

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MINIMIZING RESTRAINTS IN NURSING
HOMES: A GUIDE TO ACTION**



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INTRODUCTION

PURPOSE

In this guide, we aim to assist nursing homes in minimizing the use of physical and chemical restraints. Toward that end, we present lessons drawn from the experiences of nursing homes that have made progress in reducing restraints.

BACKGROUND

Since October 1990, the nation's nursing homes have had to comply with a new and significant Federal mandate: that nursing home residents have "the right to be free" from physical and chemical restraints not required to treat their medical symptoms. This mandate is part of a series of reforms intended to improve the quality of care in nursing homes that were enacted by Congress in the Omnibus Budget Reconciliation Act of 1987 (OBRA-87).

Congress imposed this requirement because of concerns about widespread use of physical and chemical restraints in nursing homes. Both types of restraints restrict a person's ability to move about freely. Examples of physical restraints include hand mitts, vests that tie residents to their chairs or beds, and restrictive chairs, such as gerichairs with lap trays and small wheels that limit mobility. Examples of chemical restraints include psychoactive drugs, which control mood and behavior.

In carrying out the new requirement, nursing homes have faced many operational challenges. Some of these have involved confusion about how restraints are defined. Others, probably more consequential, have involved the dynamics of changing long established practices--of introducing new routines and ways of thinking about the care of nursing home residents.

METHODOLOGY

In this guide, we report on the lessons learned by nursing homes engaged in reducing the use of physical and chemical restraints. We did not evaluate the outcomes of their approaches to restraint reduction, nor do we address how the State surveyors might interpret their efforts. Rather, we simply report lessons captured from their collective experiences.

The lessons we present come primarily from the experiences of seven nursing homes we visited in three States (see appendix B). To a lesser degree, they come from telephone and personal conversations we held with representatives of other homes and of national organizations in the field, and from our review of the published literature and guidebooks.

In selecting the seven homes for our on-site case studies, we sought to maximize the relevance of their experience to other homes. We did this by selecting homes that had received no special funds for reducing restraints and that had continuity in their nursing and administrative staff. We also chose homes that had some success in reducing restraints, that had between 51 and 150 beds, and at least 50 percent Medicaid residents. Finally, we chose homes in three States in the Northeast and the Midwest to ease our travel arrangements. (See appendix A for more details on our methodology.)

We present our lessons in three areas that reflect the operational stages of restraint reduction. These stages involve (1) establishing a commitment to restraint reduction, (2) reducing restraints, and (3) maintaining a restraint-free home. In each area, we pose a number of basic questions that we found nursing homes regularly ask. Our answers reflect the lessons that those working in the homes we visited have learned. In some instances we present our answers sequentially; however, many of the steps toward restraint reduction require ongoing attention.

We present our lessons in a question and answer format. We direct these questions and answers to those in nursing homes who are leading their homes' efforts to reduce restraints. These leaders may include administrators, nursing directors, charge nurses, certified nursing assistants, therapists, social workers, activity specialists, and others. Hereafter, our use of the pronoun "we" in a question refers to the leadership within the nursing home, while "we" in an answer refers to the Office of Inspector General study team.

ESTABLISHING A COMMITMENT TO RESTRAINT REDUCTION

We have been using restraints and have always considered ourselves to be providers of good care. OBRA is a big change for us. How do we get everyone to want to reduce restraints?

- ▶ Stress that times have changed. Just as a physician no longer routinely removes a child's tonsils, now we know that restraints should no longer be used routinely because their risks--incontinence, stiffness, loss of bone mass, and strangulation, among others--outweigh their benefits.

"Both mobility and personal autonomy are threatened by the use of involuntary restraints. No controlled trial has yet demonstrated the ability of restraints to prevent injury, but a large body of literature attests to their adverse effects, including strangulation, increased agitation, and the many complications of immobilization."

