

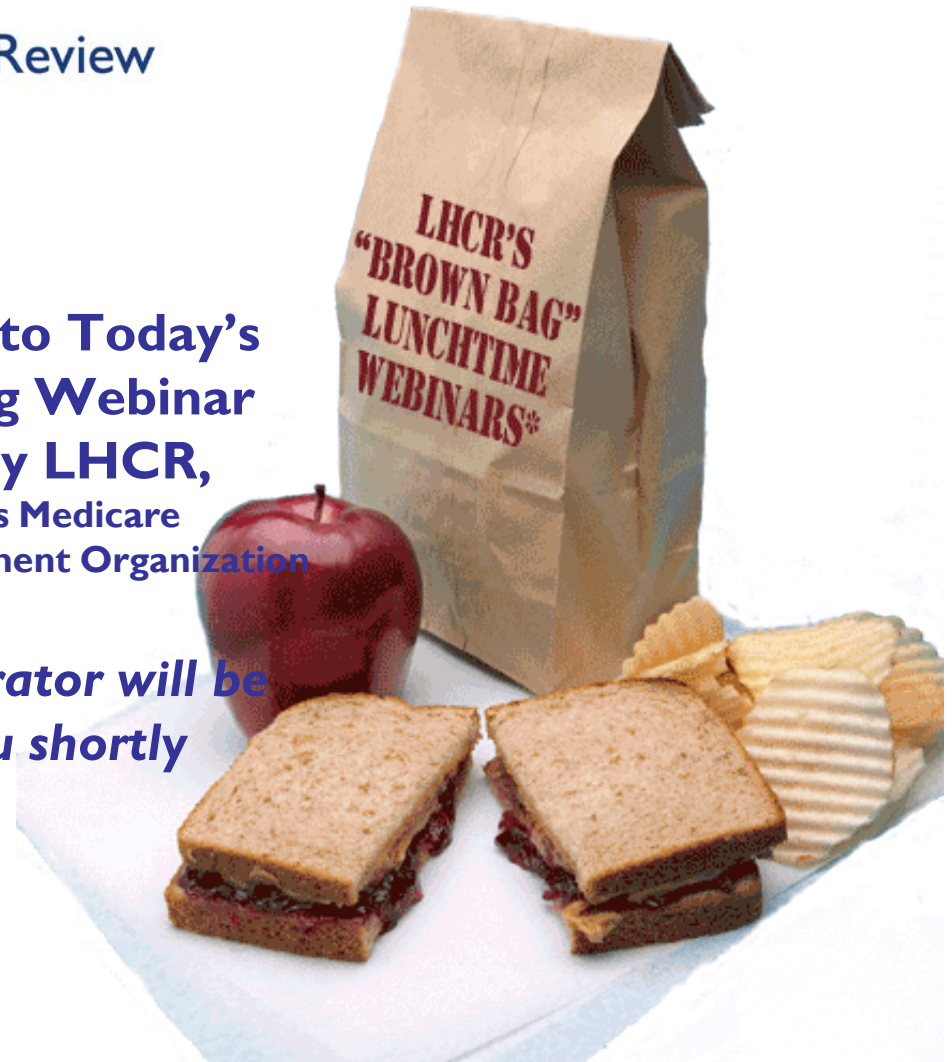


## Louisiana Health Care Review

The Medicare Quality Improvement Organization  
[www.lhcr.org](http://www.lhcr.org)

**Welcome to Today's  
Brown Bag Webinar  
hosted by LHCR,  
Louisiana's Medicare  
Quality Improvement Organization**

***Your moderator will be  
with you shortly***



This material was produced by Louisiana Health Care Review, Inc. (LHCR), the Medicare Quality Improvement Organization for Louisiana, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. LA9SoW2B108-N1868

# **REHABILITATE YOUR WAY OF THINKING: RESTRAINT REDUCTION**

**Melody Malone, PT  
Quality Improvement Specialist**

# Objectives

Participants will learn to...

