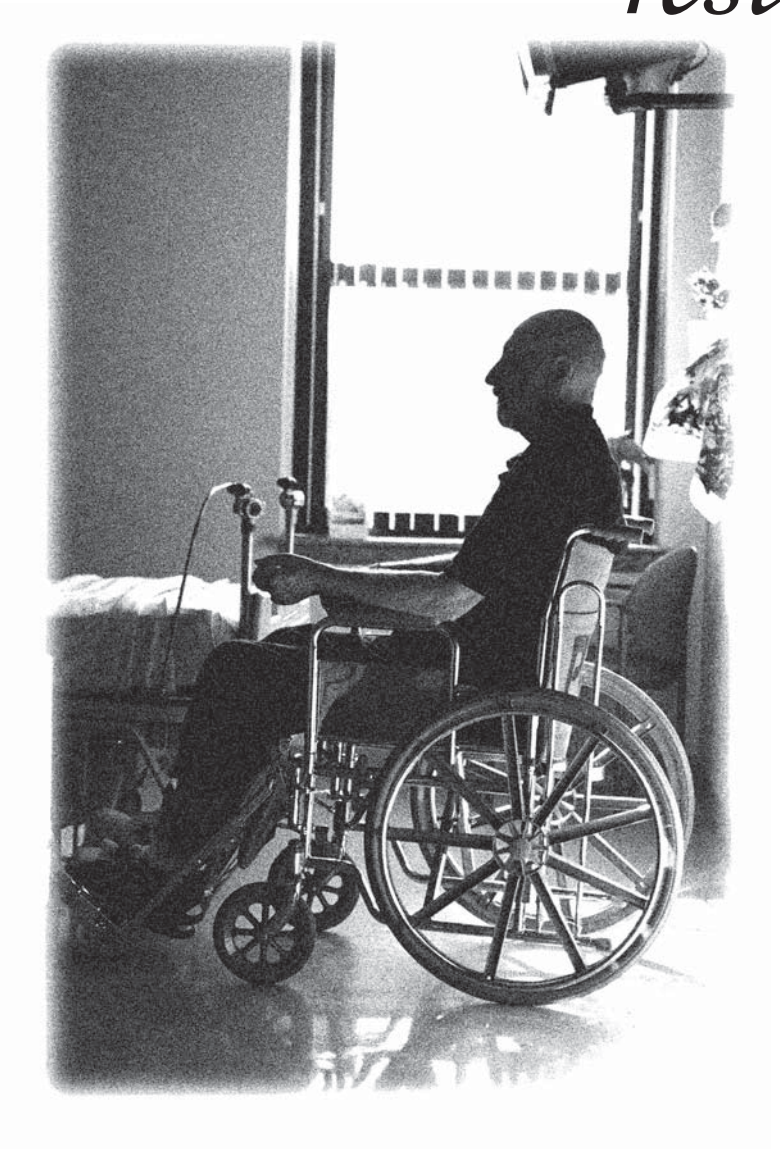
Quality care — without restraints



Self-study course

Course objectives

By the end of this course you will be able to:

1) Define restraints.

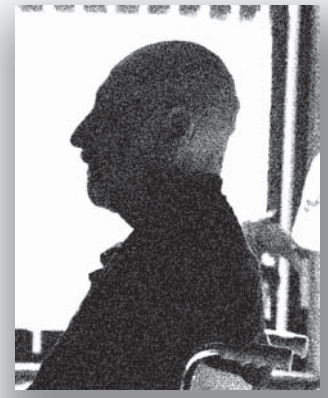
2) Understand what physical restraints and chemical restraints are.

3) List some risks with restraint use .

4) List some alternatives to restraint use.

5) List requirements when considering use of restraints.

Introduction



Providing safe care for residents with physical and cognitive impairments is a high priority for health care personnel and families. For some ten (10) plus years, there has been increased concern surrounding the use of restraints to prevent falls, control agitated residents, and prevent wandering. Studies have shown that restraints are more likely to cause harm than prevent it. Bed rails, vest and waist restraints have caused a number of injuries resulting in death. According to a report by the U.S. Food and Drug Administration (FDA), there are an estimated 100 or more deaths that occur annually in care settings in the United States as a result of restraint use. Reducing the use of restraints has become a national goal.

