

Person-directed care:
the road to restraint-free care
and quality of life

Joanne Rader, RN,MN,
PMNNP

Definition of a Restraint

- “ any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the individual cannot easily remove which restricts freedom of movement or normal access to one’s body”.

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CMS memo:S&C-07-22
June 22, 2007

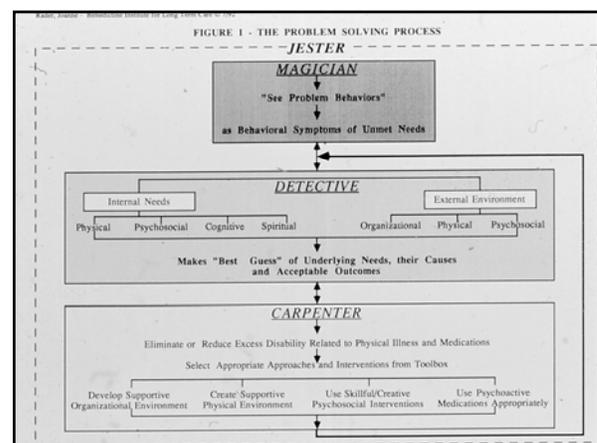
Freedom of movement –
any change in place or position for the body
or any part of the body that the person is
physically able to control

Easily removed –
Can be removed by the resident in the same
manner as it was applied by staff

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Modifying the environment to reduce restraints

Better :
Modifying the environment to
promote quality of life and mobility

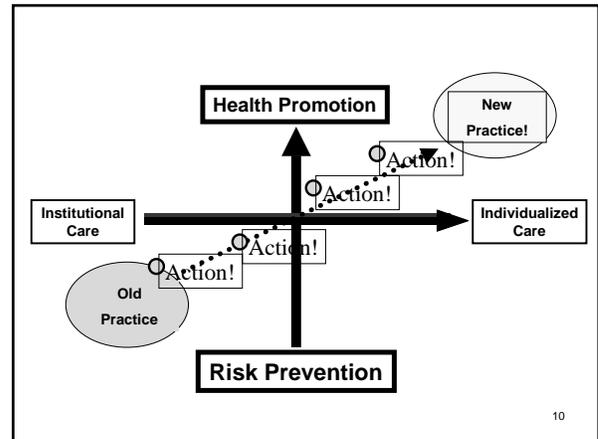
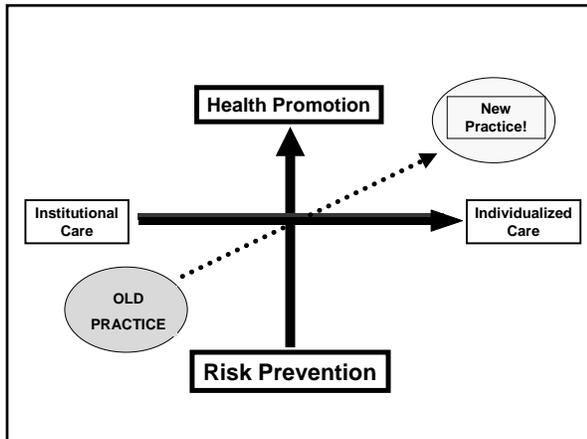
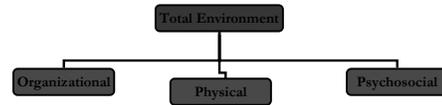


Four Roles of Problem Solving

- Magician – know the person, become the person, view the world through their eyes
- Detective – look at what is going on inside the person and outside (external environment)
- Carpenter – fix what now know is “broken” choose from a variety of interventions, including modifying the environment.
- Jester – go about the work with humor

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Environment as part of assessment and intervention

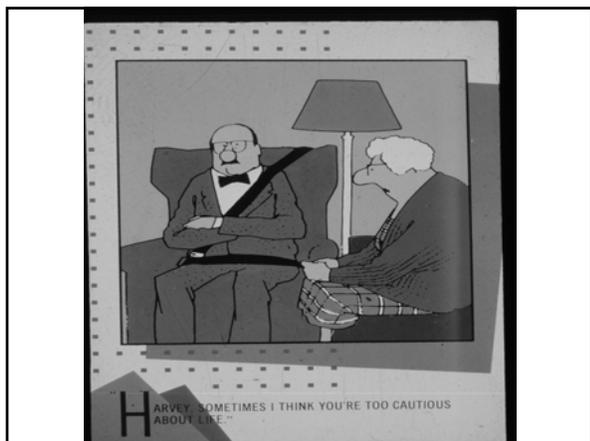


Organizational environment includes:

- Philosophy/ values
 - Resident directed care
 - Decision-making at bedside
- Systems that support relationships
 - Know the person – consistent assign
- Structure of the day
- Support and education

Organizational Environment

- Philosophy/culture



Who are we really protecting?



