Restraint Free Care in California

A Training Guide to Equip Long-Term Care Ombudsman Representatives and Consumers to Understand and Promote Restraint Free Care in California Nursing Homes

Developed by Sara S. Hunt

Produced by
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November 2007

ACKNOWLEDGMENTS

Many thanks to the Advisory Committee for their suggestions and support in developing this training program and these materials. The Advisory Committee members are: *Victoria Behbahani*, Aging Program Analyst II, *Jana Matal*, Manager, and *Joseph Rodrigues*, State Long-Term Care Ombudsman, California Department of Aging, Office of the Long-Term Care Ombudsman, Sacramento; *Molly Davies*, Program Director, WISE Senior Services, Long-Term Care Ombudsman Program (LTCOP), Santa Monica; *Tippy Irwin*, Coordinator, Ombudsman Services of San Mateo County, LTCOP; *Benson Nadell*, Program Coordinator, San Francisco Long-Term Care Ombudsman, Family Service Agency of San Francisco, Coordinator, California Local Long-Term Care Ombudsman Association (CLTCOA); *Rochelle Woolery*, Ombudsman Program Coordinator, Council on Aging, Orange County; *Joann Kidd*, Family Member, Volunteer Ombudsman Representative; *Beryl Goldman*, Kendal Corporation, Pennsylvania; *Charlene Harrington*, Professor and Associate Director, University of California San Francisco/John A. Hartford Center of Geriatric Nursing Excellence; *Mary Larson*, Healthcare Consultant II, Interim Senior Project Manager, LUMETRA; *Joanne Rader*, Associate Professor, Oregon Health Science University; *Joyce Sakkinen*, Health Facilities Evaluator Nurse, Specialty Trainer, California Department of Public Health, Licensing and Certification.

ABOUT THE AUTHORS

Sara Hunt, MSSW, is a consultant for the National Long-Term Care Ombudsman Resource Center. This guide reflects the training agenda and materials developed by Sarah Greene Burger, RN-C, MPH, FAAN, the coordinator of the Coalition of Geriatric Nursing Organizations, and former Executive Director of NCCNHR, Alice Hedt, MUA, Executive Director of NCCNHR, and Jessica Brill, MPA, MA, the Project Coordinator at NCCNHR and coordinator of this California project.

ABOUT THE TRAINING GUIDE

The development of this training guide was supported by a grant from the California HealthCare Foundation, based in Oakland, California.

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TRAINING GUIDE

Introduction

Ombudsmen are uniquely positioned to improve the quality of life of residents by advocating in their day to day work for reducing restraints. This is particularly true in California where restraint usage is among the highest in the country.

This guide provides the essential information and resources for the training of ombudsman representatives who can ultimately improve the daily lives of residents by identifying restraints, advocating for the elimination of restraints, and empowering consumers to seek, and expect, restraint free care. Use this training guide to improve ombudsman representatives' knowledge, skills, and commitment in advocating for restraint free care. Be instrumental in changing practices in your state!

There is national momentum to eliminate or reduce restraints. Currently the Centers for Medicare and Medicaid Services and the Advancing Excellence Campaign are providing national visibility and resources for reducing restraint usage. These efforts provide a unique opportunity for synergy to boost your advocacy.

This training guide is based on a California Long-Term Care Ombudsman Training Conference session conducted on June 13, 2007, in Sacramento. The material was developed and presented by Alice Hedt, NCCNHR Executive Director, Sarah Greene Burger, Consultant, and Jessica Brill, NCCNHR Project Coordinator.

Purpose

This training guide is intended to assist California Long-Term Care Ombudsman Coordinators (LTCO) in teaching ombudsman representatives about achieving restraint free care. This guide may also be adapted to use in teaching consumers and others about restraint free care.

Learning Objectives

At the conclusion of all four content segments participants will know:

- What restraints are,
- How restraints impact residents,
- Good care practices that preclude restraints,
- Applicable law and regulations,
- How to apply this content in individual advocacy and in talking with consumers and caregivers,
- Resources and support through the Advancing Excellence Campaign and other sources.

Options for Teaching

The content in this guide was presented in a day long session. Recognizing that many LTCO must present training in shorter sessions, this guide contains sections of content that may be used as stand alone presentations or combined in a way that best fits your available time frame and purpose. The Content Overview on the following page contains a brief description of the four content segments and time frames for teaching.

A range of teaching times are given for each segment. Time frames for teaching vary according to:

- the amount of discussion you include,
- the number of examples from your program or area you use, and
- how knowledgeable participants are about restraints, the Advancing Excellence Campaign, and resources.

