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Restraint Reduction: Regulations, Alternatives and Therapy Intervention

Kathleen Weissberg, OTDS, OTR/L
Redhead_lxx@yahoo.com

Objectives

- Describe at least three regulations and state survey guidelines related to restraint use.
- Identify therapy's role in restraint reduction assessment and intervention.
- List five alternatives to restraint use for falls and behavior-related issues.

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State Survey Guidelines

- F600 Free from Abuse and Neglect
- F602 Free from Misappropriation/Exploitation
- F603 Free from Involuntary Seclusion
- F604 Right to be Free from Physical Restraints
- F605 Right to be Free from Chemical Restraints

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CMS Regulations

- §483.12 Freedom from Abuse, Neglect, and Exploitation
  - The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.
- §483.10(e)(1) Dignity and Respect
  - The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent

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CMS Regulations

- §483.12(a) (2) The facility must—
  - Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

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State Survey Guidelines

- Responsibility of IDT to assess and provide least restrictive environment
- Facility must design interventions to minimize medical symptom, identify and address problems causing the medical symptom

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CONTINUED

Definitions

Physical restraint

Any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body, cannot be removed easily; restricts freedom of movement

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CONTINUED

Definitions

- Convenience
- Discipline
- Freedom of movement
- Manual method
- Medical symptom
- Position change alarms
- Removes easily

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Examples

- Bed rails that keep a resident from getting out
- Placing a chair close to a wall to prevent rising
- Using a concave mattress
- Tucking in a sheet tightly so it prevents movement
- A chair that prevents rising
- Devices such as trays, tables, cushions, bars, belts
- Hand mitts, soft ties, vests
- Holding a resident down
- Enclosed framed wheeled walker that cannot be opened
- Some position change alarms

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Examples

- Reclining geri-chair
- Upright geri-chair with lap tray
- Devices that “hold” resident in the chair
- Seat belt, not self-releasing
- Lab buddies that cannot be removed

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Examples of Convenience

- Staff are too busy to monitor the resident
- The resident does not exercise good judgment
- Staff state the family has requested
- Not enough staff
- Temporary staff do not know the resident
- Lack of staff education regarding alternatives
- Teaching the resident a lesson
- Preventing wandering
- In response to confusion or combative behavior

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Definitions

A chemical restraint is defined as any drug that is used for discipline or staff convenience and not required to treat medical symptoms

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Definitions

- Convenience
- Discipline
- Indication for use
- Medical symptom

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Examples

- Antipsychotics
- Antidepressants
- Antianxieties
- Sedatives

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Examples of Convenience

- At request to “calm down”
- To prevent wandering
- To prevent calling out
- To reduce requests for assistance
- Insufficient staffing
- During bathing

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Definitions

Double restraints refer to a condition whereby the resident is subject to two restraints (physical, chemical or both)

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Keep in Mind …

- If the resident is able to remove the restrictive device upon command it is not considered a restraint
- Documentation is key
- Restraint reduction is a team effort

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Reasons for Restraint Use

- Confusion and cognitive impairment
- Weakness and debilitation
- Climbing out of bed
- Getting up out of wheelchair
- Falls
- Inability to follow weight bearing precautions
- Wandering within the building

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Reasons for Restraint Use

- Wandering outside the building
- Inability to maintain a sitting position
- Pulling out tubes or catheters
- Physical aggression
- Yelling and calling out
- Lack of knowledge about restraints

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Physical Risks Associated with Restraints

- Decline in physical functioning
  - Dependence in ADL/mobility, strength, balance, ROM
- Respiratory complications
- Skin breakdown
- Incontinence or constipation
- Injuries
- Accidents such as falls, strangulation, or entrapment

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Psychosocial Impact from Physical Restraints

- Agitation, aggression, anxiety, delirium
- Social withdrawal and depression
- Feelings of shame
- Loss of dignity, self-respect, and identity
- Dehumanization
- Panic, feeling threatened or fearful
- Feelings of imprisonment
- Increased anger, combativeness, hostility

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Impact of Chemical Restraints