- What are we saving the hips for if we don't let them use them?

The goal of preventing all falls and injuries is not realistic

“The overall goal of fall prevention is to minimize fall risk by eliminating contributing factors while maintaining or improving the older person’s mobility and autonomy”

Rein Tideiksaar
“Falling in Old Age”

Realistic goals for people with history of falls:

- Minimize injury
- Decrease number of falls
- Honor wishes
- Reassess if average # of falls increases

Organizational Issues

- Staffing patterns
 - Old medical model- rotate staff, 7-3, 3-11 etc
 - Consistent assignments
 - Adjusting to needs
 - Uneven #,
 - Team/ buddy

Organizational Issues

- Equipment and supplies
- Support and education

What is needed for education and support:

- Consistent assignments
- Hands-on vs long lectures
- Keep it “real”
- Be sure they have needed resources
- Use skilled aides as teachers
 - Mentor
 - Aide training

Know the person

- Gentleman found frequently by staff in the halls, on his knees, holding onto the hand rail.
- Were considering putting him in a lap buddy
- Then they uncovered the reason behind the behavior

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Support for Consistent Assignment

- Results from 12 research studies:
 - Enhanced relationships
 - Improved staff attendance
 - Improved staff, resident, family satisfaction
 - Lower staff turnover
 - Improved accuracy, timeliness:
 - screening and assessments
 - Improved clinical outcomes
 - Improved quality of life

Allow for individualized care

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Consistent Assignment

The question is not **If** to switch to consistent assignment

The question is **How**

Process needs to build inclusion, rather than to be forced on people

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Suggested process

- C.N.A. shift meetings
- Care giving challenge scale – 1 to 5
 - Listen for variation of the individual rating
- C.N.A.'s select their assignment
- Sum total from scale - not the number of elders
- Re-visit frequently

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Information on Creating Consistent Assignment

- Contact your QIO person
- Go to Advancing Excellence Campaign
- www.nhqualitycampaign.org
 - Goal #8
- www.cmsinternetstreaming.com
- Check out www.PioneerNetwork.net
 - Resources
 - Household Matters Toolkit
 - Getting Started

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Importance of family education

- Prior to admission
- During stay
- At care conferences
- At the bedside

Brochures for families/consumers:
NCCNHR has new consumer guide
Stratis Health (HO)

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Physical Environment:

- Personalization
- Noise level
- Lighting
- Floor covering
- Furniture
- Seating and mobility devices
- Activity or stimulation level
- Spaces for privacy, socialization
- Safety and security

Physical Environment



personalized

Alerting device

- No proof decreases injuries
- Acts best as substitute call light
- If trying to remove not the best option
- If overused, staff ignore
- Best in acute situations?

Physical Environment

- Noise level
- Lighting
- Floor covering
- Furniture



Have/Use variety of chairs



Geri-chairs – Yuch!!



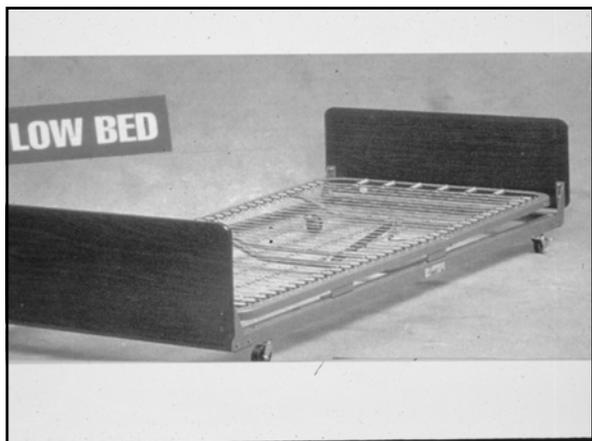
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Example of individualized fall prevention