Tips:

- Select the content and handouts according to the needs of the participants. Although each topic has a list of suggested handouts, you may decide to use different ones based on your training objectives.
- If you are teaching ombudsman representatives whose training included the 2007 California LTCOP curriculum module, "The Aging Process" or "Residents' Rights," or another session on restraints, identify the sections and teaching tools in this guide that will increase or reinforce their knowledge and skills.
- Remember that there are even more resource materials on the NCCNHR website section, California Voices for Quality: http://www.nccnhr.org/public/245_1266_13817.cfm as well as on other sections of the NCCNHR website.
- For even more fun with a group of knowledgeable LTCO, introduce the content and resources in this guide and ask them how they might use this information in talking with family members or with resident or family councils. ☺

Content Overview

You will need to add some additional time for introductions and breaks.

TOPIC	DESCRIPTION	TIME TO TEACH
Restraints	What are restraints? Who is restrained and why? Why are restraints dangerous? What does the law say? What is it like to be restrained?	1 – 1.5 hours
Good Care Practices Preclude Restraints	Knowing each person; Promoting functioning; "Everyone Wins" video and discussion; Alternatives to restraints, Good Care Practices Preclude Restraints.	1 – 1.5 hours
Apply Your Knowledge to	Small group dialogue and problem-solving	0.75 – 1.5 hours

TOPIC	DESCRIPTION	TIME TO TEACH
Assist Residents	regarding specific examples to apply resident directed care principles and to identify the role of the LTCO.	
Strategies to Decrease Restraint Use in California	Discussing ways that this LTCO Program can address the use of restraints and consumer education. Introduce tools and resources for advocacy and consumer information. Connect the restraint reduction effort with national emphasis and resources through the Advancing Excellence Campaign. Discuss goals, consumer and provider participation; tools and resources available online.	0.75 – 1.5 hours

RESTRAINTS

Teaching Points

- What is a restraint?
  - Facts and Strategies, PowerPoint (PPT) slides 1 – 7
- Who is restrained and why?
  - PPT slides 8 - 9
- Why are restraints dangerous?
  - If you use the Experience Restraints Exercise, ask the individuals who are restrained to share their reactions and observations. Option: If you reach this point less than one hour after the restraints were applied, skip this question. Ask it after you discuss the Informed Consent for Restraints developed by Dr. Miles.
  - If individuals were not restrained during this session, ask participants, "During your visits to facilities, what do you hear residents saying? What have you observed when individuals are restrained?"
  - Demonstrate on yourself or someone else, the areas of the body where pressure sores are most likely to occur. (heels, buttocks, elbows) Relate this to restraints and body areas where pressure is experienced as a result of the restraint.
  - Review and discuss the effects of restraints, including the impact on functioning. Refer to the PowerPoint slide notes for additional speaking points, PPT slides 10 – 16.
- What do staff have to do to make up for the lack of independence due to restraints? How much time do these tasks take? Capture responses on flip chart page divided into two columns: staff actions, time estimates.
- How do the laws and regulations relate to using restraints?
  - PPT slides 17 – 30
  - The Informed Consent for Restraints developed by Dr. Miles includes information pertinent to making a truly informed decision. This consent form is also useful for educating families, staff, and some residents about the risks of using physical restraints.
  - PPT slides 31 - 32.

Application Exercise

Use as time permits and as applicable to increase the audience's knowledge.

Experiencing Restraints Exercise

Add an extra fifteen to thirty minutes to the overall session time in order to conduct this exercise. The debriefing time, sharing of experiences and observations, is critical to making this a learning experience. If sufficient time cannot be added, skip this exercise.

Complete instructions for this exercise are included on page 18 in this guide.

PowerPoint Presentation

Facts and Strategies: Restraint Free Care is the Standard (includes speaker notes)
Available at: http://www.nccnhr.org/uploads/FactsandStrategiesPresentation.ppt.
(*Important: Save the PowerPoint file to your workspace BEFORE you open it, allowing you to view it in the PowerPoint program, and see the speaker notes.*)