- Describe what nursing home professionals can do to reduce restraint usage
- Identify alternatives to restraints
- Identify methods to overcome family barriers to restraint reduction

# What Exactly Is a Restraint?

# CMS Restraint Definition

“Any manual method, 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.”

# Types of Devices...

Remember, a restraint is defined based on its effect on the resident NOT what the device is called.



# MDS QI Crosswalk

<p><b>Prevalence of residents who were physically restrained</b> (11.1 on QM/QI Report)</p>	<p><b>Numerator:</b> Residents with daily physical restraints (P4c, P4d or P4e = 2)</p> <p><b>Denominator:</b> All residents with target assessment, except those with exclusions</p> <p><b>Exclusions:</b> Residents satisfying any of the following conditions:</p> <ol style="list-style-type: none"> <li>1. Admission assessment (AA/As = 01)</li> <li>2. QM not triggered and missing data on any restraints item (P4c, P4d, or P4e missing)</li> </ol>
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## SECTION P. SPECIAL TREATMENTS AND PROCEDURES

4. DEVICES AND RESTRAINTS	(Use the following codes for last 7 days)	
	0. Not used	
	1. Used less than daily	
	2. Used daily	
	Bed rails	
	a. — Full bed rails on all open sides of bed	
	b. — Other types of side rails used (e.g., half rail, one side)	
	c. — Trunk restraint	
	d. — Limb restraint	
	e. — Chair prevents rising	

# Siderails

- Not counted in the quality measure
- Counted on a nursing home's list of restraints for internal use
- Reportable to the surveyors at time of survey