In the Oregon Adult Foster Home setting, between January 2000 and December 2003, there were forty-four (44) Complaint Investigation Reports related to providers' failure to properly use a restraint, resulting in injury to residents.

As a care provider, it is your responsibility to exercise precautions against any conditions which could threaten the health, safety or well-being of a resident. Here is some helpful information regarding the definition of a restraint, risks of restraint use, some alternatives to restraint use, and requirements when considering use of restraints.

What is a restraint?

A restraint is any method, device or chemical substance which restricts the freedom of movement of a resident. Restraints can be either physical or chemical.

Physical restraint:

The Oregon Adult Foster Home Administrative Rules define a physical restraint as "any method or device which the person cannot easily remove and restricts freedom of movement or normal access to the body."

Physical restraints include, but are not limited to, posey vest, soft ties or vests, straight jackets, wheelchair seatbelt, locked chairs safety bars, lap trays, Lap Buddy, hand mitts, gerichairs, or any specialized chair that prevents rising.

Following are some examples of physical restraints:

- Use of a lap belt to prevent a resident from getting up from a chair.
- Use of a gait belt to force a resident to rise up from a chair.
- Use of a bean bag or recliner to prevent a resident from raising.
- Use of side rails (bed rails) to prevent a resident from getting out of a bed.

Locking a resident in a room, or use of a towel or childproof door knob to prevent the door from being opened from the inside, that restricts the freedom of movement of a resident, also is considered restraint.

When a resident requests a side rail and understands the associated risks (e.g., for the purpose of assisting with turning or getting into or out of bed), the side rail is not considered a restraint. If just one rail or half-rail(s) is used and it does not interfere with the resident's ability to get in and out of the bed, the rail is not considered a restraint.

If the resident can purposely remove or unlock the wheelchair seatbelt, it is not considered as a restraint.

Chemical restraints:

Chemical restraint is defined as any medication that is used for discipline of a resident or for the convenience of the provider or caregiver, and is not prescribed for treating medical symptoms.

Following are some examples of chemical restraints:

- Use of Ativan to control a resident's wandering behavior.
- High dose of a psychoactive medication for the purpose of sedating a resident or administering a sleeping medication to sedate a resident during the night for the convenience of the caregiver.
- Use of a medication to control residents' behavioral symptoms without behavioral intervention or when there are not adequate numbers of caregivers to provide intervention.

Use of physical restraints: Myths versus facts

Myths	*Facts*
1. The old should be restrained because they are more likely to fall and seriously injure themselves.	❖ Restraints do not remove the risk of falls. In fact, the risk of injury from falls may increase when restraints are applied. ❖ In those settings where restraint use has been discontinued or strongly reduced, incident rates of falls have increased with no increase in serious injury.
2. The moral duty to protect residents from harm requires restraint use.	❖ Mechanisms meant to protect a resident may have little or no safety value, and may even be hazardous (have caused deaths). ❖ "Protecting" older adults with physical restraints place them at greater risk for numerous problems of a physical, psychological and behavioral nature.
3. Failure to restrain puts the provider at risk for legal liability.	❖ State regulations prohibit unnecessary physical restraints in adult foster homes. The providers are liable when restraints are used for the convenience of the caregiver.
4. It doesn't really bother older people who are being restrained.	❖ Interviews with restrained older people reveal feelings ranging from anger, fear, humiliation, resistance, demoralization and denial.

Myth	*Facts*
5. A care provider may need to use restraints because they are so busy and don't have a lot of time to spend with each resident.	❖ The time required to follow a restrained resident for frequent inspection, monitoring and evaluation is estimated at 4 hours 35 minutes per resident in a 24-hours period.
6. Alternatives to physical restraints are unavailable.	❖ Many alternatives to physical restraints are available. See page #9. Be creative!

Adapted from: Evans L. & Strumpf, N. (1990). Myths About Elder Restraint. Image: Journal of Nursing Scholarship, 22, 124-128.

The risks with restraints

Residents with cognitive impairment are often at risk for wandering and falling. In the past, restraints were used to remind residents not to get up without assistance in an attempt to prevent these accidents of wandering or falls. However, recent studies suggest that restraints often worsen physical and mental disabilities because restraints limit a resident's ability to perform physical and mental exercise. Reduced activity imposed by restraints may cause the resident to become weaker and more confused resulting in more falls and fall-related injuries.

