

# Restraint Use, Regulations and Safe Practice Script

**Note: this script may vary slightly from the recording**

## Segment 1

### Slide 2

**In this segment, we will discuss:**

- Definition of Restraint
- Other Important Terms & Definitions
- History of Restraint Use
- Federal Guidelines
- Acceptable Uses of Restraints
- When Restraint Cannot Be Used
- Consequences of Inappropriate Restraint use

### Slide 3

Definition of Restraint:

The Centers for Medicare & Medicaid Services (CMS) defines restraint as “any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body”. A physical restraint is anything that keeps a resident from moving around or getting to a part of the body. Residents cannot remove restraints easily. So as you can see from this, many things could be considered a restraint.

### Slide 4

So in order to fully comply with CMS requirements you need to understand these Important Terms & Definitions:

**Freedom of Movement--** means any change in place or position for the body or any part of the body that the person is physically able to control. (so if a person has left side paralysis, they cannot freely move that part of the body).

**Remove Easily--** means the manual method, device, material or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (i.e.: siderails are put down, not climbed over; buckles are intentionally unbuckled; ties or knots are intentionally untied; etc.) considering the resident’s physical condition and ability to accomplish objective (i.e.: transfer to a chair, get to the bathroom in time).

**Chemical Restraint—**means any drug that is used for discipline or convenience and not required to treat medical symptoms.

### Slide 5

**Discipline—**means any action taken by the facility or staff for the purpose of punishing or penalizing residents.

**Convenience—**means any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest.

**Medical Symptom—**means an indication or characteristic of a physical or psychological condition. The resident’s medical symptom should not be viewed in isolation, rather the symptoms should be viewed in the context of the residents’ condition, circumstances, and environment. Before a resident is restrained, the facility must determine that the resident has a specific medical symptom that cannot be addressed by another, less restrictive intervention and a restraint is required to treat the medical symptom, protect the resident’s safety and help the resident attain or maintain his or her highest level of physical or psychological wellbeing.

Examples are unsteady gait, poor balance, or lack of safety awareness, violent or aggressive behaviors that place the resident or others in danger.

So you can see why it is important to understand all the terms that are used and what they actually mean.

### **Slide 6**

Now let's take a look at the history of Restraint use and why it is so important.

Over the years restraints have been applied to people for the wrong reasons. Many times it was used as a form of control. There was a lack of understanding, lack of equipment or training. In the past, Mental Health Facilities used restraints quite frequently. Often these patients were restrained both physically and with the use of medications, leaving them incapable of functioning. There have been, and sometimes still are, people who have been restrained inappropriately. This includes people being tied into chairs, or sat behind a chair table so they won't get up and wander around.

### **Slide 7**

At the time the Nursing Home Reform Act was passed by Congress in 1987, it was a widely accepted and widely used option to use restraints to manage the behavior of residents who wandered, were agitated, or who staff simply thought needed to be restrained. The 1987 law cemented a growing consensus against the use of restraints throughout nursing homes and eventually led to a complete change in how restraint use is viewed. Through the work of thousands of individuals in both nursing homes and in government, the use of physical restraints has largely been replaced with improved methods of care.

Year after year, the Centers for Medicare & Medicaid Services (CMS) and advocacy organizations, educators, and nursing homes implemented one initiative after another, building upon the earlier learning. And year after year, as nursing home staff learned more about the dangers of physical restraints and learned better methods of working with residents, the use of physical restraints has been reduced.

### **Slide 8**

Now in order for you to practice safely the Government has issued a set of guidelines on restraint use, and has issued a set of regulations known as the Federal Guidelines?

While the law and subsequent regulation do not prohibit the appropriate use of physical restraints in nursing homes, the regulation provides that "the resident has the right to be free from any physical or chemical restraints imposed for discipline or convenience, and not required to treat the resident's medical symptom." In other words, Federal and State laws prohibit nursing homes from using restraints unless they are medically needed.

The intent of this requirement is for each person to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints.

Nursing home residents have the right to refuse treatment, including the use of restraints.

### **Slide 9**

If restraints are used, they must be based on a physician's order for a specified and limited time. Restraints may only be applied by a qualified professional. So you cannot, in your everyday work think a person needs to be restrained and apply one.

### **Slide 10**

While there must be a physician's order reflecting the presence of a medical symptom, the facility is ultimately accountable for the appropriateness of that determination. The physician's order alone is not sufficient to warrant the use of the restraint and while some families and guardians may think a person should be restrained they cannot force nursing homes to restrain a relative.