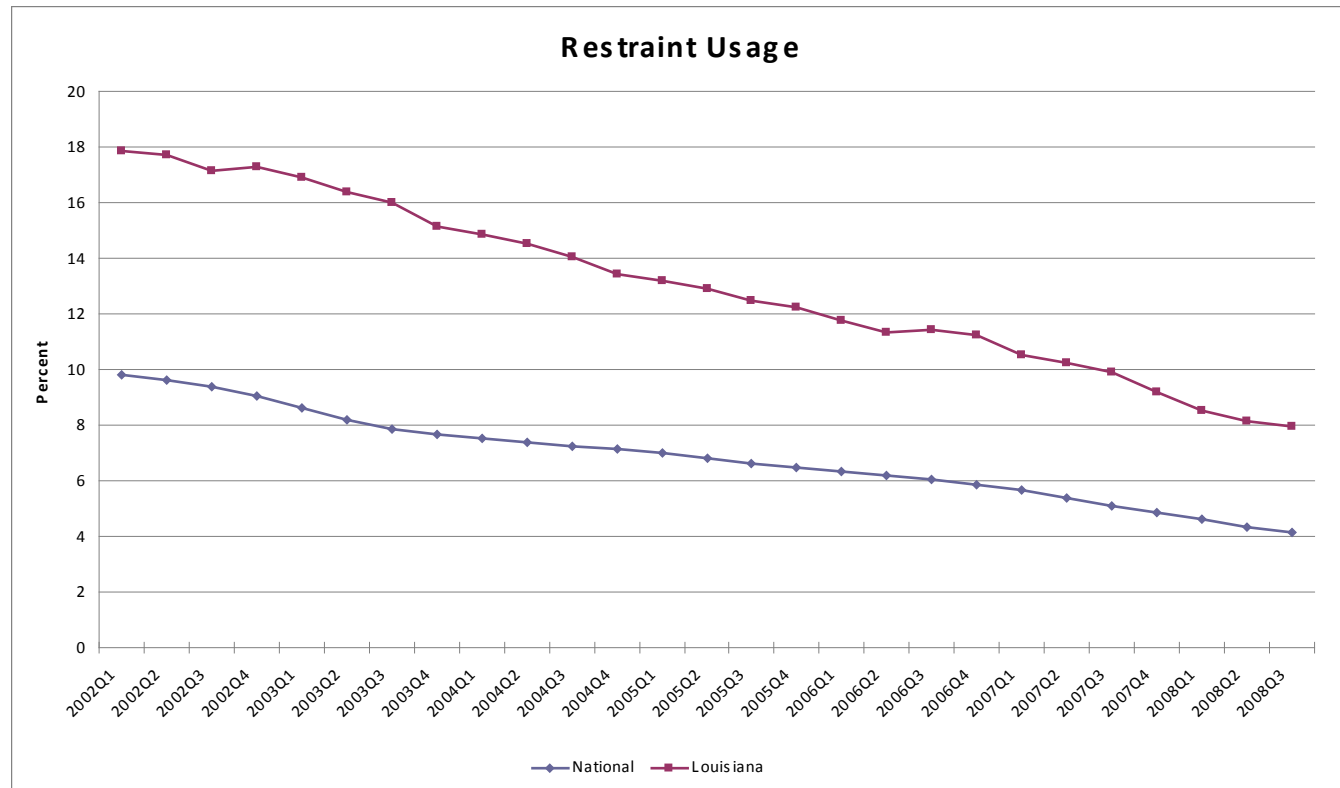
# Community of Practice

- The prevailing thinking in the community:
- What community?

# Community of Practice

- **PT** - Guide to PT Practice, APTA Position Statements & Ethics, Practice Act
- **OT** - The Guide to Occupational Therapy Practice, Code of Ethics, Practice Act
- **ST** - ASHA Desk Reference, Code of Ethics, Practice Act
- **Nursing** - Practice Act, Code of Ethics, Standards of Practice
- **LNFA** - Code of Ethics
- **Long Term Care** - Regulations ~ Feds and State, Ombudsman, AARP, etc.

# QI/QM Data –Louisiana



# Our Role in Restraints

## Our Role in Restraints:

- We are afraid to take the risk NOT to restrain
- We get the resident in a perfect seating system and fail to realize we just restrained them
- We lack creativity to utilize alternatives and fall back on the “tried and true” methods
- We weren’t trained any better!

# Our Knowledge

- Raise your hands if you were trained in school TO restrain – be honest!!
- Louisiana Universities

# Commonly Reported Reasons For Using Restraints

- Convenience
- Accident and incident avoidance
- Perceived good FOR the resident
- Litigation avoidance
- Lack of knowledge regarding alternatives