Handouts

Print and copy handouts with blanks for notes of the PowerPoint presentation slides you will use.
Available at: http://www.nccnhr.org/uploads/FactsandStrategiesPresentation.ppt.
(*Important: Save the PowerPoint file to your workspace BEFORE you open it, allowing you to view it in the PowerPoint program, and see the speaker notes.*)
Informed Consent for Restraints, developed by Dr. Miles.
Available at:
http://www.nccnhr.org/uploads/MilesrestraintconsentediedBYSteveMiles0903.pdf.
Physical Restraints: Decision Tree
Available at: http://www.nccnhr.org/uploads/T2PhysicalRestraintsDecisionTree.pdf.
Restraint Reduction Evaluation Trees: Falls, Behavior Symptoms, Wandering
Available at: http://www.nccnhr.org/uploads/T3RestraintReductionEval.Trees-Falls,BehaviorSymptoms,WanderingandMedicalNecessity.pdf.
Federal Law and Appendix PP: Restraints
Available at: http://www.nccnhr.org/uploads/T12FederalLawandAppendixPP-Restraints.pdf.
Federal Law and Appendix PP: Quality of Care
Available at: http://www.nccnhr.org/uploads/T13FederalLawandAppendixPP-QualityofCare.pdf.
California Code of Regulations: 72527 (Residents' Rights)
Available at: http://www.nccnhr.org/uploads/T15CaliforniaCodeofRegulations72527.pdf.
California Code of Regulations: 72528 (Informed Consent)
Available at: http://www.nccnhr.org/uploads/T16CaliforniaCodeofRegulations72528.pdf.

Be Prepared with

(Choose the ones applicable to your methodology.)
Flip chart and markers and easel or stand
Equipment to show the PowerPoint presentation
Copies of all handouts
Extra pencils and paper for individuals who might need something for taking notes
Restraints and someone who knows how to apply them.

GOOD CARE PRACTICES PRECLUDE RESTRAINTS

Teaching Points

- Assessment and recognition of the symptom
  - Mrs. Torselli, Facts and Strategies PowerPoint (PPT) slides 33 – 34
- Diagnosis and identification of the cause
  - PPT slides 35 - 36
- Care Planning – individualized and what does that mean?
  - PPT slide 37
- Implementation of the care plan
  - PPT slides 38 - 39
- Summary and action steps applicable to any situation
  - PPT slides 40 – 41
- Application questions
    - PPT slide 42
- Replacing restraints with good care practices: If "Everyone Wins" will be used, PPT slide 43 gives a key focus question for noticing during the video and for follow-up dialogue.

Application Exercise

Use as time permits and as applicable to increase the audience's knowledge.

Everyone Wins Video and Discussion

Allow thirty to forty-five minutes for this video and discussion.
Show this fifteen minute video.

- Review of risks of using restraints.
- How were the family member's concerns were handled by the facility? Was the facility personnel respectful? Surveyors?
- Is going slow good?
- What was the key to keeping the husband having comfort (trust) with the facility?
- What was the role of his friend?
- What were the systems in place to help residents?
- Distribute the handout, "That's Great for Other Families, but…" and ask if this information might have been helpful to the family members in this video. Encourage ombudsman representatives to use this handout as an educational tool.
- Distribute the "Guide with Video" handout and talk about how ombudsman representatives can use this with consumers.

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(*Important: Save the PowerPoint file to your workspace BEFORE you open it, allowing you to view it in the PowerPoint program, and see the speaker notes.*)

Guide with Video: Everyone Wins! The Family Guide to Restraint Free Care
Available at: http://www.nccnhr.org/uploads/T11GuidewithVideo-EveryoneWins.pdf.
That's Great for Other Families but…
Available at: http://www.nccnhr.org/uploads/C2ThatsGreatforOtherFamiliesBut.pdf.
Resident Information
Available at: http://www.nccnhr.org/uploads/C3ResidentInformation.pdf.
Restraint Risks
Available at: http://www.nccnhr.org/uploads/C5RestraintRisks.pdf.
Change Ideas for Creating Pleasant Bathing
Available at:
http://www.nccnhr.org/uploads/T4ChangeIdeasforCreatingPleasantBathing.pdf.
Change Ideas for Sleeping and Waking
Available at: http://www.nccnhr.org/uploads/T5ChangeIdeasforSleepingandWaking.pdf.
Guidelines for Placing Mattress on Low Platform
Available at:
http://www.nccnhr.org/uploads/T6GuidelinesforPlacingMattressonLowPlatform.pdf.
Individualized Care: Life Without Bedrails
Available at: http://www.nccnhr.org/uploads/T7IndividualizedCare-LifeWithoutBedrails-WheelchairSeatingasaRoadtoRestraint-FreeCare.pdf.
Individualize Wheelchair Seating: For Older Adults
Available at:
http://www.nccnhr.org/uploads/T8IndividualizedWheelchairSeatingForOlderAdults.pdf.
Physical Restraints: Essential Systems for Quality Care
Available at:
http://www.nccnhr.org/uploads/T9PhysicalRestraintsEssentialSystemsforQualityCare.pdf
Restraint Reduction Resource List
Available at: http://www.nccnhr.org/uploads/T17RestraintReductionResourceList.pdf.
Restraint Guidelines annotated with evidence bases
Available at: http://www.nccnhr.org/uploads/T18PhysicalRestraints-AnnotatedGuidelines.pdf.
Alternatives to Restraints
Available at: http://www.nccnhr.org/uploads/C1AlternativestoRestraints.pdf.