## Slide 11

Medicare and Medicaid certified nursing homes must ensure that a resident's abilities do not decline unless the decline cannot be avoided due to the resident's medical condition. Residents often lose the ability to bathe, dress, walk, toilet, eat, and communicate when they are regularly restrained. If restraints are necessary, they must be used in a way that does not cause these losses. Residents must be released from restraints and exercised at least every two hours.

Nursing homes sometimes use restraints to help keep residents in proper body alignment or position. However, proper positioning can often be achieved by using pillows, pads, or comfortable chairs. A Medicare or Medicaid certified nursing home cannot use restraints to help position residents unless it has first consulted with therapists to determine whether less restrictive support devices could meet the resident's needs.

## Slide 12

Now I will talk about what are the acceptable uses of restraints. Before a restraint can be used other least restrictive methods must have been tried and failed. Firstly there are

- Medical symptoms that warrant use of restraints (for example: unsteady gait with history of falls and lack of safety awareness related to dementia. Another example is: poor upper body control r/t CVA.)
- Violent or aggressive behavior places resident or others in danger. An example is an incident we have had is when a lady had a change in mental status. She had dementia and was confused anyway, but for some reason, her mood changed. She became obsessed with getting out of the building and kept trying to stand up and walk. She required physical assistance to walk and without help would fall. Staff members ended up being one on one with her and attempted to calm her down. She got agitated with their presence and the more she tried to get up, the closer they had to stay, the more upset she got. Soon, she was hitting out at anybody that was near her. Eventually we had to put a waist restraint on her as all the other we had tried first didn't work as she got them all off, so to keep her from getting up and falling we resorted to a waist restraint. We also had to lock the wheels on her wheelchair to keep her from hitting the other residents. Restraining someone with violent or aggressive behavior is usually a short term intervention until the aggressive behavior can be corrected.

## Slide 12

- Voluntary seclusions can also be used. This is where a person voluntarily takes some time out in their room or away from other people. Living with a lot of people is an unnatural experience. How many people do you know who live with 60 people or even 10 people for that matter? It is understandable that people can get fractious from time to time and removing themselves or being removed by a caregiver for a short period of time may be all that is needed to calm them down. In this circumstance they would not be locked in an area and could come out of their own free will. However involuntary seclusion is against the regulations. You cannot lock someone in an area and seclude them from everyone else. It is against the regulations.
- To allow life-saving medical treatments on a temporary basis. The use of restraint should be limited to prevent the resident from interfering with the life-sustaining procedure (such as to keep the resident from pulling out an IV for antibiotics) and not for routine care. Of course, the resident and or family must not have previously declined the lifesaving care.
- Having said that these are acceptable uses, the individual resident's assessments must indicate it is appropriate. As you will learn, one device can be a restraint on one person and not on another. An assessment must be completed and lesser restrictive devices must have been tried and failed. Remember – use of restraint is a last resort.

Now a note about Orthotic body devices. These can only be used solely for therapeutic purposes to improve the overall functional capacity of the resident.

### Slide 13

Now let's talk about when restraint cannot be used. It cannot be used for

- Punishment or discipline or for
- Staff convenience.
- Falls do not constitute self-injurious behavior or a medical symptom that warrants the use of a physical restraint. Although restraints have been traditionally used as a falls prevention approach, they have major, serious drawbacks and can contribute to serious injuries. Falls do not constitute self-injurious behavior or a medical symptom that warrants the use of physical restraint. Nor is there any evidence that the use of physical restraints, including but not limited to side rails will prevent or reduce falls. Additionally, falls that occur while a person is physically restrained often result in more severe injuries.

### Slide 14

So what are the consequences of inappropriate restraint use? Firstly it could be seen as unlawful. If a person's freedom is restricted by the use of an unauthorized restraint or restraint process, it could be considered assault and be against the law. So that is why staff must make sure that all lesser restrictive interventions have been tried and failed before implementation of a restraint.

The consequences of applying a restraint without following proper protocol could actually lead to severe consequences for you or your facility with either you or the facility being prosecuted. The last thing a facility needs is a mention on public record that they inappropriately used restraints which is against federal guidelines. Which again reinforces that implementing a restraint must be the last resort.

## Segment 2

**NB: this script may vary slightly from the audio**

### Slide 1

**In this segment, we will discuss the categories of restraint. These are**

- Chemical restraints
- Physical restraints

### Slide 2

You may have heard of the term Chemical restraint – but what does that actually mean?—Well it means restraining someone's behavior by sedating them rendering a person incapable of being able to function. If you remember the definition of restraint where it said at the end "restricts freedom of movement or normal access to one's body"? Well when if a person is over sedated it will restrict their freedom of movement. This is no longer an appropriate means of treatment.