Using side rails to keep a resident in bed or prevent a resident from leaving the bed, often adds to the risk of injury. A restraint can be especially hazardous for the resident with dementia or agitation, who may be harmed by attempting to climb over the rails or sliding her/his arms or legs between the rails. The resident may fall from the bed rails or be trapped between the rails (see page #16, Postures in restraint-related death).

Using a wheelchair belt or lap tray to prevent a resident from getting up or leaving can also be dangerous. If the resident tries to free him or herself from the restraint, he or she may fall or be trapped between the chair belt and tray or tip the chair over (see page #19, Postures in restraint-related death).

There is evidence that restraints are unsafe and have the potential for causing serious injury or even death. Bed rails, vest and waist restraints have caused a number of injuries and resulted in death in care settings. The Minnesota Department of Health compiled that state's death certificates from 1980 to 1988 and found that nine adult cases of death were related to a physical restraint.

Restrained residents often feel humiliated. They may become depressed, withdrawn or agitated when freedom of movement is taken away from them. Residents with cognitive impairments are no exception to feeling the same impact. They may not, however, have the capacity to verbally express it. Studies have demonstrated a dramatic decrease in behavioral problems when restraints are removed.

Risks with restraints include:	
Physical	*Mental*
❖ Injury	❖ Confusion
❖ Circulatory obstruction	❖ Resistance
❖ Respiratory problems	❖ Agitation
❖ Pressure sores	❖ Frustration
❖ Incontinence	❖ Anger
❖ Dehydration	❖ Humiliation
❖ Constipation	❖ Withdrawal
❖ Strangulation/Death	❖ Depression

What are some alternatives to restraint use?

There are effective and safe methods that can be substituted for restraints, or make the use of restraints unnecessary. Some alternatives follow:

- *Increase awareness of residents' individual needs:*

  The key to providing safe care without restraints is individualized person centered care. The team, including the resident, the provider, caregivers, family members, and medical professionals, plays a vital role in developing a care plan that meets the specific needs of each resident.

  Knowing what is important to the resident in daily life, learning what the resident's health and safety needs are, and understanding the resident's relationships are important components in improving the resident's quality of life. The payoff may be a decrease in difficult behavior that might otherwise result in the use of restraints.

- *Environmental alternatives*

  Design or rearrange the resident's living environments.

  Examples:

  - Lowering the bed closer to the floor
  - Providing comfortable seating and relaxing surroundings that minimize noise
  - Offering soothing music, and appropriate lighting.

- *Psychosocial alternatives*

  Provide regular attention to interpersonal and social needs, such as family contact, socialization with others, and outdoor and indoor activities adapted to current abilities and past interests. Encourage caregiver and resident interaction, and offer a variety of sensory stimulation activities.

  Consider:

  - Emotional distress such as loneliness, fear, anxiety, and anger
  - Mental health concerns such as depression, or the distressing impact that some delusions or hallucinations may have.
  - Provide the resident with the necessary support to help him/her recover from a stressful situation. Refer to a medical professional for mental health concerns.

❖ *Physiological alternatives:*

Always evaluate behaviors or symptoms first to identify the problem.

Consider:

- ❖ Physical needs and medical problems, such as thirst, hunger, fatigue, discomfort, pain, possible infection, etc.
- ❖ Medication effects such as confusion, sedation.

Once you have discovered the cause of the behavior, do what you can to meet the needs of the resident and eliminate the problems. If the cause for the behavior is not found, call a medical professional for assistance.

❖ *Resident at risk of falling:*

Falls occur for a number of reasons. Assessment is the key. If a provider can identify residents at risk of falling and pinpoint the specific factors that create the risk, appropriate prevention measures can be taken. Ask yourself, "Why does she/he fall?" Then ask, "What can be done to minimize falls and help her/him to be safe?"

Consider:

- ❖ Use appropriate shoes and sole-treated slippers.
- ❖ Use non-slip floor treatments.
- ❖ Create paths clear of furniture.
- ❖ Call a case manager/ RN to help with the assessment process and the design of a plan.
- ❖ Teach safe transfer techniques.
- ❖ Have transfer poles next to bed.
- ❖ Encourage consistent use of assistive devices.