Be Prepared with

(Choose the ones applicable to your methodology.)
Flip chart and markers and easel or stand
Equipment to show the PowerPoint presentation
Equipment to play the video
Copies of all handouts
Extra pencils and paper for individuals who might need something for taking notes

APPLY YOUR KNOWLEDGE to ASSIST RESIDENTS

Teaching Points

- Good Care Practices Preclude Restraints: Facts and Strategies PowerPoint (PPT) slides 43- 44.
  Overview of good practices and may be used as a review or as an introduction. As you cover each topic, refer to key information from the applicable handout to encourage ombudsman representatives to use the handout information as an advocacy resource.
  - Individual/environmental/organizational
  - Promote resident's function
  - Minimize likelihood of resident needing to get up unaided
  - Customize seating
  - Well lighted safe facility
  - Home environment – culture change
  - Culture change grew out of the restraint reduction movement. In the 1980's Carter Williams went to Europe to study what they do in providing care to frail elders without restraints.
    - Decrease the risk of resident wandering.
    - One cause of distress for other residents is to have individuals with dementia wandering into their space. Can use dutch doors, police tapes, dark linoleum
    - Accept the fact that restless, anxious residents must be encouraged to walk when able and plan for that in the individualized care plan.
  - Re-evaluate life support measures – delirium. If a resident has delirium, a restraint may be necessary in order to determine and treat the cause of the delirium. If the cause is not found and treated, death may result. Thus, the risk of using a restraint for a short time outweighs the risk of death from untreated delirium.
- Apply your knowledge: Mrs. Betts, Mr. Gonzales and Mrs. Chin Ling, PPT slide 45
  - Divide into small groups, assign a reporter for each group, set time limit for group work.
  - Refer to PPT presenter notes for ideas.
  - Reports from groups. Point out key aspects of good care practices to eliminate or avoid restraints.
  - Be clear about the role of ombudsman representatives.
- Summarize with the handout, "How Quality Care Practices Preclude Restraint Use for Nursing Home Residents."

PowerPoint Presentation

Facts and Strategies: Restraint Free Care is the Standard (includes speaker notes)
Available at:
http://www.nccnhr.org/uploads/FactsandStrategiesPresentation.ppt. (*Important: Save the PowerPoint file to your workspace BEFORE you open it, allowing you to view it in the PowerPoint program, and see the speaker notes.*)

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Scenarios: Mrs. Betts, Mr. Gonzales, and Mrs. Chin Ling
Available at: http://www.nccnhr.org/uploads/T1Scenarios.pdf.

Physical Restraints: Decision Tree
Available at: http://www.nccnhr.org/uploads/T2PhysicalRestraintsDecisionTree.pdf.

Restraint Reduction Evaluation Trees: Falls, Behavior Symptoms, Wandering
Available at: http://www.nccnhr.org/uploads/T3RestraintReductionEval.Trees-Falls,BehaviorSymptoms,WanderingandMedicalNecessity.pdf.

Change Ideas for Creating Pleasant Bathing
Available online at: http://www.nccnhr.org/uploads/T4ChangeIdeasforCreatingPleasantBathing.pdf.

Change Ideas for Sleeping and Waking
Available at: http://www.nccnhr.org/uploads/T5ChangeIdeasforSleepingandWaking.pdf.

Guidelines for Placing Mattress on Low Platform
Available at: http://www.nccnhr.org/uploads/T6GuidelinesforPlacingMattressonLowPlatform.pdf.

Individualized Care: Life Without Bedrails
Available at: http://www.nccnhr.org/uploads/T7IndividualizedCare-LifeWithoutBedrails-WheelchairSeatingasaRoadtoRestraint-FreeCare.pdf.

Individualized Wheelchair Seating: For Older Adults
Available at: http://www.nccnhr.org/uploads/T8IndividualizedWheelchairSeatingForOlderAdults.pdf.

