California Ombudsman Bi-Annual Training Conference, Spring 2007

FACTS AND STRATEGIES: RESTRAINT FREE CARE IS THE STANDARD

Developed by Sarah Greene Burger, Consultant

NCCNHR: The National Consumer Voice for Quality Long-Term Care

Supported by a grant from the California HealthCare Foundation based in Oakland, California

What is a restraint?

- Usual Types – advertisers lingo
- Unusual types
- Common elements and conditions
- Bedrails
- Can thinking about restraints change over time?
  - Alarms
  - Wheelchairs
  - Locked units

Physical Environment

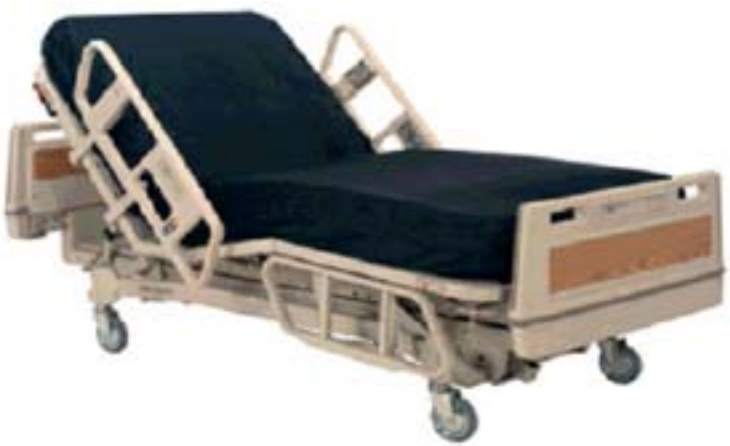
Seating and mobility devices

*Slide material designed by Joanne Rader, RN, MSN, and shared with Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health and Human Services. Contents do not necessarily represent CMS policy. 8SOW-RI-NHQIOSC

What is a restraint?

- Usual Types – advertisers lingo
- Unusual types
- Common elements and conditions
- Bedrails
- Can thinking about restraints change over time?
  - Alarms
  - Wheelchairs
  - Locked units

Bed Rails



*Slide material designed by Joanne Rader, RN, MSN, and shared with Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health and Human Services. Contents do not necessarily represent CMS policy. 8SOW-RI-NHQIOSC

What is a restraint?

- Usual Types – advertisers lingo
- Unusual types
- Common elements and conditions
- Bedrails
- Can thinking about restraints change over time?
  - Alarms
  - Wheelchairs
  - Locked units

Summary slide

- “Any manual method or physical or mechanical device, material, or equipment attached to 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.”

  Guidance to Surveyors 42CFR483.13(a) F221

Who is restrained?

- Most common
- Unusual situations

Summary slide

- Little old frail ladies who can’t walk safely
- Distressed Men who appear to threaten others
- People living with dementia
- Residents who need emergency assessment or treatment

Why are restraints progressively dangerous for residents?

- Let’s hear from our restrainees
  - Skin
  - Brain and emotions
  - Gastro-intestinal
  - Cardiovascular
  - Respiratory
  - Urinary
  - Excretory
  - Nervous
  - Musculoskeletal system