### Slide 3

As we learned in the History of Restraints, this used to be a common practice. While it may appear easier to take care of people with troublesome or inappropriate behavior if they were kept sedated it can make it difficult for them and you to keep them mobile for such basics as taking them to the toilet. However, the regulations very clearly state that medication used for discipline or the convenience of the caregiver is unacceptable.

Most Nursing Homes will say they don't use chemical restraints.

### Slide 4

Psychoactive medications, used appropriately can benefit residents, but it's a fine line if the medication renders them incapable of functioning—that's when it can be considered a chemical restraint.

These are very strong medications and if used inappropriately can actually do more harm to the resident. Keep in mind that the shortest acting medication takes about 20 minutes to work, so the behavior may not even be a problem by that time. It should never be used as the first intervention.

All previous interventions must be documented as tried and failed. You should also be very careful using PRN medications which are medications ordered by the physician, but it is up to the discretion of the person charged with the responsibility of making the decision on when to use it. This puts a big responsibility on the nurse so you better be able to defend your reason for using the medication by your documentation and facts.

### **Slide 5**

So what are some examples of medications that have potential to be a chemical restraint? Well here are some common medications in use that you may have come across. They fall into 3 main groups. Firstly there are Anti-psychotics. These are such drugs as Haldol, Seroquel, Zyprexa. The next group is Anti-anxiety and includes Ativan, Valium, Xanax, Atarax, Buspar, Vistaril and the last group is Sedatives/Hypnotics like Ambien. So if you are giving any residents these medications or they have been commenced on them at any time, you need to know they have the potential to be a restraint if given in doses too large for the frail person to take. Your observation skills are very important here. If you notice them to be or are becoming more drowsy, stiff and difficult to move or anything else that is different, you must report this to the physician immediately and record it in the person's notes.

### **Slide 6**

Now we have talked quite a lot about chemical restraint and what constitutes chemical restraint but it only fair to give you some alternative to using pills to manage or control a person's behavior so here are some things you can do instead of calling for a pill. Firstly try Distraction use some action to get their mind off the problem. This could be singing, or telling them something funny. It could also be to take them for a walk. You could offer them something to eat or drink or even take them to the toilet.

### **Slide 7**

You could try repositioning, shifting their position. Some people sit for quite long periods of time. If they cannot move themselves it can become very uncomfortable. Try an exercise for yourself or with colleagues. Set a timer or sit where you can see a clock with a second hand on. Sit completely still for just 1 minute. Observe how you feel. How many times do you want to scratch your head, or nose; want to move your legs or arms; shift your bottom. Just imagine how you would feel if you couldn't move and there is no one around. Would you call out? What if you didn't know where you were; if the place was unfamiliar to you? You know where you are most of the time but if you have memory loss and you didn't recognize the people around you.

You could also try putting on some relaxing or soothing Music that may relax the person. This could work. You could also try an activity with them. Reading a book to them or looking at some family photos or picture books may help.

### **Slide 8**

Maybe just being there for them 1:1 or giving them Back Rub. People in care may miss touch, hugs or holding their hand. Put yourself in the person position and imagine how you might feel in the same situation.

Maybe they may have pain so assess them for that. Many people suffer chronic pain and if a person cannot explain that they are in pain verbally you can be assured they will show it in their behavior. If the environment is over stimulating then remove them from it. It may be too much noise or other people behavior may be upsetting the person. However one of the most important things is to speak calmly and quietly. They do not need to be shouted at or made to feel a nuisance. It will only make the whole situation worse.

## **Segment 3**

**NB: this script may vary slightly from the audio**

### **Slide 1**

Now let's look at physical restraint and what that is.

## Slide 2

**Physical Restraint** is when you use equipment, devices or furniture to restrict a person's normal right to freedom movement.

## Slide 3

Whether or not a particular item is considered a physical restraint depends on the purpose and effect of its use. If the item is used to restrict movement, it is a restraint. However, the same device may have the effect of restraining one individual but not another.

Keep in mind, if the resident can "remove easily", the device it may not be considered a restraint. For instance: if the resident can remove a seatbelt from the wheelchair on command, it is not restraining them. But—they must be able to remove the seatbelt consistently every time you ask them to.