Physical Restraints: Essential Systems for Quality Care
Available at: http://www.nccnhr.org/uploads/T9PhysicalRestraintsEssentialSystemsforQualityCare.pdf

Restraint Reduction Resource List
Available at: http://www.nccnhr.org/uploads/T17RestraintReductionResourceList.pdf.

Restraint Guidelines annotated with evidence bases
Available at: http://www.nccnhr.org/uploads/T18PhysicalRestraints-AnnotatedGuidelines.pdf.

How Quality Care Practices Preclude Restraint Use for Nursing Home Residents
Available at: http://www.nccnhr.org/uploads/NCCNHRHowQualityCarePracticesPrecludeRestraintUseforNursingHomeResidentsinormationpiece6.5.06.pdf.

Alternatives to Restraints
Available at: http://www.nccnhr.org/uploads/C1AlternativestoRestraints.pdf.

Be Prepared with

(Choose the ones applicable to your methodology.)
Flip chart and markers and easel or stand
Equipment to show the PowerPoint presentation

Copies of all handouts
Extra pencils and paper for individuals who might need something for taking notes

STRATEGIES to DECREASE RESTRAINT USE in CALIFORNIA

Teaching Points

- There is a national campaign that relates to the restraint reduction efforts in California: Advancing Excellence (AE). Promoting Quality PowerPoint (PPT) slides 17 – 22
  - AE provides visibility, resources, and support for the focus on restraints.
  - AE is an opportunity for ombudsman representatives and consumers to push for good care and to ask facilities what they are doing in specific areas.
  - AE provides additional public information about facilities that participate.
  - AE adds momentum to the dialogue about reducing restraints, consistent assignment, and other key areas of care.
- Ombudsman representatives and consumer can participate in promoting quality through this campaign. PPT slides 23 – 29.
- Select some of the handout resources primarily for ombudsman representatives.
  - Review these. The consumer fact sheet "Expect and Promote Excellence" would be a good starting point.
    - Refer to the "Project Overview and Action List" for additional ideas for advocacy.
    - Ask, "How might this information (on the handouts) be used in individual advocacy?"
    - "How might it be used to inform facility staff or to deal with a widespread practice?"
    - Capture the ideas on a flip chart.
- If time permits, discuss similarities and differences between restraints in nursing facilities and in residential care facilities for the elderly. Include points such as:
  - Differences in residents' rights,
  - How residents are restrained, e.g. chair is positioned close to a wall so that resident cannot get up;
  - The impact of restraints on resident functioning and quality of life.
  - How ombudsman representatives can address restraints in individual advocacy or in educating staff.
- Select some of the handout resources primarily for consumer education.
  - Review these.
  - Ask, "How might this information be used with consumers? Family councils? Resident councils?"
  - Refer to the "Project Overview and Action List" for additional ideas for consumer education.
  - Capture the ideas on a flip chart.
- Review the restraint reduction information for presenting to resident or family councils that was provided by the California Office of the LTCO, adapted from Texas. Discuss how to use this information.
- There are many resources and opportunities for advocates to promote reducing restraints. Ombudsman representatives need to incorporate this knowledge and awareness into their daily work.

- Summarize by listing key actions for individual ombudsman representatives to implement and actions that the local program will implement. Use ideas from the preceding discussions about individual advocacy and consumer education for the summary.

PowerPoint Presentation

Promoting Quality: Opportunity for Advocates to Make a Difference, Alice Hedt, June 13, 2007

Available at: http://www.nccnhr.org/uploads/PromotingQualityPresentation.ppt. (*Important: Save the PowerPoint file to your workspace BEFORE you open it, allowing you to view it in the PowerPoint program.*)

Handouts

Print and copy handouts with blanks for notes of the PowerPoint presentation slides you will use.

Available at: http://www.nccnhr.org/uploads/PromotingQualityPresentation.ppt. (*Important: Save the PowerPoint file to your workspace BEFORE you open it, allowing you to view it in the PowerPoint program.*)

Consumer fact sheet: "Expect and Promote Excellence in California Nursing Homes: Physical Restraint Free Care"

Available at: http://www.nccnhr.org/uploads/FactSheet.pdf.

Project Overview and Action Checklist

Available at: http://www.nccnhr.org/uploads/FallT1Projectoverviewandchecklist.pdf

Summary: Advancing Excellence in America's Nursing Homes Campaign

Available at: http://www.nccnhr.org/uploads/T1SummaryofAECampaign.pdf.