Resident at risk of wandering

Consider:

- Provide a home-like environment.
- Learn what is important to the person and attempt to meet those needs.
- Create opportunities to be outdoors on a regular basis.
- Design a structured and predictable daily routine.
- Create a safe and secure home environment inside and outside.
- Place night-lights throughout the home to assist residents who get up at night.
- Place a pressure-sensitive mat at the door that sounds an alarm to alert you to movement.
- Put STOP or DO NOT ENTER signs on doors, or paint doors the same color of the walls.
- Put a black contact paper in the shape of a large rectangle or oval on the floor in front of an outside door.
- Have an activated alarm system to alert you if the person leaves the home without supervision.

Side rails safety

If the use of side rails has been determined necessary, make sure space between the mattress and side rails is small enough to prevent the resident from becoming trapped. Make sure openings in side rails are narrow enough to prevent a resident from slipping through or getting his or her head trapped between bars; add covers over side rails that can protect a resident from being caught in them.

What are requirements when considering the use of restraints?

The use of physical restraints is discouraged and should only be considered after a full assessment and other less intrusive interventions have been tried. However, restraints are sometimes useful as a temporary measure in providing needed medical treatment, such as specialized feedings or wound care, or when other less restrictive measures have failed to provide adequate safety. Restraints have the potential for causing injuries, particularly when they are improperly used or when they are modified without direction from a medical professional. Restraint is the last option only after other alternatives have been tried and have failed.

There are requirements and safety guidelines in place under the Oregon Adult Foster Home Administrative Rules when consider using of restraints.

OAR 411-050-0447(9), Residents' Bill of Rights, states that each resident has the right to:

> "Be free from chemical and physical restraints except as ordered by a physician or other qualified practitioner. Restraints are used only for medical reasons, to maximize a resident's physical functioning, and after other alternatives have been tried. Restraints are not used for discipline or convenience."

OAR 411-050-0447(4)(e) Psychoactive Medications, states:

> (A) A provider must not request a psychoactive medication to treat a resident's behavioral symptoms without a consultation from the physician, nurse practitioner, registered nurse or mental health professional. The consultation must include a discussion of alternative measures to medication use including behavioral interventions. These medications may be used only after documenting all other alternative considerations and only when required to treat a resident's medical symptoms or to maximize a resident's physical functioning. Psychoactive medications must never be given to discipline a resident or for the convenience of the adult foster home. Psychoactive medications as defined in these rules may be used only pursuant to a prescription that specifies the circumstances, dosage and duration of use.

OAR 411-050-0447(4)(l) Physical Restraints, states:

(A) **Physical restraints may be used only after a physician/nurse practitioner, registered nurse, Christian Science practitioner, mental health clinician, physical therapist or occupational therapist assessment, consideration and documentation of all other alternatives, and only when required to treat a resident's medical symptoms, or to maximize a resident's physical functioning.** If, following the assessment and trial of other measures, it is determined that a restraint is necessary, the least restrictive restraint must be used and as infrequently as possible. All physical restraints must allow for quick release at all times;

(B) **A written signed order from the physician/nurse practitioner or Christian Science practitioner must be obtained and placed in the resident record.** The order must include specific parameters including type, circumstances and duration of the use of the restraint. There must be no p.r.n. (as needed) orders for restraints;

C) **The provider must place the restraint assessment in the resident record.** The assessment must include procedural guidance for the correct use of the restraint, alternative less restrictive measures which must be used in place of the restraint whenever possible, and dangers and precautions related to the use of a restraint;

(D) **The frequency for reassessment of the physical restraint use must be determined by the prescriber based on the recommendations made in the initial assessment.** The reassessment may be performed by the physician/ nurse practitioner, registered nurse, Christian Science practitioner, mental health clinician, physical therapist or occupation therapist;

(E) **Physical restraints may only be used with the resident's or resident legal representative's consent which will be documented in the resident's record;**

(F) **Physical restraints may not be used for discipline of a resident or for the convenience of the adult foster home;**

(G) **Residents physically restrained during waking hours must have the restraints released at least every two hours for a minimum of 10 minutes and be repositioned, offered toileting, exercised or provided range of motion during this period.**

(H) **Physical restraint use at night is discouraged and shall be limited to unusual circumstances.** If used, the restraint shall be of the design to allow freedom of movement with safety. The frequency of night monitoring for resident safety and need for assistance shall be determined in the assessment; There will be no tie restraints of any kind used to keep a resident in bed.