(J. Francis, "Using Restraints in the Elderly Because of Fear of Litigation," New England Journal of Medicine 320, no. 13 (1989): 870)

- ▶ Stress the residents' quality of life: removing restraints can make them happier and restore their dignity.
- ▶ Have everyone try on a physical restraint for 10 or 15 minutes so each can really understand what it is like.
- ▶ Invite staff from homes that have already reduced restraints to give a presentation on how restraint reduction has

One director of nursing found her staff skeptical about removing physical restraints safely. She surveyed them confidentially using questions from the Kendal Corporation's "Untie the Elderly" program. She asked about their training in the use of restraints, when they use restraints and why, how they felt about restraint use, and how they thought restraint elimination would affect their jobs. After reading their responses, she was better equipped to address their concerns and restraint practices individually.

worked for them, or arrange visits to those homes. Residents of nursing homes pose similar challenges. Seeing or hearing about a peer's experiences demonstrates that restraint reduction is possible. And such objections as "but you don't understand what *our* residents are like" are less likely to be made.

- ▶ Involve everyone in the home because each has a role to play. As restraints are reduced, it becomes vital that everyone, from the housekeepers to the kitchen staff and receptionists, knows what to do if someone is wandering toward an exit or sliding down in a chair. And don't be discouraged if some people are reluctant to try restraint reduction. Sometimes it takes their seeing actual progress before they really believe it can work.
- ▶ Recognize up front that reducing restraints takes time. It is a big change for many homes and requires a new way of approaching old problems. Don't delay starting because you're concerned that something might go wrong--something probably will, but it need not be traumatic, and in fact, could be a learning experience.

A director of nursing led her home's restraint reduction efforts alone. When the home became restraint-free, she was recruited by another home to reduce its restraints. After she was gone, the home began using restraints again. Without commitment from others, the home was unable to maintain its restraint-free care.

Our home operates on a tight budget. How can we reduce restraints without spending a lot of money?

- ▶ None of the homes we visited identified costs as a barrier to reducing restraints. These homes had no extra funds, such as a grant, to reduce restraints.

- ▶ In general, the homes we visited reported using their staff more creatively rather than hiring more staff. Two homes, however, did create new positions in conjunction with their restraint reduction. One home hired two new certified nursing assistants to provide one-on-one care for formerly restrained residents needing extra attention; the other, a rehabilitation aide to walk residents and help them with other activities.

" 'We don't have the staff to do that.' In some nursing homes that may be true; however, it will also be true that the same staff will, in all likelihood, not be able to care properly for residents in restraints with that low a staffing ratio. Understaffed facilities and facilities that do staff sufficiently to meet residents' needs will find that they are able to use their staff time better when they pay more attention to individual needs and reduce their use of restraints." (S. G. Burger, Inappropriate Use of Chemical and Physical Restraints, National Citizens' Coalition for Nursing Home Reform (1989): 30-31.)

- ▶ Most homes identified minor costs for providing training and purchasing positioning devices such as cushions. In some cases, family members provided reclining or rocking chairs to replace gerchairs, so the home incurred no expense.
- ▶ None of the homes mentioned any renovations related to restraint reduction. For example, none moved nurses' stations or added new rooms. Most already had alarm systems in place to alert everyone if a resident wandered out the door.

What will restraint reduction mean for our malpractice liability risks?

- ▶ The homes we visited mentioned an increased awareness of liability risks, but no increased costs. In fact, one home shopped around and found a carrier that offered a less expensive policy.

"The limitations placed on the use of physical restraints in the Omnibus Reconciliation Act of 1987 (OBRA) and the guidelines interpreting those limitations are finally putting to rest the myth that restraints must be used in order to avoid legal liability. In fact, court decisions never supported that myth, even through all the years when the use of restraints had become so widespread that their application could be presented as a part of 'reasonable care' for the protection of patients." (A. R. Hunt, "Dispelling the Liability Myth," Untie the Elderly 3, no. 1 (April 1991): 1)

- ▶ Document your residents' consent to have their restraints removed.

One nurse told us how she documented a confused woman's consent to have her restraint removed even though this woman was unable to speak, read, or write. The woman shook her fist angrily and stomped her feet at anyone who attempted to apply a restraint. Although she was unable to express it in words, this woman clearly communicated her desire to be free from restraints. The nurse described her gestures in the record to document consent.

- ▶ Document carefully every aspect of your restraint reduction efforts in each resident's care plan. Include the results of any restraint alternatives you have tried, goals for the resident, and how the resident will be monitored. In the event of a lawsuit, establishing that due care was taken to protect that individual from harm becomes vital.¹

¹ S. G. Burger, *Inappropriate Use of Chemical and Physical Restraints*, National Citizens' Coalition for Nursing Home Reform (1989): 8.