- Subdued, sedated, or withdrawn
- Asleep during hours that he/she would not normally be
- Limits to functional capacity
- Loss of autonomy, dignity, self-respect and orientation
- Confusion, cognitive decline, withdrawal, depression
- Decreased activity levels, including social activities
- Decline in skin integrity
- Decline in continence level
- Weight loss if missing meals

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Resident Rights

Residents have the right to be free from any physical restraints or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms

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Restraint Myths

- Restraints prevent falls and injury
- Restraints safeguard residents from harm
- Facility is at risk if restraints are not used
- A resident feels secure when restrained
- Restraints decrease risk of falls
- There are no other alternatives
- Restraints can substitute for nursing care
- Restraints are effective to manage resistance and control behaviors

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Restraint-Related Issues

- Restraint reduction is an IDT process
- Referral to therapy cannot be for the sole purpose/goal of "reducing the restraint"
- Skilled therapy indicated to address positioning, balance, strength, gait and transfers
- The decision to reduce a restraint is a team process
- Family and/or resident can request a restraint

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Restraints and Falls

- Falls do not constitute self-injurious behavior or a medical symptom that warrants the use of a physical restraint
- No evidence that restraints, bed rails, or position change alarms will prevent or reduce falls.
- Falls that occur while a person is physically restrained often result in more severe injuries

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IDT Approach to Restraints

- Does the resident want the device/chemical?
- Does the device/chemical act as an enabler?
- Have other less restrictive interventions for the problem behavior been tried and documented?
- It is individualized?
- Does documentation support use?

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Using a Restraint

- Resident and/or legal representative must make an **informed** decision
- Least restrictive device is used
- Device is limited to specific times
- Restraint is justified; included in care plan
- Evidence of consultation
- May be used temporarily
- When a physical restraint is used, the facility must:
- Ongoing re-evaluation of the need

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Using a Restraint

- The facility must provide evidence that:
  - The resident's medical symptom that requires the use of a physical restraint has been identified
  - A practitioner's order is in place for the use of the specific physical restraint based upon the identified medical symptom

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Imminent Danger

- Physical restraint is a measure of last resort
- Ongoing direct monitoring and assessment
- Address interventions that may address the symptoms or cause of the situation
- Ensure the resident is protected
- Discontinue the use of the restraint as soon as the imminent danger ends
- Documentation and MD order must support use

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Bed Rails

- What is the medical symptom being treated by using bed rails?
- Risk for entrapment or falls
- Partial bed rails may assist with bed mobility
- To determine if a bed rail is being used as a restraint, the resident must be able to easily and voluntarily get in and out of bed when the equipment is in use
  - If the resident cannot easily and voluntarily release the bed rails, the use of the bed rails may be considered a restraint

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Entrapment

- Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention
- Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself
- Facilities must attempt appropriate alternatives before installing bed rails and they must inspect and maintain rails

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Position Change Alarms

- Any physical or electronic device that monitors resident movement and alerts the staff when movement is detected
  - Chair and bed sensor pads, bedside alarmed mats, alarms clipped to a resident's clothing, seatbelt alarms, infrared beam motion detectors
  - Do not include wander guards
- Some have the unintended consequence of inhibiting freedom of movement

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Position Change Alarms

Negative potential outcomes

- Loss of dignity
- Decreased mobility
- Bowel and bladder incontinence
- Sleep disturbances
- Confusion, fear, agitation, anxiety, or irritation

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Restraint Reduction Program

- Interdisciplinary team approach
- Purpose of a restraint reduction program
  - Eliminate or reduce the use of restraints
  - Provide safe environment that facilitates maximum functional independence

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Restraint Reduction Protocol

- What symptom prompted the need for a restraint?
- Has the cause of the symptom been identified?
- What efforts have been made to treat or eliminate the cause?
- Can the medical problem be treated without using a restraint?
- What alternatives have been considered and tried? Are other options still available?
- What are the risks and side-effects of using the restraint?
- What are the nursing home's policies on using restraints?

