admitted, Neil says. "But if a family member of a resident who's having a behavioral problem expresses concern about the resident's safety - and the possible need for a restraint - staff show the family member all of the various interventions they are using to meet the resident's needs," Neil explains. "Staff also involve the family in the care plan process and we re-emphasize how the facility's core value is to avoid restraints," Neil adds.