REDUCING RESTRAINTS

How can we get started reducing restraints?

- ▶ Assess the condition of all restrained residents before you get started. Know whether they suffer from low blood pressure when changing position from lying to sitting or sitting to standing, whether they suffer from low blood sugar between meals, what nonpsychoactive medications they take, and whether they cause sleepiness or other side effects. These conditions may increase the risk of falls and need to be addressed before removing restraints.

One home restrained a gentleman because he fell repeatedly. In reviewing his complete medical history, staff discovered he suffered low blood pressure--which made him dizzy and apt to fall--because the dose of his blood pressure medicine was too high. By checking his blood pressure every day, and administering the medicine only when indicated, this home reduced the dose by two-thirds. Now he is unrestrained, and walks around safely.

- ▶ Review the restraint use among your residents. Find out who is using physical restraints or psychoactive drugs, which type of restraint or drug, how often it is used, and why it is used.
- ▶ Using the information from your review, categorize the physically restrained residents according to some plan. For example, categorize them according to why they are restrained (wandering; leaning in chairs; unknown) or how often they are restrained (never, but has a restraint order; rarely; regularly; always).

- ▶ Involve your residents' physicians and/or your consultant pharmacist in assessing the proper use of psychoactive drugs. The pharmacist can help you determine whether the use of these drugs is proper under OBRA and can recommend that the physicians reduce doses or change drugs. Consider designing assessment forms to trigger questions about particular diagnoses that need to be present if certain drugs are used.

The administrators or medical directors usually wrote letters or made calls to ensure their residents' physicians knew about the homes' new policies related to OBRA. Despite their efforts, not all physicians cooperated. Each home told us that at least one physician was reluctant to reduce psychoactive drugs. Homes that used the same consultant pharmacist each month noted that, over time, the physicians and pharmacists built a professional relationship that helped those homes reduce the use of psychoactive drugs.

- ▶ Begin reducing psychoactive drugs before physical restraints for those residents who are restrained both physically and with drugs. Reducing the drugs first can increase alertness, thereby decreasing the likelihood of falls after physical restraints are removed.

- ▶ First reduce physical restraints for those residents who you think will fare best. Your groups of why or when residents are restrained can help you decide where to start. This way you can build experience, confidence, and momentum for the tougher cases later on.

Nursing homes are finding creative solutions to replace restraints. At one home, a confused woman had been restrained in a chair with a vest because she liked to lean over and play with her toes, and often ended up on the floor. By simply giving her a large stuffed animal instead of strapping her in a chair, she forgot about her toes and played with the animal. At another home, staff had restrained a confused blind woman in a gerichair. Knowing she was Catholic, they gave her rosary beads when they moved her from the gerichair. She remained occupied, content, and safe without the restraint.

- ▶ Limit reduction to a few residents per week per unit to keep the process manageable. If all restraints are removed at once, everyone in the home may feel overwhelmed, and the risks for problems such as falls might increase.

Everyone's biggest concern is safety. Once we remove restraints, how do we prevent our residents from falling, becoming agitated, or wandering?

- ▶ Monitor carefully those residents whose restraints you eliminate--make sure they are in view of the nurses' station.

To enhance the monitoring of newly released residents, one home made sure that small handbells were within reach when residents were out of bed and away from their call bells or out of sight of the nurses' station. They asked the residents to ring the bell before they tried to get up unassisted, and staff--still afraid of falls--made sure they answered those bells quickly.

- ▶ Strengthen the residents so their risk of falls will decrease. After a period of limited mobility due to restraints, they need to regain their lost muscle tone.

- ▶ Some homes we visited had an initial increase in falls after reducing restraints, but no more serious injuries. Others had no increase in falls at all. In fact, some nurses and nursing assistants were surprised that many residents stayed seated without a restraint.

At one home, the staff had a problem with a woman wandering into the nurses' station, where she maneuvered among the desks and cabinets by reaching for chairs on wheels to keep her balance. This led to a few falls. Rather than replacing the chairs or restraining the woman, the charge nurse asked a blind woman who enjoyed crocheting to crochet a long strand in a bright color. The charge nurse then hung the crocheted strand across the entrance to the nurses' station. The wanderer no longer entered that hazardous area, but was free to wander safely in the halls.