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CONTINUED

Physician Disclosure

- Reason for the restraint and why it is recommended
- Medical condition for which the restraint is needed
- Type of restraint that is recommended
- How long and how often the restraint will be used
- How the relevant medical condition will be affected
- Nature, degree, duration, probability of side effects
- Reasonable alternatives
- Right to accept or refuse care and treatment
- Activities/tasks completed while restraint is off

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CONTINUED

IDT Documentation

- The length of time the restraint is anticipated to be used
- Who may apply the restraint
- Where and how the restraint is to be applied and used
- Time and frequency the restraint should be released
- Who may determine when the medical symptom has resolved
- Type of monitoring and supervision
- How the resident may request staff assistance
- How needs will be met during use of the restraint
- Re-evaluation
- Other interventions to be considered

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Restraint Reduction Assessment

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Reasons for Skilled Service

- Positioning
- Mobility/gait
- ROM/strength/tone
- Balance
- Activity tolerance
- Transfers
- Cognition/perception affecting mobility

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Initial Assessment -- Fall History

- Number of falls
- When and where did the fall occur
- Precipitating factors
- What was resident doing when fall occurred
- Environmental/medical factors
- Adaptive equipment
- Positioning
- Preventative measures prior to the incident
- Injuries sustained
- Fear of falling

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Initial Assessment

- Reason for referral
- Functional level prior to episode (PLOF)
- Other medical complications that may affect therapy (PMH)
- Medications impacting the plan of care

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Physical Assessment

- Range of motion
- Strength
- Muscle tone and reflexes
- Pain/edema
- Sensation
- Motor Control

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Physical Assessment

- Balance
  - Deficits
  - Balance reactions/strategies
  - Righting reactions
  - Ability to self-correct balance
  - Ability to right self

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CONTINUED

Functional Assessment

- Self-care skills
- Mobility
- Gait analysis
  - Quality of gait
  - Gait deviations
  - Assistive devices
  - Level of assistance
  - Safety awareness

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CONTINUED

Initial Assessment

- Cognition/communication
  - Safety awareness
  - Follow simple commands
  - Communication skills
- Perception
  - Neglect, field cut, depth perception

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Initial Assessment

- Environment
  - Barriers
  - Modification
  - Footwear
- Positioning
  - Positional needs
  - Ability to operate wheelchair

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Documentation

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Goals

- Goals may relate to
  - Bed or wheelchair positioning
  - Functional mobility/transfers
    - Ambulation, transfers or bed mobility
  - Balance/falls
  - Functional performance

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Goals

- Caregiver will demonstrate independence with assisting pt to walk 50 feet with FWW to/from bathroom for toileting
- Pt will transfer bed <> WC via stand pivot transfer with CGA and equal weight bearing B LEs with 1-2 VCs for safety
- Through the use of a WC drop-seat and wedge cushion and removal of leg rests, pt will (I) propel WC using LEs 150' to the dining room
- Pt will sit in a geri-chair two hours daily utilizing solid back insert and knee abductor wedge for extensor tone inhibition and prevention of skin breakdown in order to attend daily activities programs

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Goals

- Pt will achieve upright posture while seated in wheelchair with use of solid seat insert and lateral supports for 30-35 minutes during functional tasks
- Pt will achieve 4 hours out of bed/out of room in WC with ® lateral support and gel cushion to participate in facility BINGO activity
- Through use of (L) lateral support while seated in WC pt will inhibit abnormal flexion posture for 2 hours to participate in facility craft activity
- Pt will facilitate normalized tone by weight bearing through R LE during standing 5 minutes with min A and with equal weight bearing B LEs

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Restraint Reduction Treatment

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Treatment Interventions

- Compensatory techniques to reduce falls
- Establishing a cueing hierarchy
- Analysis of ability to generalize skills
- Environmental modifications for safety
- Compensatory strategy development for cognitive deficits
- Behavioral management strategies
- Staff education/instruction
- Establishing a FMP/RNP

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Treatment Interventions

- Fall management strategies
  - Balance, postural control, praxis, gait, footwear, etc.
- Proper positioning techniques and devices
- Exercise programs
- Safety training during task performance
- Establishing simple routines
- Assistive device instruction
- Consistent sequence and/or commands
- Task simplification

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Treatment Planning

- Adapting the environment or seating system
  - Cushions
  - Foam
  - Lateral supports
  - Arm positioning
  - Positioning belt
  - Seat
  - Removing obstacles in the environment
  - Lighting considerations
  - Stimulation in environment