(I) **Side rails used to prevent a resident from getting in or out of bed are considered restraints.** Side rails or half rails, which are requested by the resident, to allow the resident to easily get in and out of bed or improve functioning are not considered restraints;

(J) **Physical restraint use must be recorded on the care plan showing why and when the restraint is to be used, along with instructions for periodic release.** Any less restrictive alternative measures planned during the assessment and cautions for maintaining safety while restrained must also be recorded on the care plan; and

(K) **Use of restraints must not impede the three minute evacuation of all household members.**

USE OF A PHYSICAL RESTRAINT WITHOUT AN ASSESSMENT, DOCUMENTATION OF ALTERNATIVE METHODS, AND AN ORDER FROM A PHYSICIAN, IS CONSIDER ED ABUSE.

Conclusion

There have been some exciting changes in the philosophy and practice of delivering care to frail elders in all care settings. One especially positive development is a renewed emphasis on individualized care that promotes dignity. Such individualized care is based on full respect for the elder as an adult with fundamental rights, including freedom of choice and movement. This philosophy of care has resulted in a dramatic change in thinking about "quality of life," "quality of care" issues and the use of restraints.

The use of restraints has received considerable attention in the last decade as attempts have been made to reduce or create a restraint-free environment. In an adult foster home setting, the use of restraints is not recommended. As a provider, it is your responsibility to exercise precautions against any conditions which could threaten the health, safety or well-being of a resident. You need to look at other interventions that promote safety and quality of life, and alternatives to restraint use. Restraints are the last option only after other alternatives have been tried and have failed.

The Oregon Department of Human Services has received a number of Complaint Investigation Reports in regard to providers' failure to properly use restraints. If you have any questions or if you find yourself in a situation where you are unsure whether you can provide the level of care required by a resident, do not hesitate to call the Licenser for clarification and assistance.

You may also contact a DHS case manager, RN, physician, or other medical professional for assistance. You may call the Seniors and People with Disabilities (SPD) Central Office in Salem for help. The toll free number is 1-800-232-3020.

References:

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Joanne Rader, R.N., M.N.,Carmen Spencer, R.N.,B.S.N. and Maggie Donius, R.N.,M.N. (1997) *Working with Difficult Behaviors and Creating Alternatives to Medications and Restraints: A manual for Adult Foster care Providers*, Oregon Department of Human Services.