- ▶ Analyze the fall and incident data and use it to prevent further incidents. For example, is there a pattern to someone's wandering? Do most falls occur at a certain time or in a certain place? Is a piece of furniture tipping too easily?

One home analyzed its incident reports and found that most incidents--falls and episodes of wandering--were occurring in the lobby during shift changes. The home changed this pattern by simply assigning a nursing assistant to the lobby area during shift changes.

- ▶ Log all agitated behaviors using precise language. Note what might have caused the behavior, and what worked to resolve it. If you can find the cause--too much noise, too cold, loneliness, hunger--you can avoid the behavior by addressing the cause without resorting to restraints. For example, make sure a tray of late-night snacks is available, and a sweater or blanket is within reach.

At one home, the consultant pharmacist expressed frustration at the inadequate documentation of agitated behavior. Because agitation can manifest itself in many ways--biting, yelling, wandering, head banging--how could she know whether the particular agitation documented was caused by an improper drug or dose, or by some other incident? But if the nurse or aide documents the specific behavior, like spitting, it helps the pharmacist make the proper recommendations in the drug regimen reviews.

How will restraint reduction affect our activities program?

- ▶ Most of the homes we visited expanded their activities while reducing restraints, particularly activities for confused residents. They even used simple tasks, such as folding towels or sorting mail, to engage a confused resident. Many also noted that the nursing assistants were providing more one-on-one activities, such as puzzles, games, letter writing, or simply visiting, for those residents less interested in or suited to group activities.

Many of the homes we visited have increased the use of music in their activities. Some provide headphones with soothing or familiar music during late afternoon. Others use music in midmorning programs with the more confused residents, and encourage clapping, foot tapping, singing, and dancing.

- ▶ Become familiar with your residents' social histories, and use that information to develop activities they will relate to and enjoy. For example, if someone worked at a newspaper, perhaps he or she would enjoy starting a newsletter for the home with some other residents.

- ▶ Develop a mobility program to strengthen residents. Now that your nursing assistants are free from tying and untying restraints, they can devote more time to walking residents.

One respondent assured us that any home--even one without much space for activities--can implement an inexpensive mobility program by purchasing overhead pulleys, pedals for chairs, and games like plastic horseshoes, bowling sets, and Velcro dart sets. Mobility programs not only strengthen residents and improve their breathing, but also provide another activity for them to enjoy.

- ▶ Develop more activities for those periods when falls, agitation, or wandering increases. Staff at homes we visited said that late afternoon activities helped reduce agitation.

Once we have tried letters, phone calls, and personal meetings, what do we do if a family member still wants to keep a loved one restrained?

- ▶ Present a list of the risks to residents' well-being with and without restraints. The visual impact of the lopsided list weighs heavily in favor of restraint removal. Some of the homes we visited include such a list in the consent forms that families sign.

<u><i>RISKS WITH RESTRAINTS</i></u>	<u><i>RISKS WITHOUT RESTRAINTS</i></u>
<i>Falls, Strangulation, Loss of Muscle Tone, Pressure Sores, Decreased Mobility, Depression, Agitation, Reduced Bone Mass, Stiffness, Frustration, Loss of Dignity, Incontinence, Constipation</i>	<i>Falls</i>

- ▶ Contact your ombudsman. Maybe the family simply needs to hear from a knowledgeable third party that removing restraints is okay.
- ▶ Try the same approach you used with those in the nursing home: stress to the family that times have changed, and removing restraints will improve the quality of their loved one's life. Invite family members to try on a restraint for 10 or 15 minutes.
- ▶ Document the residents' own preferences regarding restraints and share these with families.

One woman told us about her grandmother, who was discharged from the hospital to the nursing home. While hospitalized her personality changed completely; she had been given Haldol and restrained physically. The nursing home weaned her from the Haldol, and the granddaughter happily reports that her grandmother is back to her former self and is wearing out her tennis shoes by walking so much.

MAINTAINING A RESTRAINT-FREE HOME

Typically, the night shift has fewer staff than other shifts. How do we make sure that those on the night shifts leave restraints off?

- ▶ Make sure that everyone from the night shift is included in training related to the home's restraint reduction.