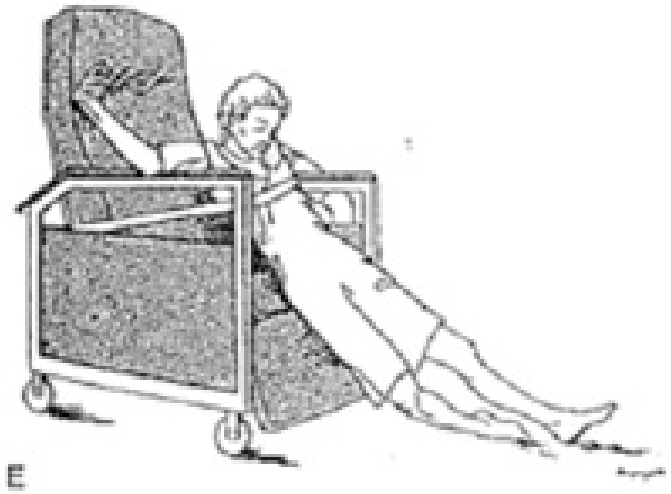
Summary Slide

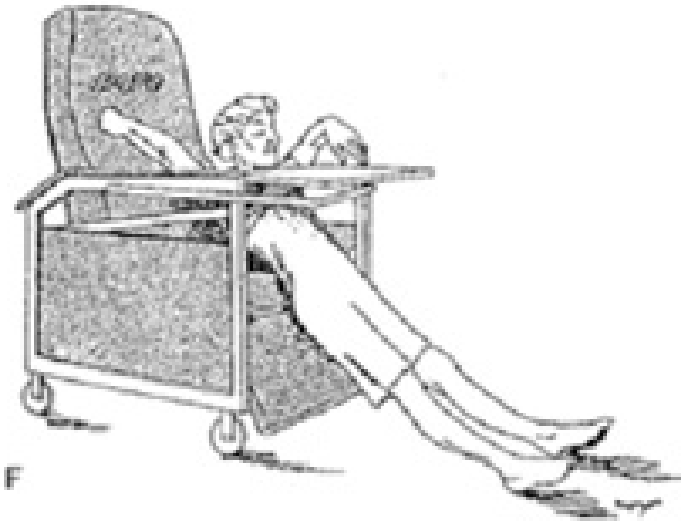
- Bruising, cuts, redness, pressure sores
- Panic, anxious, combative, increased confusion or Lethargy, depression, yelling, calling out
- Decrease in appetite/weight loss, dehydration, fever

Summary Slide continued

- Swelling of an ankle or lower legs, tight shoes, death
- Tightness in chest, pneumonia, delirium, bedrail death
- Incontinence, catheter, Urinary tract infections, Constipation
- Tension
- Muscle and bone wasting, contractures over time

Miles, JAGS, 1992





*Slide material designed by Joanne Rader, RN, MSN, and shared with Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health and Human Services. Contents do not necessarily represent CMS policy. 8SOW-RI-NHQIOSC

Figure 1. Asphyxiated patient (scanned photograph).

*Slide material designed by Joanne Rader, RN, MSN, and shared with Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health and Human Services. Contents do not necessarily represent CMS policy. 8SOW-RI-NHQIOSC

*Slide material designed by Joanne Rader, RN, MSN, and shared with Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health and Human Services. Contents do not necessarily represent CMS policy. 8SOW-RI-NHQIOSC

*Slide material designed by Joanne Rader, RN, MSN, and shared with Quality Partners of Rhode Island, the Medicare Quality Improvement Organization for Rhode Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the US Department of Health and Human Services. Contents do not necessarily represent CMS policy. 8SOW-RI-NHQIOSC

Federal Law:

Sec 1819 42 U.S.C> 1395i-3 ©Residents' Rights:

FREEDOM FROM RESTRAINTS—The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical and chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

Federal Law continued

Restraints may only be imposed—

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances as specified by the Secretary until such an order could reasonably be obtained.)

Federal Law continued

(b) provision of services

(1) Quality of life

(2) A skilled nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

Federal Law continued

(b) provision of services

(2) A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care.

Do you think this statement is true?

The Federal quality of life and care requirements are incompatible with Physical Restraints.

Federal Regulations
Part 483 Subpart B

Sec 483.13 Resident behavior and facility practices

Restraints: The resident has the right to be free from any physical or chemical restraints imposed for purposes of *discipline or convenience*, and not required to treat the resident's medical symptoms.

Guidance to Surveyors
42CFR483.13(a) F221

- **Medical Symptoms** is an indication or characteristic of a physical or psychological condition (elements: identify the medical symptom; subjective symptoms cannot be whole reason for a restraint; restraints mask underlying symptoms, MD order not a sole reason.)

Guidance to Surveyors

42CFR483.13(a) F22

- **Discipline** is defined as any action taken by the facility for the purpose of punishing or penalizing residents.

- **Convenience** is defined as any action taken by the facility to control resident behavior or maintain residents with a lesser amount of effort by the facility and not in the residents' best interest. Restraints may not be used for staff convenience.

Federal Regulations

Subpart B

42CFR483.25(h) Quality of Care, Accidents

- The facility must ensure that the resident environment remains as free of accident hazards as is possible and each resident receive adequate supervision and assistive devices to prevent accidents

Federal Law

- **Accepting or refusing restraints.** The resident's right to participate in care planning and the right to refuse treatment are addressed in 483.20 and 483.10 respectively. These rights include the right to accept or refuse restraints.

Federal Regulations

Sec. 483.25 Quality of Care expand the law's requirement that a facility provides services to achieve the "highest practicable well-being." A resident's condition, including activities of daily living; pressure sores; incontinence; range of motion; and psychosocial functioning, must "not diminish unless circumstances of the individual's clinical condition demonstrate that diminution is unavoidable."