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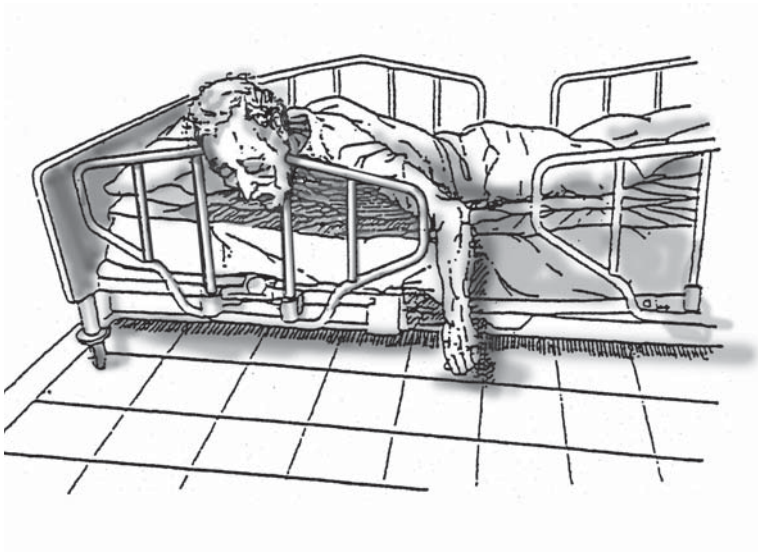
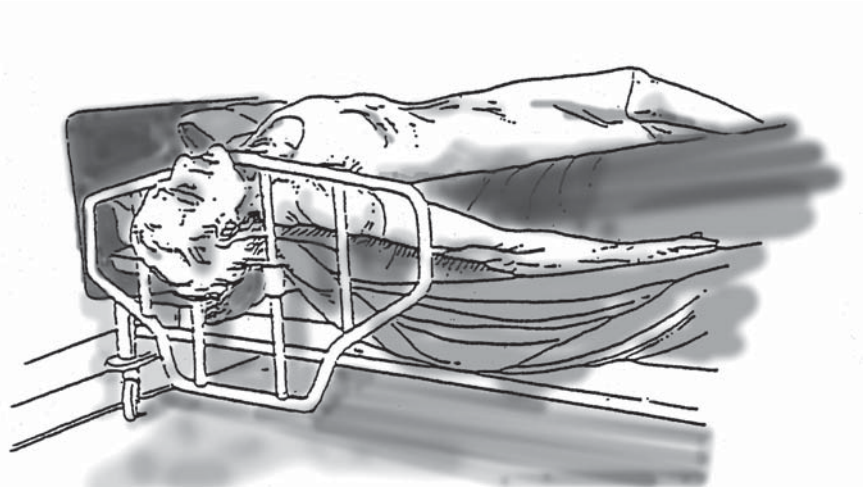
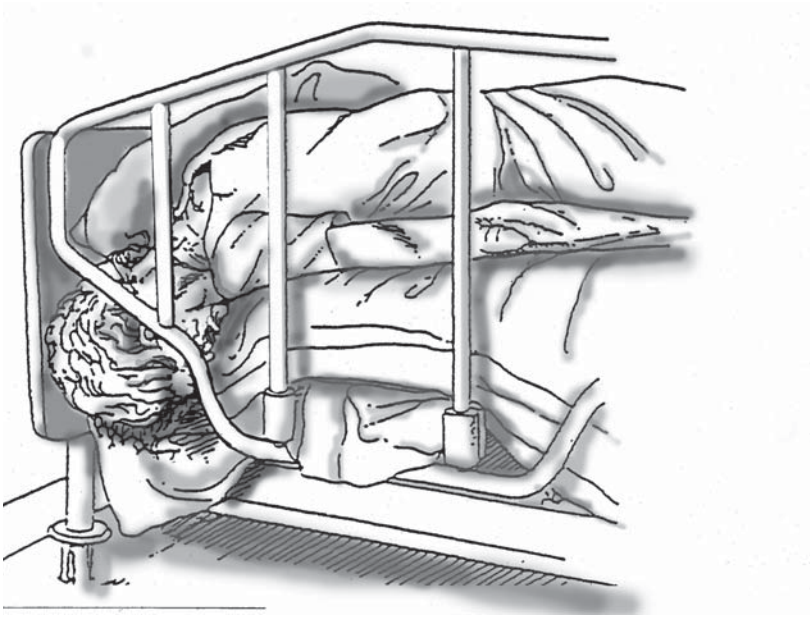
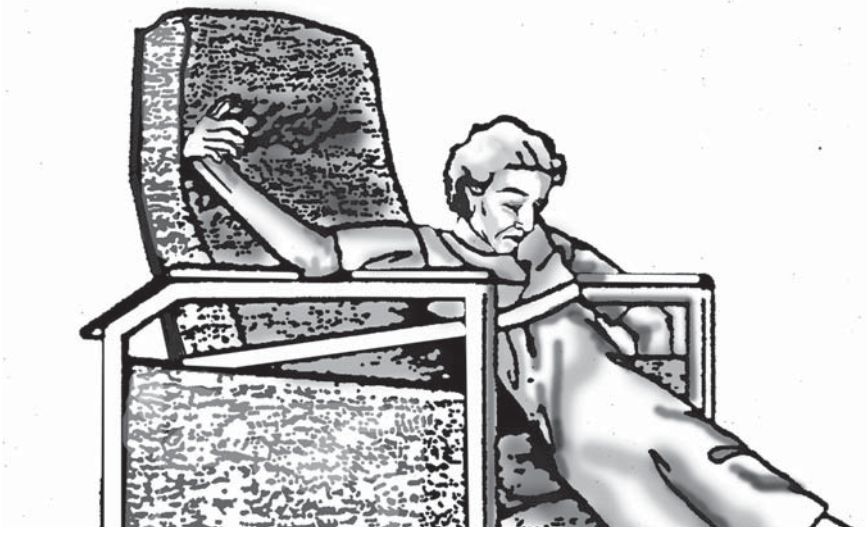
Postures in restraint-related deaths









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