At one home, the evening shift staff missed out on some inservice presentations about restraint reduction. Because most falls at that home occurred between 6 and 8 P.M., the evening staff was especially reluctant to reduce restraints, so their need for training was great.

- ▶ Establish an on-call system so that whenever someone wants to use a restraint, someone from the leadership team is called first.

- ▶ Stress the importance of adapting to the needs and schedules of the residents. This may be especially important for those working the night shift, who may be used to seeing everyone in bed and quiet. Once restraints are removed, interaction among residents and the night shift may increase because residents may want to get up and have a snack, or watch late-night television.

A certified nursing assistant from a night shift told us she wished she knew more about drugs and their side effects, because she might be less apt to ask the nurses to get a drug order if she really understood them.

Once we've made progress, how do we maintain our momentum?

- ▶ Throw away your restraining devices to prevent restraint habits from resurfacing.
- ▶ Reassure everyone that falls have not increased by sharing fall data with them, and provide a forum for everyone to share their concerns and success stories with one another.

- ▶ Encourage everyone to question any restraints and to make sure other, nonrestraining approaches are tried routinely.

One way to keep everyone in the home involved in restraint reduction and ensure that all residents are routinely assessed is to start a "Room of the Day" program. Each day, one resident room is featured, and every department in the home must visit there. Maintenance can check that all equipment is functioning, and that handrails are the right height and chairs won't tip easily. The kitchen can bring a favorite snack or a bud vase with flowers. And the therapists can conduct an assessment. By rotating the rooms featured each day, everyone in the home is involved and every resident is routinely assessed.

- ▶ Reinforce your restraint reduction through inservice training. Offer training on behavioral approaches to agitation, the side effects of psychoactive drugs, managing wandering, communicating with residents who suffer Alzheimer's disease or are otherwise confused, body positioning and range of motion, and promoting resident independence.

- ▶ Implement a no-restraints admission policy, and be sure your residents' physicians and hospital discharge planners know about it. Include the policy in your pamphlets for families.

Take a look at your admission forms. Do they include a box to check for a restraint as needed for safety? If they do, revise those forms so it won't be so easy to order restraints. (J. Rader, Magic, Mystery, Modification, & Mirth: The Joyful Road to Restraint-Free Care, Benedictine Institute for Long Term Care (1991): 5)

- ▶ Tout your home's success at reducing restraints, and recruit staff interested in working in a restraint-free environment.

One home was part of a small chain in which the administrators and nursing directors from each home met regularly. Shortly after the nursing home reforms became effective, a local news program featured one of the chain's homes because of its restraint-free care. That publicity lit a fire among the other homes to follow suit.

CONCLUSION

In this guide, we focused on one aspect, albeit one very important aspect, of a nursing home's responsibilities. Nursing home owners, boards, administrators, and staff face many complexities in running homes in a manner that is both cost-effective and conducive to high-quality care. While we have not addressed these other complexities in this guide, we have sought to provide lessons that are consistent with them and that come from the homes' own experiences--not from a vision of what could be in an ideal world. Thus, the significance of the lessons we present is in their origin. And each has worked in the homes we visited. Readers will have to decide for themselves how well they can work in their own homes.

We recognize that the lessons we present are only a beginning, providing a general sense of direction rather than a blueprint to success. Further experience almost certainly will result in many more lessons. The process of removing restraints and maintaining a restraint-free home is an ongoing one that calls for continuous learning. It can be frustrating, but as the director of a State nursing home association indicates, it can also be extremely gratifying:

Our facilities report that there has not been an increase in severity or frequency of falls or incidents; that there has been a profound improvement in the quality of life for these residents; that mobility programs have been instituted which served to increase physical functioning; that the morale of staff has increased to a significant degree; and that families visit their relatives in the nursing home more often.²

² Vivienne Wisdom, Executive Director, New Hampshire Health Care Association, "Nursing Home Accord Stirs Confusion among States," quoted in the *Los Angeles Times*, March 18, 1991: A1.

APPENDIX A

Methodology

We conducted case studies at seven nursing homes to reach an in-depth understanding of lessons nursing homes had learned by reducing physical and chemical restraints. We selected homes by randomly picking a sample of 96 homes from the HCFA Medicare-Medicaid Automated Certification System (MMACS) that met our criteria. Our criteria included: (1) reduction in the use of physical restraints and psychoactive drugs between the two most recent certification surveys; (2) location in Massachusetts, New Hampshire, New York, or Ohio for ease of travel; (3) bedsize between 51 and 150, and; (4) portion of residents receiving Medicaid or Medicare meets or exceeds 50 percent.