We can't say enough that a restraint must only be used as a last resort. Everything else you have tried has not been successful at treating the problem. Now I know I talked about this in previous slides but we cannot talk enough about examples of things you can do rather than restrain a person so let look at this example:

You cannot immediately choose to put a waist restraint on a resident because they continuously try to get up from their wheelchair. What could you try first? First of all, try to determine why they are getting up. Do they need to go to the bathroom? Are their arthritic legs bothering them? Do they need to take a little walk and stretch them? Sometimes it's as simple as that. If those interventions weren't successful, try to distract them...See if there is an activity going on that the resident would enjoy, give them a magazine to look at, talk to them. I have done many med passes with a resident beside me in order to keep them safe. Maybe they want to lie down for a bit. Try some food or drinks. See if they are in pain and give them medication if they have something ordered—if not, notify the physician and get something for them. Sometimes family members will come in and spend time with them. There are many things that must be tried first before a restraint can even be considered. If all these things fail, there are still interventions that can be tried such as an alarm that will let you know they are getting up, adjustments to their wheelchair, restorative nursing programs, etc. Many nursing facilities have policies in place that permits only nurse managers to approve restraint use. This is to ensure that everything possible has been tried before the restraint is ordered.

Most of the time, the person being restrained has cognitive impairment otherwise, they would recognize the dangers and comply with safety measures. So, put yourself in their shoes for a minute. You don't recognize where you are. All of the people around you are strangers. Who can you trust? Who can help you? All of a sudden, you think you need to get home. Maybe your kids are getting off the bus and no one is there for them. Or your husband will be home from work and you need to get supper ready. Or your mother is worried about you and you must let her know where you are. There are any number of reasons confused people act out. Now, consider all these things going through your mind and next you find yourself "tied up". Oh, my! How Scary! You are now being kept against your will by people you don't know. What are they going to do to you? You have to let someone know where you are so they can help you out of this mess. Keep this in mind. While the restraint may provide some level of protection, remember you are restraining a person. You must keep the person's best interests foremost in your plan.

## Slide 4

So what are physical restraints? Well they are seat belts on a chair. Now it could be that it is on for safety reasons but if a person cannot remove it themselves it is a restraint. It could be foam pillows that prevent

getting up Now if this was used to keep them off an area to of their body to prevent a pressure sore in bed, it is not a restraint but if it is to stop them getting up it is. It may also be hand mitts. The most common times these would be used is to prevent a resident from removing something from their body such as a wound dressing, a g-tube or an IV.

### **Slide 5**

It could also be leg restraints which are applied to keep a person from walking around or arm restraints that keep a person sitting in a chair or still vest, pelvic or waist restraint that stops them getting out of a chair. Now would you like to be tethered so you cannot move or get up? Would this not make you all the more determined to get out of the situation you are in.

Wedge cushions that keep a person off an area or in one position. How awful that must feel or lap cushions that don't allow people to move freely

### **Slide 6**

It could also be lap trays the resident cannot remove easily. Now you may use a lap tray or a tray attached to a chair so someone can eat a meal or for an activity but it must be removed when the activity or meal is finished. It cannot just be left there because it serves as a way of keeping a person in the chair. Even locking a person's brakes on the wheelchair so they cannot move around can be considered a restraint. So you need to think very carefully before you consider using any of these devices. If they haven't been approved and the intent is not for the good of the person then it cannot be used.

### **Slide 7**

A person can also be considered restrained by facility practices that meet the definition of restraints. These may be things such as tucking in or using Velcro to hold a sheet, fabric or clothing tightly so that a resident's movement is restricted or using a chair that prevents a resident from rising independently such as a low chair or beanbag chair

### **Slide 8**

Using a chair or bed which is placed so close to a wall that prevents the resident from rising or getting out of bed can also be considered restraint as the person cannot move freely. Using side rails can also sometimes restrain residents but can be a danger or hazard for the person if they try to climb over them. And of course Seclusion. This is definitely a restraint as confining a person to a room where they cannot get out is restricting a person's freedom of movement. So you see, many things that you may think are for the good of the person, may be interpreted as for the good or ease of the staff. In all accounts you cannot apply any device to any person unless a full assessment has been made which is what we will talk about next.

## **Segment 4**

**NB: this script may vary slightly from the audio**

### **Slide 1**

**In this segment we will discuss**

- Assessment
- Consent
- Care plan
- Implementation

### **Slide 2**

Firstly let's talk about Assessment

Before any restraint can be implemented, there is a process that has to be completed. As I said, a restraint cannot be applied just because you think it should be. While there must be a physician order reflecting the presence of a medical symptom requiring the restraint, CMS will hold the facility ultimately accountable for the appropriateness of that determination. The physician's order alone is not sufficient to justify restraint use. This process is mandatory and starts with the Assessment,

So what are you going to determine in the assessment? These are things that must be looked at: Firstly determine what are the medical symptoms that led to the consideration of the use of restraints? You need to define what are the behaviors you are trying to control? Does the resident display violent or aggressive behaviors and does the behavior place the resident or others in danger? Is the restraint temporarily needed to allow for emergency care? (i.e. wrist restraints to allow lifesaving IV fluids or medications).