# Convenience

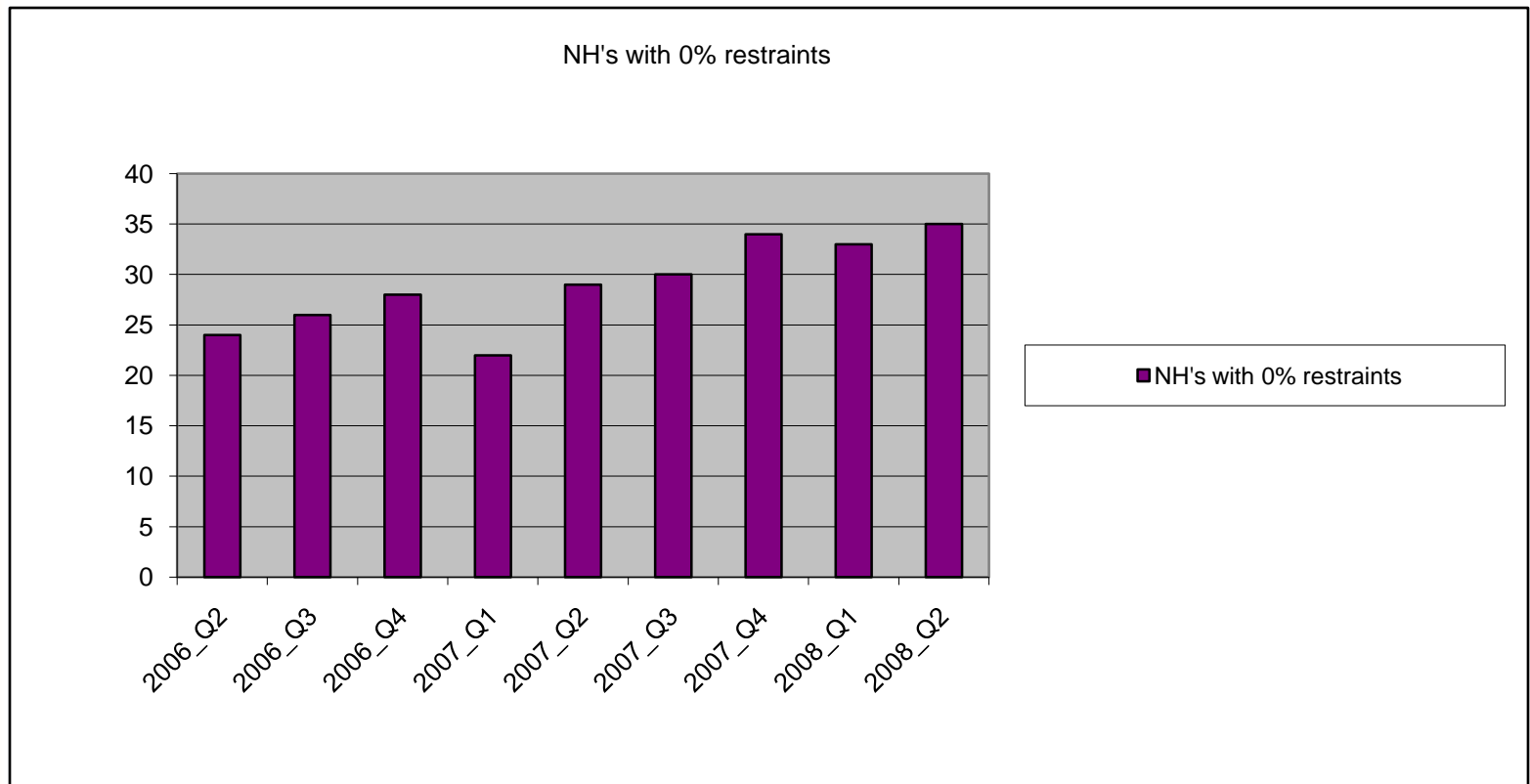
- Do the Math—Release and Reposition
  - 10 res. X 10 minutes X 6/day = 600 minutes = 10 man hours/day
  - 23,727 (8.4%=2,014) residents in the state = 2,014 FTEs/day