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Treatment Planning

- Treating musculoskeletal deficits or performance components
  - Strengthening exercises
  - Facilitation/inhibition of tone
  - ROM
  - Modalities to address tone, strength, ROM, pain
  - Balance training

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Treatment Planning

- Treating functional deficits
  - Toileting
  - Standing/mobility
  - Wheelchair mobility
  - Transfers/bed mobility
  - Topographical orientation/memory
  - Communication skills

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Treatment Planning

- Gait with assistive device on even and uneven surfaces
  - Obstacle negotiation
  - Negotiating turns
  - Quick stops/starts

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Treatment Planning

- Training in use of adaptive equipment/assistive devices
  - Walker, cane, crutches
  - Handrails
  - Sliding board
  - Gait/transfer belt
  - Orthotics, braces, immobilizers
  - Hoyer lift

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Frequency and Duration

- Based on barriers to function, deficits and complications
- Recommendations should not be completed on a screen or evaluation
  - Least restrictive device should be utilized
  - Functional abilities maximized
  - Changes made gradually and monitored for effectiveness
  - Nursing education must occur

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Restraint Alternatives

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Alternatives to Restraints

- Close monitoring by staff
- Using wheelchair only for transportation
- 15-minute checks on resident by staff
- Teach to ask for assistance (use call bell)
- Positioning with appropriate equipment
- Increased activities throughout the day
- Keeping necessary items within reach
- Maintaining wheelchairs/assistive devices

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Alternatives to Restraints

- Involve therapies
- Plan/implement a toileting schedule
- Re-position as needed
- Monitor medications
- Provide activities of interest
- Education
- Bed alarms/chair alarms
- Frequent monitoring
- Respond to needs

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Alternatives to Restraints

- Tailoring care and caregiver assignments
- Providing therapy and restorative care
- Helping residents get in and out of bed as often as needed and desired
- Increasing staffing levels to improve supervision
- Training staff on methods to calm residents who are anxious or agitated
- Individualized rest periods
- Increased physical and social activities

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Cognition

- Structured, predictable routine
- Activities that relate to current preferences
- Resident's name and pictures on their door
- Validate residents' feelings

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Unsteady/Fall Risk

- Use knowledge of the resident's lifelong habits to anticipate needs
- Ensure comfortable seating
- Treat positioning, ROM, balance, gait, strength deficits
- Increase ambulation skills
- Eliminate medications

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Unsteady/Fall Risk

- Comfortable well-fitting shoes
- Address vision or hearing problems
- Monitor the facility for safety hazards
- Modify the environment
- Make available and train staff on adaptive devices

69

Side Rails

- Respond promptly to call bells
- Investigate why the resident wants to get out of bed
- Give resident something to eat and drink at night
- Mattress on floor beside the bed
- Keep beds as low to the floor as possible

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Seating Issues

- Individualize seating
- Vary the locations where the resident sits
- Provide a variety of types of chairs
- Make adaptations to the wheelchair

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Behavior Issues

- Know behavioral patterns
- Staff approach
- Provide consistent caregivers
- Use a calm, gentle, consistent approach
- Keep instructions and cues simple
- Appropriate structured activities
- Modify the environment

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Behavior Issues

- Use music and relaxation techniques
- Respect life roles and routines
- Assess for the trigger/cause of behavior
- Assess medications and side effects
- Provide choices
- Change position during the day
- Distract from agitating stimuli

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Wandering

- Make the environment as safe as possible
- Resident's name and picture on their door
- Curtained swinging café door with a buzzer at entrance to the resident's room
- Ensure each resident wears an identity bracelet

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Wandering

- Modify the environment
  - Grid made with masking tape in front of doors
  - Mirrors on doors
  - Camouflage doors with wallpaper
  - Theatre rope in front of exit doors
  - Dark tiles in front of exit doors
  - Stop signs on exit doors

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Environmental Adaptations

- Provide a safe environment
- Change the resident's environment
- Beds low to the floor, call bells in reach
- Use alarms for safety
- Create a "homelike" environment
- Use signs and pictures to identify rooms
- Adaptations for wandering
- Alarm systems