You also need to ascertain if these symptoms are caused by failure to meet individual needs in accordance with the resident assessments. Is it the use of rehabilitative/restorative care? Is it the lack of providing meaningful activities? Can you manipulate the resident's environment, including seating to avoid the use of a restraint?

You also need to look at whether the cause(s) of the medical symptoms can be eliminated or reduced?

### **Slide 3**

You need to know if lesser restrictive alternatives have been tried and deemed unsuccessful and why they were unsuccessful.

### **Slide 4**

Is the chosen restraint is the least restrictive intervention for the person and how you plan the care for the time the restraint would be in use. Remember this needs to be for the least amount of time the restraint will be on. You would also need to explain how the restraint would work to treat the medical symptom, protect the resident's safety and assist the resident in attaining or maintain his/her highest practicable level of physical and psychosocial well-being.

So as you can see the assessment is very detailed and designed for the protection of the resident, but also for everyone else involved to make sure there is no other alternative.

### **Slide 5**

Now let's talk about consent. Firstly Informed Consent has to be obtained before a restraint is implemented.

### **Slide 6**

So what actually is Informed Consent? Well it is a process of discussion that takes place between a person and a health care professional that results in the person authorizing or agreeing to undergo a specific medical treatment based on the information that is given to them.

### **Slide 7**

This discussion must outline the procedure including the risks and benefits of the undergoing the treatment. The purpose of this is make sure the person fully understands what is going to happen to them and what they can expect as a result of the treatment. Remember, a person always has the option to refuse.

If you have ever had surgery, and undergone an anesthetic you had to give consent. Before you gave consent, the doctor would have explained what the surgery involved, how they would do it and what you could expect as a result of having the surgery before you signed the form. Or you may have had to undergo some treatment or been put on some medication by your doctor, and while you may not have had to sign a form, you will have been given all the information about the treatment including what you would



expect to have happen as a result of or during the treatment before you went on the medication or had the treatment.

### **Slide 8**

Now the facility has some responsibilities in the process too. Above I have said what Informed consent is, now let's see it in action. The facility must explain the reason a restraint is being considered and how it's use would treat the resident's medical symptoms the person is experiencing. They also have to outline how it will assist the resident in attaining/maintaining his/her highest practicable level of physical or psychological wellbeing.

### **Slide 9**

They also must include any potential risks and the benefits of all options under consideration. So what might the options be for the person? Well they could include not using a restraint at all, and alternatives to restraint use) must also be explained and also the potential negative outcomes from using a restraint.

### **Slide 10**

So what are the potential negative outcomes of restraint use? Well they include, but are not limited to: The resident's physical functioning may decline. As a result of being in a restraint the person may lose their ability to ambulate and because if they don't weight bare and muscle wasting may occur. They could develop contractures of the legs because they are kept in one position for too long. Now this should never occur as if a person is in a restraint, you must make sure their position is changed regularly and they are released from in as the care plan designates.

They will almost definitely lose their autonomy and be reliant on caregivers for all their cares. Any care that is given should never take about the rights of the person to free will so this has to be considered as well.

### **Slide 11**

They are also at risk of developing of pressure sores/ulcers and these only develop through poor nursing and leaving a person sitting or confined in one position for a long period of time. It doesn't take long for older people develop pressure sores so you need to be very aware of this.

Incontinence is another area to be avoided. If a person cannot get to a toilet, then they will become incontinent and apart from their loss of dignity it will make extra work for you.

The could be at risk of increased incidence of infections especially urinary infections

### **Slide 2**

Delirium, agitation and loss of dignity and self-respect are also potential negative outcomes. How would you feel if you were restrained, couldn't move as you would like and you did not know why you couldn't. Would you not become more confused and agitated? What would it do to your dignity especially if you became incontinent as well? How would you feel about yourself?

### **Slide 13**

One very real possibility would be they would withdraw into themselves and become depressed. Put yourself in the same position? People will either do one of two things if they are restrained or feel they are locked into a corner. They will either give up or withdraw or they will come out fighting or be aggressive or agitated. If they have reduced social contact it could actually make them worse and they want to call out all the time.

Restraint use may constitute an accident hazard. Restraints have been found in some cases to increase the incidence of falls or head trauma due to falls and other accidents like strangulation or entrapment. So restraints in effect can reduce independence, functional capacity, and quality of life. Alternatives to restraint use should be considered and discussed with the resident. So you can see there are many

potential risks to using restraints and alternatives use might include such things as modifying the resident's environment and/or routine. This may in fact have a far better and more positive outcome for the resident, you and their family.