2008 Q1 QIES data

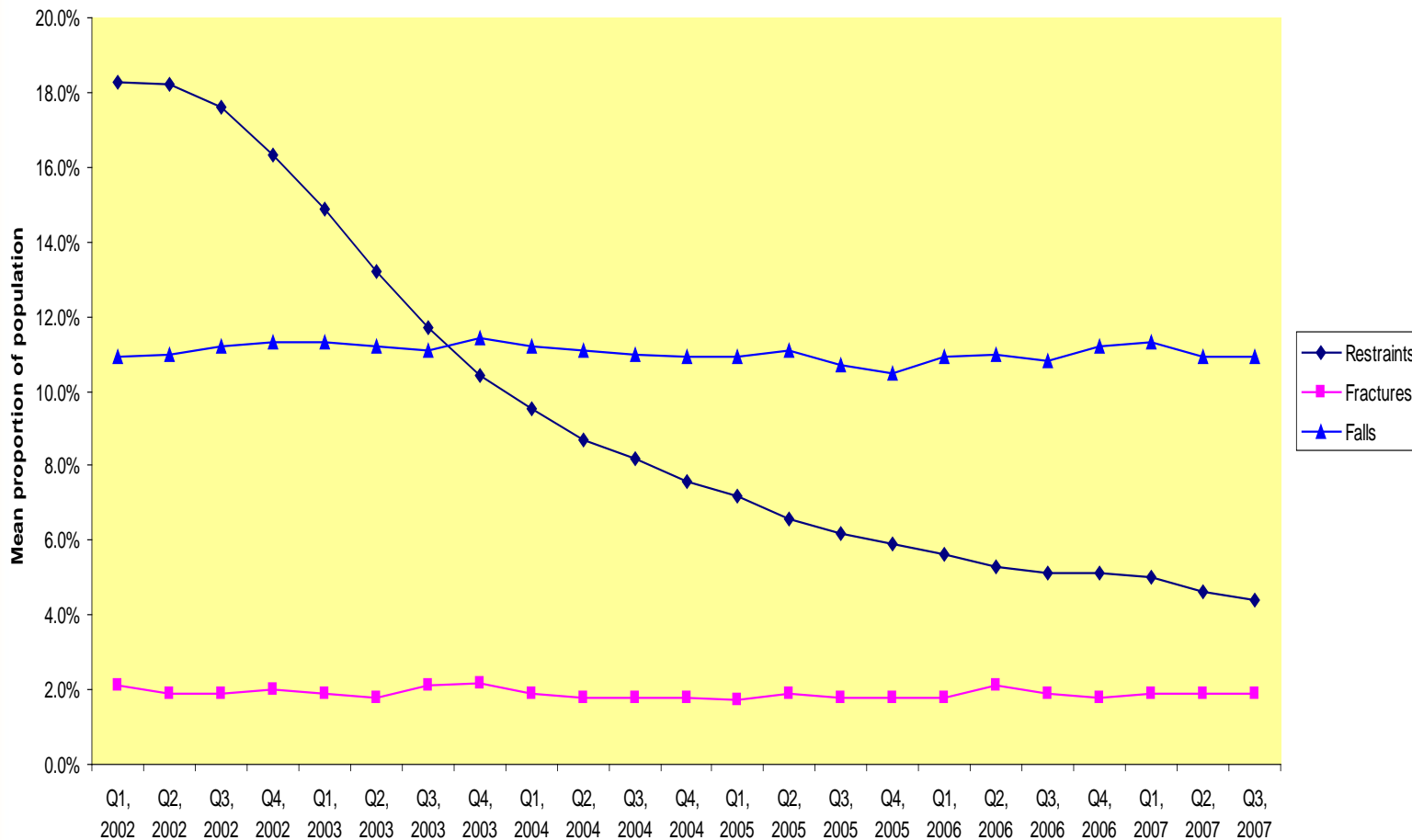
# **They Prevent Falls & Keep the Resident Safe?**

- Scientific research shows this is a false belief

# La NH's with 0% Restraints



Texas trends for restraints, fractures, and falls  
 Data source: MDS QI/QM Reports, Jan. 2002 - Sep. 2007



# LIFE IS A RISK!

- President Ronald Reagan
- What expectations do we set up in the resident and family's minds?
- F323 – Unavoidable accidents

# **“It’s good for the resident?”**

- How do you feel when you can’t do something you want to do?

# Perceived good?

- Depression
- Agitation
- Frustration
- Loss of dignity
- Loss of confidence
- Thoughts of suicide
- Increased boredom, loneliness, helplessness
- Feelings of being punished

## **LITIGATION**

**A review of the claims shows one case against a PT in just under 10 YEARS!<sup>7</sup>**

- Healthcare Providers Service Organization (HPSO), underwritten by CNA
- 40,000+ PT/PTA/SPT + 5,000 PT firms
  - open and closed claims
  - Snap shot of claims due to other mechanisms of coverage

# Consent

- Restraining a resident without consent could be considered false imprisonment
- Were substantial risks disclosed and alternative interventions considered?

# Family Request



Can the family demand we apply a restraint to their loved one?

# Family Request - NO

The facility has the responsibility to evaluate the appropriateness of that request, as they would a request for any type of medical treatment.

