

Process for Eliminating Physical Restraints in Long Term Care

A. Introductory Phase (*Administrator*)

1. Absolute support of the administration and governing body of the facility must occur.

- Introduce topic to governing body through distribution of supportive literature, state and federal regulations.

2. Gain their full commitment and establish facility-wide policy.

- The facility must state a commitment to a no-restraint policy upon admission (see Introductory Phase #7). This policy should be discussed with any potential resident and his/her family prior to admission.
- Content should include: a statement that physical restraints are a violation of resident rights, autonomy, and dignity and that all possible measures will be utilized to avoid the use of these devices. In addition, a statement of the multiple negative physical, emotional, and social effects of their use must be made.

3. Designate a responsible, dedicated, supportive staff person ("Change Agent" or "Cheerleader") to oversee the process.

- There is no specific discipline (or position) that needs to be selected for this role. Anyone within the organization who has a deep personal commitment to this philosophy of care can be successful.

4. Together with the Administrator, gain cooperation from Medical Director. (*Change Agent*)

- Medical Director must be involved as an active participant and advocate.
- Meet with all physicians:
 - ~ Invitation sent from Administrator and Medical Director
 - ~ Group meeting with all attending physicians
 - ~ Discuss individually with physicians who cannot attend

5. Introduce topic to staff in all departments. (*Change Agent*)

- Gain insight into staff attitudes regarding removal of physical restraints
- Interview staff of all departments and all shifts to learn of staff concerns regarding restraint elimination
 - ~ Distribute literature regarding restraint elimination
 - ~ Facilitate small group discussions
 - ~ Distribute a letter or memo to staff stating commitment of facility to the elimination of restraints based on the premise of improving residents' quality of life. The letter needs to assure staff that they will not be held responsible for residents' falling during the transition phase as long as they are doing their job, and not being neglectful.

6. Inform families of policy change (*Administrator/Change Agent*)

- A letter of explanation written by the facility administrator, nursing administration or the Restraint Reduction Committee should be sent to residents, families, and physicians. This letter should include a statement regarding the philosophical, as well as legal, shift

toward a standard of care that emphasizes autonomy, quality of life and the resident's right to be free from restraint. It should also explain the detrimental effects and risks associated with the use of physical restraints and a statement of the regulations surrounding physical restraint use.

- Arrange family meetings (customize):
 - ~ Unit by Unit
 - ~ Small Groups
 - ~ Individually

7. Facilitate Restraint Reduction Committee (*Change Agent*)

- Identify and select interdisciplinary members for the Restraint Reduction Committee. It is important to choose representatives from all disciplines including, but not limited to, nursing (a mix of CNAs, RNs, and LPNs from all shifts), physical therapy, occupational therapy, social services, activities, and admissions. Choose, when possible, those staff members who have had experience in restraint reduction and/or restraint free care, and/or those who seem most philosophically supportive of restraint reduction.
- The first task of the Restraint Reduction Committee is to write a facility policy that makes the application of restraints an unacceptable option for staff.

B. Implementation Phase (*Restraint Reduction Committee*)

1. Customize formal education programs for each group interfacing with facility

- Review types of restraints; i.e., chemical/physical
- Discuss adverse effects of using restraints: physical, emotional, psychosocial
- Education regarding effects of restraints and restraint elimination should be ongoing for staff. Mini restraint reduction/elimination sessions (15-20 minutes) can occur right on the units and are an invaluable educational opportunity. They should involve the resident, CNAs, housekeeping staff, and other interdisciplinary team members from all shifts, and can include case studies and problem solving sessions. Many resources are available (videotapes, audiotapes, articles and books).

2. Examine present use of restraints on a case by case basis

- To start the Restraint Reduction Committee process, it's advantageous to begin restraint reduction work on one unit of residents. It's best to choose the unit that has the strongest staff commitment to restraint reduction and not move to another unit until all restraints have been successfully eliminated. Minimally, the CNAs from day and evening shift who work with the resident selected should be actively involved in the committee's work. The CNAs know the resident best and are the experts, armed with valuable information about the resident's daily habits, routines, idiosyncracies, and abilities. The CNAs, along with the other committee members, should collaboratively choose the easiest resident(s) to work with first, and over time move to the more difficult resident situations. The committee process is systematic and methodical, and focuses on one resident at a time leaving sufficient time for team discussion and collaboration.
- Begin eliminating restraint use on the easiest cases first.
- Designate a Restraint Reduction Committee member to gather information required to evaluate the resident prior to restraint removal. Different team members can be assigned to collect information for each resident. To assure a safe and successful removal of

physical restraints for each resident, it is important that time is allotted to this process. Evaluation should include, but not be limited to, the following considerations:

- ~ Why was restraint ordered originally? What was the reason for restraint?
- ~ What is the resident's current medical and psychosocial status? Is there any medical condition that might increase risk of falls (e.g., infection, irregular heart rate, orthostatic blood pressure changes)?
- ~ Are there other risks of resident falling? How is the resident's gait, transfer technique, posture, strength?
- ~ What medications is the resident currently taking? Do any of these medications increase fall risk? Do not substitute physical restraints with chemical restraint!
- ~ What are the resident's toileting habits? Is he/she independent/continent/incontinent?
- ~ Are there specific times when resident is restless, agitated, combative, etc?
- ~ What activities does the resident enjoy? Obtain history of enjoyable activities and hobbies from resident and family, when possible. What are potential diversionary activities?
- ~ Does the resident need assistive devices or special seating considerations for comfort/posture? Would PT or OT evaluations be helpful?
- Answers to the above questions direct the Restraint Reduction Committee in choosing appropriate services and alternatives to assure safe removal of restraints.
- Once a resident is selected for restraint reduction, designated staff, such as the social worker or a CNA, need to talk with the resident involved and his/her family. They should be provided with information as included in the admission policy (see above). The resident and family need to be assured that every effort will be made to provide for the resident's safety during the restraint reduction process, and alternative strategies and interventions will be utilized. There is research available that can be shared with families assuring them that serious falls do not automatically increase with restraint removal. In fact, serious falls occur more often in restrained individuals than in those left unrestrained.
- Residents who have had restraints removed should be reviewed at the Restraint Reduction meetings until members feel comfortable that the resident is functioning safely without restraints. Evaluations should occur on at least a monthly basis. Should a problem arise, the committee should assess needs and seek suitable alternatives or adaptations.

3. Development of Individualized Care Plan

After considering relevant factors, the Restraint Reduction Committee should develop an individualized care plan for each resident in cooperation with the unit staff. Quality of life of the resident should be the primary operating concern. The individualized care plan will be a reflection of all of the information gathered about the resident past/present roles, interests, habits, routines, behaviors, physical capabilities, and potential risks. Remember to focus on the needs of the resident, not the staff. For example, if the resident has always bathed before bed at night, then the staff should honor the resident's preference for an evening bath. Innovative staffing and flexibility in routines are some ways that individual needs can be respected as staff alter their own routines to accommodate the needs of each resident. Primary care nursing, assigning each CNA to the same group of residents on a "permanent" basis, is the most effective way to know the

resident and his/her likes and dislikes.

Adapt the environment to the resident, not the resident to the environment. If, for example, the resident slips from one type of chair, the appropriate intervention is to find a more comfortable and appropriate chair.

If staff are hesitant/fearful, start by removing restraints for a very specific period of time. For example, have Mr. J sit without his restraint near the staff desk in a comfortable chair (not a geriatric chair) during times when staff are charting or during an activity that Mr. J particularly enjoys. Gradually increase his time out of the restraint incrementally.

Incorporate the movement toward restraint elimination in his care plan.

Determine who will be responsible for notifying the resident's physician of the decision to remove restraints. A member of the Restraint Reduction Committee might be the most appropriate choice.

Avoid the application of restraints once they have been eliminated!

Document what works and what doesn't work. Remember that each person is an individual what doesn't

work for one resident, might work well for another.

C. Evaluation Phase

1. Re-examine staff perceptions regarding restraint elimination.

(Administrator/Change Agent)

- Keep a notebook/journal at the staff desk that all staff can use to write concerns or insights into the resident's daily routines and needs. Encourage all staff to participate in maintaining this valuable resource and communication tool between staff in all departments. Examples include: housekeeping staff member notes that the resident goes to the bathroom in stocking feet after her nap (a safety consideration); or, activities staff share insight into what the resident enjoys from the activity cart (providing information helpful to staff when the resident is awake at 3:00 am). This notebook could also be used to note what interventions or strategies are working best with the resident. This input from all shifts and all disciplines is helpful in developing individualized care plans.
- Track incidents of falls, injuries, etc. through Quality Improvement mechanisms. Keep a Fall log. Accurate records identify the time of any fall, the circumstances around the fall (what the resident was attempting to do, where the resident was going, what type of shoes the resident was wearing, etc.). Restraint removal does not mean that resident safety will be compromised. By accurately assessing the environment/specifics of falls, you will be able to make adaptations to the environment specific to each resident's individual needs.
- Re-interview or resurvey staff to elicit thoughts regarding restraint elimination.

2. Re-examine resident, family and physician perceptions regarding restraint elimination *(Administrator)*

- Through letters, meetings and casual conversations, elicit comments and ideas about the elimination of physical restraints.

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