#### **Slide 14**

So who can give consent? Obviously the resident can and generally this is the best option however in the case of a resident being incapable of making a decision, the legal surrogate or representative may exercise this right.

#### **Slide 15**

However, the legal surrogate or representative cannot demand that a restraint be used without a proper assessment and it is established that this is the best course of action. Nor can they give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of the regulation solely based on a legal surrogate or representative's request or approval.

#### **Slide 16**

Now the responsible person can refuse a restraint if they feel it is not the best option or for any other reason they feel is appropriate. They are of course acting on behalf of the resident and it has to be assumed that these are the people that know the resident best and would make a decision based on this knowledge. However they can only exercise this right based on the same information that would have been provided to the resident.

So as you can see, there is a lot of work that needs to be done before a restraint can be applied.

#### **Slide 17**

So what is the expectation of the CMS? Well it expects that for residents whose care plans indicate the need for restraints, the facility engages in a systematic and gradual process towards reducing restraints. This means to try to discontinue the restraint or try a lesser restraint. Typically done quarterly.

#### **Slide 18**

So what must the Care Plan include? Well the facility must design its interventions not only to minimize or eliminate the medical symptom, but also to identify and address any underlying problems causing the medical symptom. So how are you going to do this?

#### **Slide 19**

Here are some likely Interventions that the facility might incorporate in care planning. They could include things that will provide restorative care to enhance abilities to stand, transfer, and walk safely This may mean that the person would need to be stood up, and given the opportunity to move freely at least every 2 hours or as stipulated by the care plan.

It may mean to provide a device such as a trapeze to increase a resident's mobility in bed or it could be that you bed its placed lower to the floor and surrounding the bed with a soft mat to provide a soft area for the resident in case they were to fall out of bed

#### **Slide 20**

In some cases equipping the resident with a device that monitors his/her attempts to arise may be useful as an alter to staff when a person goes to get out of bed.

It could also mean that frequent monitoring by staff with frequent interventions like assisting a person to the toilet for residents who attempt to arise to use the bathroom.

If a person understand then using visual and verbal reminders for them to use the call bell for Another suggestion may to provide exercise and therapeutic interventions, based on individual assessment and care planning, that may assist the resident in achieving proper body position, balance and alignment, without the potential negative effects associated with restraint use.

So you see there are things that can and must be done if a person has had a restraint prescribed but they just cannot be left for long periods of time. I would hope that as a caregiver you would have the best interests of the resident at heart and that you would make sure you checked a person frequently to make sure they are safe, comfortable and content. However to ensure this, there are guidelines in place. So what are these guidelines?

### **Slide 21**

Federal Guidelines mandate which is an order that a resident with a restraint is checked every 30 minutes and the restraint released with range of motion given at least every 2 hours. So this means that you must check a person every 30 minutes, and I would hope you would interact with them at this time. That is talk to them and make sure they are comfortable. Also that at least every 2 hours you will either stand the person up or get them to move or if they are in bed, you would move their arms and legs and change their positions so that they are comfortable. Just imagine how it must feel to be in one position for a period of time?

### **Slide 22**

So when can the restraint be implemented? Well this can only be applied when the assessment and care plan has been completed. So you can see there is quite a lot that has be done first and this can take quite some time to complete.

### **Slide 23**

So who can apply this restraint? Well it can only be applied by someone who has had been trained in applying the particular device may apply it. This will most likely be determined by facility policy. Some facilities only want nurses to apply the device initially, others may allow nurse aides to apply the device. But either way, the staff member must have knowledge of how to apply the restraint appropriately and safely.

## **Segment 5**

**NB: this script may vary slightly from the audio**

### **Slide 1**

**In this segment we will discuss**

- Why Monitoring is important
- Physical risks
- Mental and emotional risks
- Medical risks
- What you need to know

### **Slide 2**

Why monitoring is important. In practice, restraints have many negative side effects and risks and in some cases these far outweigh any possible benefit that can be derived from their use. Evidence does not support the notion that the use of physical restraints, including but not limited to side rails, will prevent, or reduce, falls.

Additionally, falls that occur while a person is physically restrained often result in more severe injuries. Restraints pose a possible safety hazard as many residents have been hurt and even died being entangled in them.

### Slide 3

Whenever a restraint is used there are always some risks. Don't think that by applying a restraint to a person that all the problems will be solved. They won't. They could in fact create more problems of a different nature. So you need to know what those risks are and observe what is going on for the resident and report them accurately in the resident's notes and other monitoring forms in your facility.