Use of transfer pole



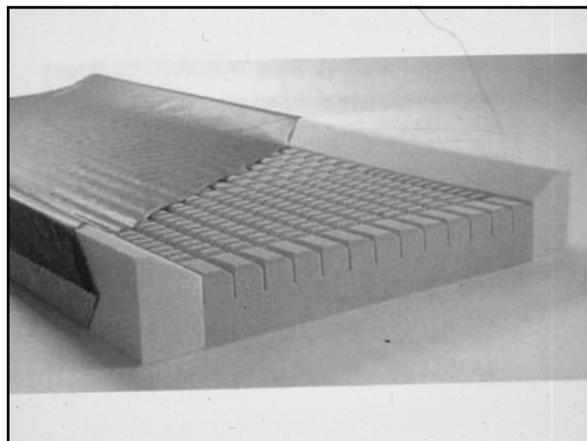


Use of Low Height Beds

- Reduced barrier and decreased height of fall may contribute to reduced injuries in high-risk group
- Low-height bed may be appropriate for frail, unsafely mobile older adults
- Might be defined as restraint but is still best intervention

Need for High-Low Beds

“Guess-timate” is need 5-10% of beds with this capacity



Flex our nursing muscle



Nurse/Admin Power

Insisted on new beds before take DON job where there were pressure sore problems

Risks of Physical Restraints

- **Physical**
 - Cardiac Overload
 - Bone Loss
 - Edema
 - Skin Trauma
 - Contractures
 - Pressure Ulcers
 - Malnutrition
 - ↑ Infections
- **Psychological**
 - Agitation
 - Aggression
 - Depression
 - ↑ Confusion
 - Social Isolation
 - Traumatic Memories

Risks of Physical Restraints cont.:

- Death
- Serious Injury

Miles SH, Irvine P, Miles & Parker (1998) caused by physical restraints. The American Family Gerontologist 1992, 32(6), 76 2-66.



Figure 1. Asphyxiated patient (scanned photograph).

Miles, JAGS, 1992

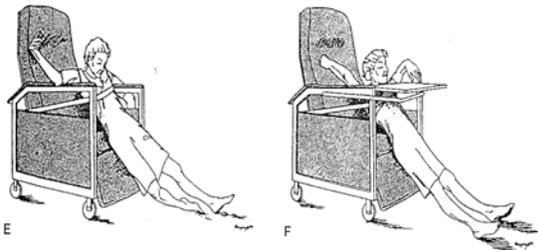


Figure 1. Postures in restraint-related deaths. Figures were done by Elizabeth Dempsey of Biomedical Graphic Communication at the University of Minnesota.

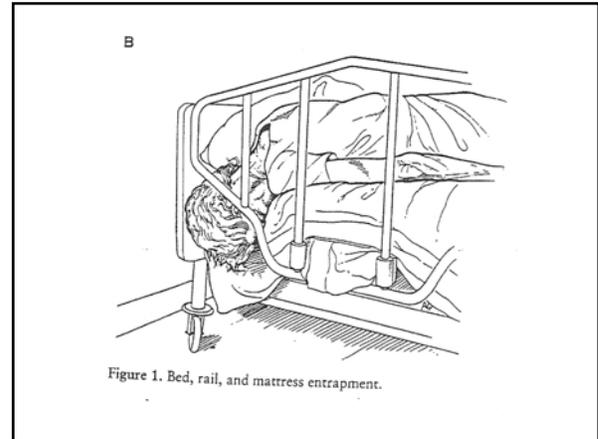
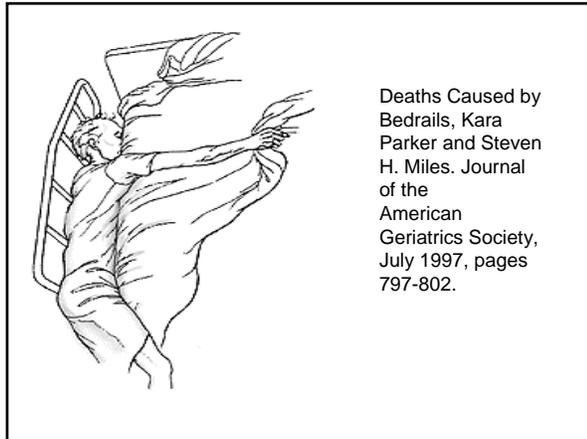
Proven Benefits of Physical Restraints:

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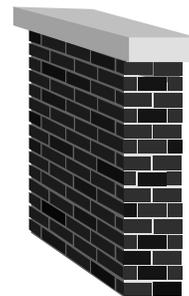
Siderails

- 1995 FDA Safety Alert
- Growing evidence of siderail-related entrapment injuries and deaths
- Risk for spread of infection with vancomycin-resistant enterococci, and nosocomial *Clostridium difficile*

Side rails as a hazard



Siderail = Barrier



- Perception of Cognitively Impaired Person

A Guide to Bed Safety



For copies:

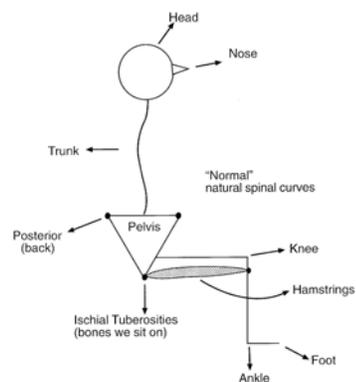
- www.fda.gov/cdrh/beds/
- For reporting:
- 1-800-FDA-1088

Physical Environment Seating and mobility devices



Lap “buddy”: is it really the person’s friend?

- Used to keep in uncomfortable chair?
- Used to hold up trunk and upper extremity weight?
- Keep them from doing what they want to do?
- Give them place to gently rest their arms?
- Usually it is a very bad “quick fix”
– Hard to move or cross legs- try it!



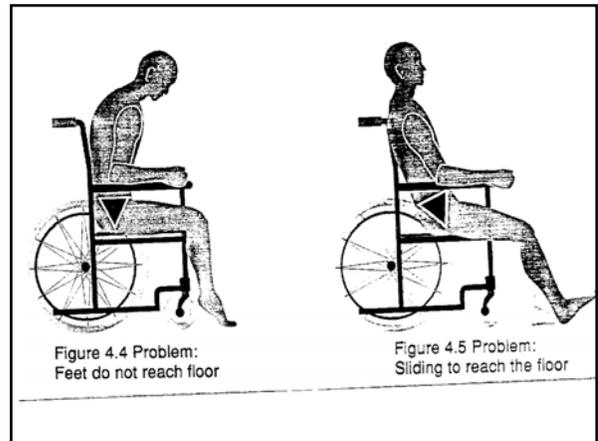
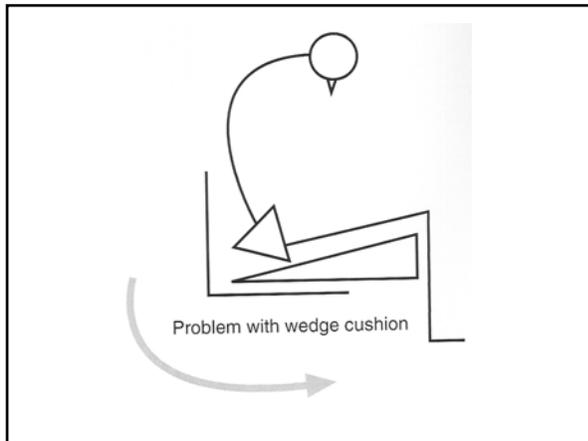
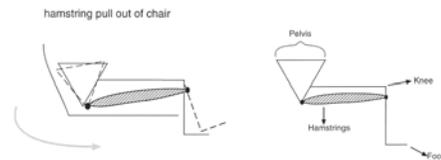
If person has tight hamstrings, quick fixes can make sliding out of chair worse and cause pain

Examples of quick fixes:

*** Elevating the footrest**

*** Using a wedge cushion**

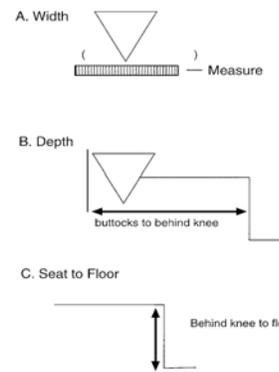
Tight hamstrings are common



Observations that should trigger seating assessment:

- Leaning or sliding in wheelchair/ chair
- Use of tie –on restraints
- Use of geri chair as restraint
- Crying and yelling
- Agitation and restlessness
- Seat belts over abdomen
- Use of tray tables, lap pillows
- Skin problems r/t pressure