California Regulations accept/refuse Restraints

22 CCR s 72528 Informed Consent Requirements

(1) reason for treatment/nature of illness

(2) nature of treatment procedures: length/duration

(3) probable degree/duration of improvement (or not) with/without RX

(4) nature, degree, duration, probability of side effects/significant risks

(5) reasonable alternative RX and risks and why this is best

(6) patient has a right to accept or refuse the proposed RX, and consent can be revoked.

California Regulation accept/refuse restraints continued

- Before initiating physical restraints or the prolonged use a device that may lead to the inability to regain use of a normal bodily function, facility staff shall verify that the patient's health record contains documentation that the patient has given informed consent to the proposed treatment or procedure. (emergency exception)

Disclosure of treatment risks may be withheld if:

(1)Patient or his representative waives the requirement

(2)A physician relied on documented objective facts that would demonstrate that the knowledge would seriously upset the patient so he would not consent to the treatment

Dr. Steven Miles Consent form for Restraint Use

Given current research about the restraints in long term care facilities, a scientifically supportable consent form would read as follows:

Dr. Steven Miles Consent form for Restraint Use, continued

…I understand that restraints often cause people to feel angry, afraid, demoralized, and humiliated. Both my appearance as a restrained person and the regressed or aggressive behavior that may be caused by the restraint pose a risk that others will see me as the kind of impersonal being that needs to be tied. If this occurs and with a decreased ability to humanly present myself or to assert my needs, restraints may decrease the likelihood that my physical, emotional, and social needs will be met.

With these understandings, I consent to be restrained as recommended.

Date Signature

Scenario

Mrs. Torselli is living with dementia and arthritis, generally has an agreeable disposition, and spends her days in a culture change home helping to wrap the silver in napkins for the next meal. She walks unsteadily, sleeps in a low bed with floor pads around it. The consistent staff know her needs and preferences and are able to meet them proactively. She never has to ring the call bell for toileting, water, snacks etc., because her team knows her routine so well. Recently she has been ringing the call bell at night and then hitting the nurse aide who answers it with the call bell cord. One nurse aide was injured. Mrs. Torselli's family is involved regularly with her care team. What is the process an ombudsman would expect the interdisciplinary care team to follow to avoid handmits on her at night?

Recognition of the symptom and Assessment

Symptom =

Scenario

Mrs. Torselli is living with dementia and arthritis, generally has an agreeable disposition, and spends her days in a culture change home helping to wrap the silver in napkins for the next meal. She walks unsteadily, sleeps in a low bed with floor pads around it. The consistent staff know her needs and preferences and are able to meet them proactively. She never has to ring the call bell for toileting, water, snacks etc., because her team knows her routine so well. Recently she has been ringing the call bell at night and then hitting the nurse aide who answers it with the call bell cord. One nurse aide was injured. Mrs. Torselli's family is involved regularly with her care team. What is the process an ombudsman would expect the interdisciplinary care team to follow to avoid handmits on her at night?

Diagnosis and identify the root cause – which do you think is the most likely root cause?

- Rule out physical causes
- Rule out environmental causes
- Rule out personnel cause
- Rule out lifelong habits / psychosocial

Individualized Care Planning

Would an “I Care” plan be useful here?

Implementation of the care plan

- Where would you find this information?

Monitoring Care Plan

This completes the process unless the symptom reappears.

Summary

- Recognition of the symptom and Assessment

  Symptom= change in behavior
- Diagnosis and identify the root cause
  - Rule out:
    - Physical causes: e.g. new medication, pain, infection, unmet need
    - Environmental causes e.g. a short in the call bell, noise
    - Personnel cause such as a new CNAs, abuse
    - Lifelong habits especially involving family. Explore home situation and routine and how it differs from her present home. Family lay on her bed at home and realized that a porch light always on at home and the call light represented that to this woman.

- Individualized Care Planning
  - I like to have my porch light on at night
- Implementation of the Care Plan
  - Installed a porch light in her room at night – extra batteries available
- Monitoring:
  - Call bell ringing stopped

- What would have happened in a non-culture change facility?
- What questions would ombudsmen ask to assure every detail is found?

EVERYONE WINS

- If not restraints, then what do we do?

Good Care Practices to Preclude Restraints

- Individual/Environmental/Organizational
- Promote resident function
- Maximize likelihood of resident needing to get up unaided
- Individualized seating/ Different sized chairs
- Well lighted safe facility
- Home environment/Culture Change
- Decrease the risk in wandering
- Accept that restless, anxious residents need to walk
- Re-evaluate life support measures

INIDIVIDUAL AND FACILITY ADVOCACY

A. Mrs. Betts

B. Mr. Gonzales

C. Mr. Chin Ling