### Slide 4

I have put them into 3 categories just to give you a better understanding of these dangers. The risks are

- Physical
- Mental and emotional
- Medical so I will talk about each of these sections separately

### Slide 5

Physical risks

They can become a falls risk. When a person is not able to walk freely or restricted from walking and weight bearing muscles wasting and reduced bone density are likely to increase their risk of falling through poor balance. A person may resist the restraint and suffer bruising, cuts or abrasions on their body. A person may get up from the chair with the table in place and fall flat on their face suffer fractures as well. A person with a bed rail on may climb over the side and suffer an injury or their continual movement around the bed cause bruises to their body. So while having a bed rail in place may seem like a logical thing to do the risks to the person may be higher than not have a bed rail in place. Fractures are a very real consequence with facial, ribs, hips or arms being a nasty result.

### Slide 6

Chronic constipation is another risk of using a restraint. Exercise is good for our bowels. It helps them to move. If a person is just sitting and not moving around then it could cause or make an existing constipation problem worse.

Incontinence is also another problem. If a person is not toileted regularly you can guarantee they will become incontinent. What do you think this does to a person's dignity and self-esteem? Having control of our bowel and bladder is a primal instinct. It is something that is rewarded as a milestone. Imagine just how it would feel if you knew you wanted to go to the toilet, yet you were restricted and not allowed to relieve yourself?

Pressure sores are another risk of restraint. As I mentioned earlier, bed sores are preventable. Don't ever be responsible for a person getting a pressure sore because you did not move them enough and kept them restrained. And of course poor circulation is another problem that could occur which could contribute to pressure sores and also to them being cold. You know what it is like when you lie down and rest. Your body temperature drops and you need more clothes on or a rug, so don't forget to make sure a person is warm with enough clothes if they are confined to a chair or bed.

### Slide 7

When people are confined to their chair or bed, their muscles become weak and this of course leads to them losing the ability to walk or perform other activities. This also affects their bone density. Now as people age their bones become brittle anyway and it is activity like walking that helps to strengthen them, along with diet of course. This may contribute to them having a hip fracture or some other fracture. Keeping people as mobile as possible is a benefit and you need to make sure you help the person to do so.

### Slide 8

People can also lose their appetite and not want to eat. This can have a big effect on their wellbeing. Elderly people lose their subcutaneous fat so you need to make sure that they eat the high protein foods and weight loss is not good for a person.

Infections like urinary tract infection or infected pressure sores can also be a problem and further exacerbate a person's condition.

Strangulation & death can definitely a potential physical risk. I should hope it never happens but it highlights the fact that restraints have some very real risks to a person and why they need to avoided as much as possible.

### **Slide 9**

Mental and emotional risks with restraints are very real too. They include isolation and withdrawal. A person in a restraint is often more likely to have less social contact so it can compound an already serious situation for a person. Just imagine how you would feel if you were confined to a chair or bed and visited by people. Would you not feel as though you were being isolated from people and become withdrawn feeling you can't win or can't get out of the situation?

### **Slide 10**

Some people can become very agitated with less things to do. It can even affect their sleep from an emotional point of view or from the fact there is nothing else for them to do but sleep as they cannot get out of the chair or bed. It can also lead to depression which is a very serious mental health issue. No amount of medication is going to lift their mood if they feel they are trapped.

### **Slide 11**

Some people may feel they are being punished and this can bring up all sorts of issues for them. Somewhere in their past they may have been or felt restrained and all these memories flood back to them making them really upset.

Any person left to sit in one position for an extended period of time needs to be acknowledged as a person and have their position changed on a very regular basis to prevent skin breakdown and promote comfort. A person who does not or cannot ask for anything is at risk of becoming invisible so remember to stop and talk to these people in your care every time you go past and shift their position very slightly. Give them a smile or a light rub on their back. Everyone needs to be touched otherwise they become sensory deprived which means they lose the ability to be aware of their physical body. And don't forget to offer them a drink of water. These are the little things that make a person happy and feel well cared for regardless to whether they are in a restraint or not. Do it for all or anybody in your facility not just the person or people you are looking after on a particular day. Just imagine how you might feel if you had to sit and watch people walk past you several times a day and are not ever acknowledge. Would it make you feel like an object perhaps or someone of little worth?

If a person is restricted from moving and they can't no matter how much they try, are at severe risk of becoming resigned, depressed and very withdrawn. They just give up. Wouldn't you? They may become more agitated so you have a bigger problem than you started with. And how do you measure the loss of dignity and humiliation a person feels? These are all very real risks of using a restraint.