We further narrowed our sample by conducting a screening interview with the homes' administrator or director of nursing. During that interview we verified the information from MMACS and asked some questions about their restraint reduction efforts, auspices, continuity in leadership positions throughout their restraint reduction efforts, and whether they had received any special funding to reduce restraints. We excluded homes that either had turnover in leadership positions while reducing restraints or had received special funding, such as a grant, to reduce restraints. Based on the information from MMACS and the screening interview, we selected seven homes in three States which we believe reflect typical experiences in reducing restraints (see appendix B). The table below highlights some of their characteristics.

Home	# Beds	# of Residents	% Medicaid	Auspices	Location
1	82	82	83	Nonprofit Independent	Rural
2	90	85	68	For Profit Chain	Urban
3	115	106	60	Nonprofit Independent	Rural
4	114	108	63	For Profit Chain	Urban
5	53	52	63	For Profit Independent	Rural
6	130	126	71	Nonprofit County	Rural
7	100	93	65	For Profit Chain	Urban

We visited each home for one or two days and discussed the restraint reduction process with administrators, nursing directors, medical directors, consultant pharmacists, physical and occupational therapists, activity directors, social workers, and training coordinators. We also spoke with staff nurses and certified nursing assistants

from different shifts to get their perspectives. We used discussion guides with both closed- and open-ended questions and collected and reviewed any written policies related to restraints. In some instances, we discussed the home's restraint reduction with residents' family members by telephone.

Prior to visiting these seven homes, we visited six homes during our background research. Three of these homes are well known for their restraint-free care. During these visits, we tested our protocols and discussion guides.

Although the case studies constituted our primary source of information on how to reduce restraints, we conducted telephone interviews with administrators and nursing directors at homes in Florida, Michigan, Oregon, and Vermont. We also talked with representatives of the following national and State groups: the National Citizens' Coalition for Nursing Home Reform, American Health Care Association, American Association of Homes for the Aged, American Medical Directors' Association, American Occupational Therapists' Association, American Society of Consultant Pharmacists, New Hampshire Health Care Association, and Kendal Corporation. Finally, we spoke with an independent consultant and staff at HCFA, a State survey agency, and an ombudsman program. Many of these people provided the written materials that we reviewed for this report (see appendix C).

APPENDIX B

Homes Selected for Site Visits

Massachusetts

Baldwinville Nursing Home
Hospital Road
Baldwinville, MA 01436

Willow Manor Nursing Home
30 Princeton Boulevard
Lowell, MA 01851

New Hampshire

Exeter Healthcare
131 Court Street
Exeter, NH 03833

Maple Leaf Health Care Center
198 Pearl Street
Manchester, NH 03104

Ohio

Arbors at Waterville
555 Anthony Wayne Trail
Waterville, OH 43566

Blakely Care Center
600 Sterling Drive
North Baltimore, OH 45872

Countryside Continuing Care Center
1865 Countryside Drive
Fremont, OH 43420

APPENDIX C

Bibliography

Many of the people we interviewed shared publications with us, which we list below. This list does not represent everything that has been published about restraint reduction, but many of these publications offer extensive bibliographies.

S. G. Burger, *Inappropriate Use of Chemical and Physical Restraints*, National Citizens' Coalition for Nursing Home Reform, 1989.

M. Downs, *Eliminating Restraints Resource Manual: A Guide for Nursing Home Staff*, The Vermont Free-To-Be Project, 1990.

Hospital Association of New York State, *Restraints and the Frail Elderly Patient: Practical Considerations for Hospitals and Nursing Homes*, 1990.

Massachusetts Executive Office of Elder Affairs, *A Practical Guide to Reducing the Use of Restraints in Nursing Homes*, 1990.

National Citizens' Coalition for Nursing Home Reform, *Nursing Home Reform Law: The Basics*, 1991.

J. Rader, *Magic, Mystery, Modification, & Mirth: The Joyful Road to Restraint-Free Care*, Benedictine Institute for Long Term Care, 1991.