Figure 14



Not All PTs and OTs have been trained to do good wheelchair seating

- The wheelchair vendors not allowed to touch/ move the person
- Need a thorough mat assessment to determine fixed contractures and needed adaptations
- QIOs have manuals and DVDs for NH staff and for PT and OT that they can share

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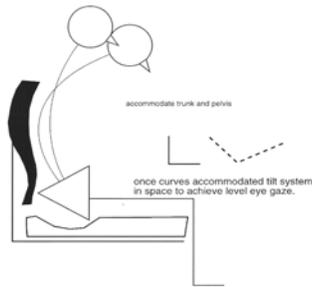
Individualized Wheelchair Seating: For Older Adults

- Part I – A Guide for Caregivers
- Part II – A Guide for Professionals
- Debbie Jones, PT
 - Joanne Rader, RN, MN
 - Lois Miller, RN, PHD1998

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Custom cushion with tilt in space chair to achieve level eye gaze

Figure 12B



The “Blob” in the Geri-chair: dependent in all ADLs



- Art in a customized wheelchair:
- Able to feed self, assist with transfers, brush teeth with cuing, move short distances in w/c by self, interactive and social



Getting Funding for wheelchairs

- Ask for PT assessment
- Do a mock up of equipment
- Take pictures, video, invite in family
- Be a broken record- be an advocate

Creative ways

- Ask families to donate used equipment
- Try organizations
- Make part of capital campaign
- Push for change in regulations (CMS) related to funding in nursing homes

Gerichair Use:

- To prevent rising
- To keep seated for meals
- To provide place of rest

Recliner/ Lazy Boy Use

- How many of you are a family member spends time in one?
- Good for a pacer who gets so fatigued but he/she can't stop
- If they relax into it, when they get their strength back may be able to get self out
- Not a restraint
- or may need assistance – than may be defined as a restraint but a useful one

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Alarm Use:

- To prevent rising?
- As substitute call light?
- Temporarily?
- Long term?
- Benefit and burden

Seat belt use:

- Purpose
 - Prevent rising?
 - Prevent falling out?
- Position
- Stabilize pelvis



Fig 2. Effective seat belt placement for older adults.



Fig 3. Poor seat belt placement for older adults.

Sometimes restraint free care is not “pretty”



Bed height and slippers



Body pillow



Mrs. Jones :

- Mrs Jones, a 89 yo with Parkinson's disease and some dementia, values her independence and freedom to move about even though she sometimes uses a wheelchair and is prone to falls. She detests the chair alarms and hides them. Currently she is falling 2-4 times a month, mostly when she tries to transfer herself back to bed from her sling back, sling seat wheelchair, in the evenings.

- Most falls are non-injury falls. She has had some bruising and skin tears.
- She sometimes has used as Merry Walker, but has tried to climb out of it and runs into people so the staff d/ced its use

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Realistic goals for Mrs. Jones :

- Support her freedom, mobility and choice
- Reduce evening falls in half to 1-2 per month
- Reduce skin tears and bruising r/t falls
- Reduce or prevent injury falls

Example of documentation:

- "I value my independence and freedom to stand and walk about even though I fall . I don't like the chair alarms and take them off and hide them. I like using the Merry Walker at times. I want to go back to bed right after dinner and I will put myself back if you don't."
- Currently she is falling 2-4 times a month, mostly when she tries to transfer herself back to bed from her wheelchair after supper. Most falls are non-injury falls. She has had some bruising and skin tears.

Example of documentation:

• Assessment:

Because of her wish to be independent and mobile, we expect she may continue to have some non injury falls 1-2 times a month but the benefits of her freedom to move outweighs the burden of further restriction. Since most of falls are related to putting herself back to bed after supper, we have addressed that in our plan .We have shared her safety and mobility plan with her family and protective services.

Mrs. Jones :

Plan is:

- Monitor all falls for time, place, behaviors and degree of injury to determine patterns
- Have CNA offer to help her back to bed after dinner as soon as she finishes eating
- Remove chair alarm
- Keep her elbows and forearms covered with stockinette or clothes to minimize skin tears

Mrs. Jones care plan cont.