# What Are the Risks of Restraint Use?

- Death by:
  - Strangulation
  - Suffocation
  - Broken neck
- Pressure ulcer formation
- Pneumonia
- UTI
- Dehydration

## Restraint Use Risks *(continued)*

- Loss of muscle tone
- Decreased mobility—inability to stand, walk, turn...
- Reduced bone mass from lack of pressure on long bones
- Stiffness
- Incontinence
- Constipation/impaction

**“What are your beliefs  
regarding restraints?”**

# “How do I cope with fall and injury risks?”

- We do it one resident at a time
- There is no *one-size fits all* solution
- There are only resident-specific solutions

# “How do I cope?”

- Reducing restraints means trying multiple interventions
- No two residents are exactly alike regardless of the diagnosis or problem *label*
- Keep asking *Why, Why, Why?*

# Reduction When, How, Type....



- Assessment and recognition
- Diagnosis/cause identification
- Treatment and risk management
- Ongoing monitoring
- Reduction

# It Takes a Team....

To identify...

- The risks
- All the potential alternatives
- The results of all interventions that are attempted

# Alternatives

- Therapeutic
  - Therapist
  - Restorative
  - Bedside nursing staff
  - Facility-wide programming
- Environmental & equipment changes

***What would a prudent person do?***

# **Yes, But: “We already do that.”**

- Review why the restraint had been applied
- Did the resident have a trial of less restrictive intervention before applying restraints?

# Physical Needs to Address...

- Medication evaluations
- Massage
- Therapeutic touch
- Food and drink
- Aqua shoes
- Toileting schedules
- Warm baths
- Sensory/communication aides
- Proper fitting clothing
- Exercise programs

# Psychosocial Needs to Address...

- Play to the resident's strengths
- Provide for sense of security
- Wandering paths
- Offer choices
- Plants
- Staff dress – encourage independence
- Know resident's agenda
- Be calm/  
self-assured
- Pets and children
- Classes for frequent fallers
- Volunteers
- Same caregiver

# Activities to Try....

- Buddy system
- Restorative care
- TV, video, music, picture books
- Punching bags
- Arts & crafts
- Distraction based on their “work”
- Repeated activities
- Singing
- Restraint-free time while residents are supervised or visited is a good way to begin restraint reduction in the most difficult clinical situations

# Environmental Options...

- Non-wheeled chairs
- Wing back chairs
- Gliders
- Use of tables
- Couch for sleeping
- Hand bells
- Music
- Floor patterns
- Visual barriers, mural
- Non-skid surface in bathrooms
- Pad dangerous furniture corners
- Dining room chairs
- Easy chairs
- Proper fit chairs
- Bed placement

# Environmental Options...

- Recliner for sleeping
- Tap bells
- Lighting
- Motion detectors
- Grab bars
- Rest areas in halls
- Room identifiers

# The Road to Restraint Reduction in Our Homes

1. Support from administration & medical director
2. Multidisciplinary restraint review committee
3. Family support for restraint reduction
4. Identify barriers to restraint reduction
5. Educate – replace myths with facts

# Prepare to Succeed

- Long-term commitment is required  
(*6-12 months minimum*)
- Identify educational needs of family & staff
- Design an educational program for all staff on all shifts
- Shift the care planning emphasis from problem-centered to resident-centered problem-solving

# Key Components of Successful Restraint Reduction Programs

- Allocation of staff time for restraint reduction
- Restraint reduction in the easiest residents first
- Work on one wing/hall/neighborhood at a time
- Use multiple interventions to address the *resident's needs* rather than a care problem

# Process Changes We Must Make

- Change our thinking—active is better
- Life is a risk!
- Think of freedom—they are still Americans
- Assume (or act as if) the facility is a restraint-free environment
- Always include reduction in the treatment plan
- Be driven by the effect of the device
- Let your creativity run wild!

## IN CONCLUSION...

- ✓ Most staff have doubts and fears
- ✓ Knowledge of alternatives is minimal
- ✓ Perceived risks are not valid when knowledge and leadership take over

**“It’s Time...”**

# ...To Untie Our Elders!

*Restraint reduction  
in the nursing home*

# QUESTIONS?

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