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Strategies for Fall Risk

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New Admissions

- Careful history-taking regarding previous falls
- Close observation
- Thorough orientation to facility
- Family involvement and visits
- When possible, placement in room with similar arrangement to previous bedroom

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History of Falls

- Thorough assessment for risk factors
- Exploration of associated events before, during and after fall
- High risk identification system
- Use of companion or closer observation

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Altered Mental Status

- Eliminate excessive noise
- Room assignment near nurses' station
- Picture of toilet on bathroom door
- Adequate lighting
- Activity programs
- Family education and involvement
- Use of companion or closer observation

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Weakness

- Thorough physical assessment and treatment of underlying cause
- Frequent observation
- Reconditioning as appropriate

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Confined to Bed

- Call bell within reach
- Exercise program as appropriate
- Low position
- Mattress on floor
- Brakes in proper working order
- Non-skid adhesive strips on floor
- Bed crank handles in closed position
- Opportunities to use toilet
- Bed alarm system

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Confined to Chair

- Proper height for individual
- Proper design for specific problem
- Appropriate cushions or propping devices
- Non-restrictive reminders to remain seated
- Consistent opportunities to use toilet

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Confined to Wheelchair

- Used only for transport or promotion of independence
- Brakes in working order
- Foot rests in closed position when not in use
- Consistent opportunities to use toilet

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Altered Balance/Gait

- Thorough assessment of specific problem
- Muscle strengthening exercises
- Assistive devices
- Non-skid tips on assistive devices
- Walking program
- Properly sized footwear and clothing
- Maintenance programs for mobility and ROM

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Visual Impairment

- Eye examination
- Eyeglasses regularly cleaned
- Remove unnecessary furniture
- Adequate lighting (day and night)
- Avoid glare
- Avoid "busy" floor patterns
- Unobstructed and non-skid floor surfaces
- Equipment in working order

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Frequently Asked Questions

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Physician's Orders

Q: Are physician's orders needed for therapy recommendations?

A: Therapists need a physician's order to make resident-specific recommendations.

If therapy is only agreeing with a recommendation made by nursing, then a physician's order is not needed.

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Who Makes the Decision?

Q: Who makes the decision to restrain or de-restrain?

A: By creating an Interdisciplinary Restraint Reduction team, this important decision making becomes a shared process

Therapy should not evaluate solely on the basis of restraining or de-restraining. Restraint reduction is a facility team responsibility.

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Restraint Re-Evaluation

Q: When is a restraint re-evaluated?

A: Re-evaluation timelines depend on many factors

- Temporary measures – monitor daily
- Awaiting functional gains -- as resident progresses
- Quarterly at a minimum

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NO RESTRAINTS

N: No one person makes the decision

O: OBRA does not mandate “restraint free”

R: Recognize this as an ongoing process

E: Ensure a safe environment

S: Standing orders must be eliminated

T: Try creative approaches

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NO RESTRAINTS

R: Remove all unnecessary medications

A: Activity

I: Individualize resident assessments/care

N: Needs of the resident, not the facility

T: Thought process as well as actions must be documented

S: Support each other

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Summary

Key Points

- IDT involvement is key to a successful restraint reduction program
- A thorough assessment is critical
- Understanding impairment type will drive treatment approach
- Therapy must treat the underlying deficits, not simply evaluate for restraint elimination
- A comprehensive treatment plan involving all disciplines is most effective

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Resources

- *The Pioneer Network* http://www.pioneernetwork.org
- *Untie the Elderly* http://www.ute.kendal.org
- *Kendal Corporation* www.kendal.org
- *Pennsylvania Restraint Reduction Initiative* www.parri.kendaloutreach.org
- The Posey Company www.posey.com
- Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospital, Long Term Care Facilities, and Home Care Settings available at http://ute.kendaloutreach.org/learning/documents/clinicalguidance_SideRails.pdf

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CONTINUED

Resources

- *U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality* http://www.ahrq.gov
- *U.S. Department of Health and Human Services, Office of Inspector General* http://www.oig.hhs.gov
- *U.S. Food and Drug Administration* http://www.fda.gov
- *The American Geriatrics Society* http://www.americangeriatrics.org
- Primaris Healthcare Business Solutions http://primaris.org/resource_solution/nursing-homes/

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