### **Slide 12**

Now let's talk about Medical Risks

As I mentioned before, a person in a restraint or an enabler is at risk of becoming invisible. If they can't or don't call out to you, they are no problem and very easy to walk past. I know how busy you are in your day but you know the end result is they may become dehydrated, constipated or suffer Urinary Tract Infection's through lack of fluid or constipated through lack exercise. These are all due to poor care and can be avoided.

### **Slide 13**

They could develop pneumonia through sitting or lying in the one position for too long or die from asphyxiation! Yes they could get into a position that they are unable to get themselves out of and suffocate.

So you see. Restraints do have risks attached to them. They are not a panacea that will fix the problem. This is why the assessment process is so important. It is crucial to ensure the person you are considering for a restraint does actually need to be restrained. Is this the last resort? The only option? The risks could well outweigh any benefits.

#### **Slide 14**

##### **So what do you need to know and do?**

You need to know where the restraint documentation is kept. That includes the orders, consent, monitoring forms and how to accurately report on how the person is while being restrained. You may also be the senior person on duty when a State Survey occurs and the surveyor may ask to see it. Like all Policies and Procedures in your facility, it is your responsibility to know where the documentation is kept. While you are not required to know EVERYTHING that is written in the manuals, you are expected to know where to find the information.

What care the person requires. This will be on their care plan, service delivery plan or lifestyle plan so you need to be very familiar with this plan so the person gets the right care. This includes the basics of life like nutrition and hydration, toileting, basic care, activities and so forth. You also need to note if there are any improvements in the person or not. What is their mental state like? Is it beneficial to the person or is it making the person worse—if this is the case, you must report this to management ASAP?

How they act and react on your duty. It is important that every detail is recorded so the doctor, managers and nursing staff know if the overall goal has or is being achieved. That is, is it working or not working. Maybe they don't need it after all? Maybe it distresses them? Remember the management team value and needs your input and are reliant on what you observe, record and report. So it is really important to observe your client, record and report anything you see, hear, how they feel, any changes, how much they eat or drink, are their bowels and bladder moving normally, condition of their skin, how they respond and react to people. In fact anything you notice about the person.

#### **Slide 15**

You need to understand each type of restraint and what it entails. You are also obligated to attend training sessions. Know how to safely use Physical Restraints and also know what to do if you have to personally restrain a person. This is why training is very important. If you do not know what you are doing or can do, you not only put yourself and your job at risk you also put the person in your care and the facility at risk as well so if you are in doubt, then ask. A manager would much prefer you ask questions before a problem arises.

#### **Slide 16**

So what are the facility responsibilities? Well the Facility has a number of things that they must do on an ongoing basis to meet the Restraint Use Requirements as set down by CMS. We have already discussed the major areas from assessment through to implementation so the facility must make sure the process has been done appropriately. The facility is responsible to make sure the least restrictive device for the least amount of time is used, it is reviewed and reduction attempts tried at regular intervals at least quarterly.

#### **Slide 17**

The facility must have a Restraint policy and a restraint committee which meets regularly. Members on this team could be Director of Nursing or her designee, Charge Nurse, Nurse Aide, Physician, Therapist, Social Services, Activity Director, and the resident or responsible party. Frequency of the meeting will be determined by the Restraint Policy. It is usually 3 to 6 monthly depending on the policy. All these meetings must have minutes taken and recorded. All restraints are reviewed at this time.

#### **Slide 18**

They must also ensure that the Care Plans or Service Deliver plan or Lifestyle plans, which every you call them in your facility, reflects the care the person requires and that these are updated regularly or whenever there is a change in the persons conditions or circumstances so you can provide the best care for the person.

They must also make sure that staff receive training on restraint use and the regulations so that they do not inadvertently apply a restraint or violate the regulations. They must also know and understand what is required in reduction the restraint. If regulations are violated, it can have severe consequences for everyone as I mentioned earlier.

Make sure that all staff attend and receive training on Restraint Usage, Regulations and Reduction so that a restraint is never applied inappropriately.

### **Slide 19**

They must ensure that all restraints applied are authorized and the appropriate documentation is completed. So you can see that everyone in facility has obligations and responsibilities.

### **Slide 20**

Now let's talk about Restraint free facilities

Many facilities are now boasting that they are "restraint free". However these facilities must still assess all of the devices used by each resident. If the resident can remove the device when instructed, it is not a restraint. When the resident cannot remove the device, it is a restraint.

### **Slide 22**

Most of the "Restraint Free Facilities" have a policy in place that states they are Restraint Free. The trick to remaining restraint free is not always refusing to use the restraint, it is often declining admission or discharging a resident that must be restrained.

If these facilities truly have no restraints, they are not required to have the committee but they must have a policy. They must still do regular assessments on all devices to make sure they do not evolve into a restraint as the resident's condition changes.