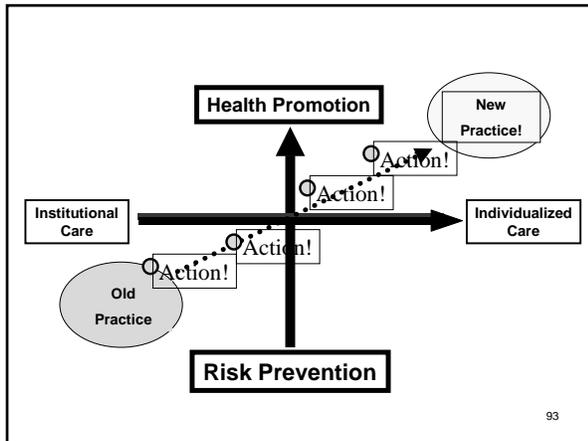
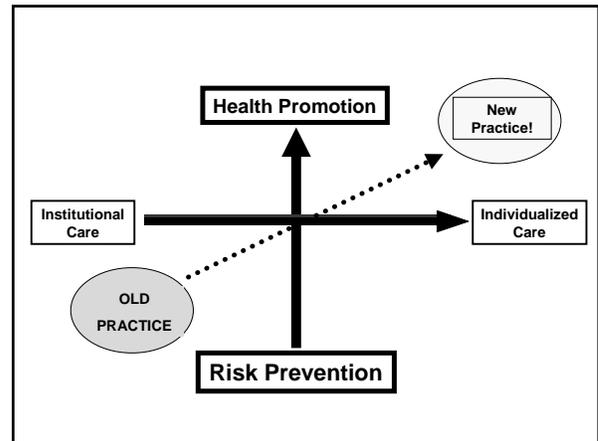
- Have PT assess advisability of wheelchair use and purchase of more comfortable wheelchair if appropriate
- Have Pt assess modifying use of Merry Walker
- Have PT assess for proper bed height, shoes, use of transfer pole and placement of bed and furniture in her room
- Discuss realistic expectations with family
- Be sure that care plan and actions match

Mrs. Jones plan cont.:

- Encourage to attend exercise group and walk to meals with assistance (unless too tiring)
- Discuss tx of osteoporosis with Dr
- Consider hip protectors
- Continue restorative care
- If increase in # of falls or severity of injury, reassess
- Contact Protective services, surveyors, ombudsman and family proactively

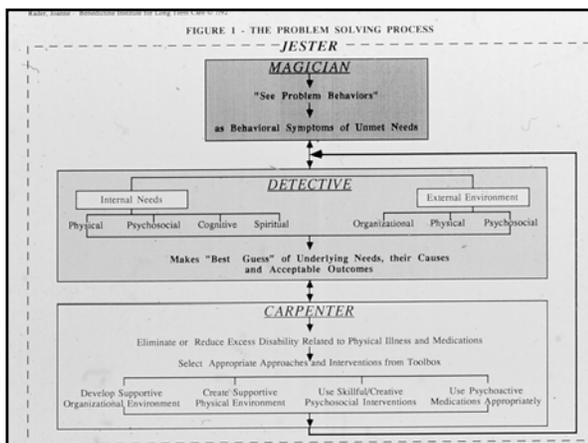
It is about:

- knowing the person
- finding the root cause of behavior
- honoring the person's wishes while developing safety plan
- modifying risk factors (internal and external)
 - Ex osteoporosis – exercise, meds, hip protectors
 - External – organizational policies



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Putting it all together



Some solutions need to be facility wide interventions

Falls after dinner
Falls at elevator

We need to be creative and be willing to take calculated risks

What I see and hear r/t falls and restraint use:

- RCM's going down routine list of possible interventions and paper compliance
- little deep investigation of root cause of fall and residents wishes
- omitting the CNA's input
 - Ex- put siderail down
- omitting resident choice
- safety at all costs



Surveyors:

- Need to know people will fall and get injured
- Need to not expect unlimited interventions for continued falls
- Leads to doing "dumb stuff"
 - Triple alarms

Get involved in your state coalition for culture change

- Find ways to get surveyors involved in the learning and growing process
- Oregon's teams using the Civil Monies Penalty (CMP) funds
- Identify common concerns and brainstorm how to address them

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I choose to err on side of resident choice and mobility

- do your assessments
- involve those you are most afraid of
- document, document
- follow your own plan