Goals: How the Campaign Goals Will Improve Quality

Available at: http://www.nccnhr.org/uploads/T3AEQualityCampaignGoals.pdf.

Technical Goals: Advancing Excellence Campaign

Available at: http://www.nccnhr.org/uploads/T4AETechGoals.pdf.

NCCNHR position on Advancing Excellence Campaign

Available at: http://www.nccnhr.org/uploads/T5NCCNHRltrAECampaign.pdf.

Tips for Local Ombudsmen in Advancing Excellence Campaign

Available at: http://www.nccnhr.org/uploads/T9TipsforlocalombudsmeninAECampaing.pdf.

Consumer Involvement in Advancing Excellence Campaign

Available at: http://www.nccnhr.org/uploads/T10ConsumerInvolvementCampaignwgoals307.pdf.

Consumer Resources:
NCCNHR Guide to Choosing a Nursing Home
Available at: http://www.nccnhr.org/uploads/C1GuidetoChoosingaNH.pdf.
Consumer Fact Sheet: Advancing Excellence Campaign
Available at: http://www.nccnhr.org/uploads/C2ConsumerFactSheet.pdf.
Sample letter to Resident Councils for Advancing Excellence Campaign
Available at: http://www.nccnhr.org/uploads/C6SampleLtrtoRes.Council,CO.pdf.

Restraints:
Expect and Promote Excellence in California Nursing Homes: Physical Restraint Free Care: Consumer Fact Sheet
Available at: http://www.nccnhr.org/uploads/FactSheet.pdf.

Resources contributed by the State Office of the Long Term Care Ombudsman:
Alternatives to Restraints
Available at: http://www.nccnhr.org/uploads/C1AlternativestoRestraints.pdf.
Guide with Video: Everyone Wins! The Family Guide to Restraint Free Care
Available at: http://www.nccnhr.org/uploads/T11GuidewithVideo-EveryoneWins.pdf.
That's Great for Other Families but…
Available at: http://www.nccnhr.org/uploads/C2ThatsGreatforOtherFamiliesBut.pdf.
Resident Information
Available at: http://www.nccnhr.org/uploads/C3ResidentInformation.pdf.
Restraint Reduction
Available at: http://www.nccnhr.org/uploads/C4RestraintReduction.pdf.
Restraint Risks
Available at: http://www.nccnhr.org/uploads/C5RestraintRisks.pdf.
Restraint Reduction: Presentation to Family Councils
Available at: http://www.nccnhr.org/uploads/C6RestraintReductionPresentationtoFamilyCouncils-SampleAgenda.pdf.

Be Prepared with

(Choose the ones applicable to your methodology.)
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Copies of all handouts
Extra pencils and paper for individuals who might need something for taking notes

Experiencing Restraints Exercise Instructions

Purpose: To increase personal understanding about the effects of restraints.

Supplies needed: a variety of physical restraints such as vests, lap belts, mitts, chair alarms, lap buddies

Expertise needed: proper application of restraints

Instructions:

- Without any explanation or instructions, apply the restraints to individuals in the session. Do not ask permission to restrain someone!
- Conduct the session as if there nothing was different than in any other training session.
- If a break occurs, even for lunch, do not pay attention to individuals who are restrained or ask them if they want to be released.
- As indicated in the Teaching Points, ask the individuals who were restrained to share their reactions and observations. If necessary, push them a bit to be very honest. Then ask individuals around them to share their observations. Capture salient points on the flip chart.
- Remove the restraints.
- Ask everyone what they gained from this exercise.
- How will they use this information or perspective in their work?

Tips:

- If possible, apply the restraints early in the day or session to provide a more realistic experience of being restrained.
- If possible, ask someone to apply the restraints while you are introducing the session or you apply them while someone else is making announcements or giving information.
- Try to include a break during the session while individuals are restrained.
- Be vague if questions are asked about assisting a restrained person, particularly during a break.

Handouts

Topic: RESTRAINTS

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

INFORMED CONSENT FOR RESTRAINTS[1][2]

My physician and clinical care team recommend that I be restrained with the following devices_____. This recommendation is based on their professional judgment and on a fall-predicting test that identifies me as being at an increased risk of falling due to (circle all that apply): history of falling, sedating medications, impaired mobility, impaired cognition, or impaired sight.

Though fall-related injuries are a major cause of accidental disability and death in long-term care facilities, research does not show that restraints prevent fall-related injuries. Studies suggest that restraints usually increase, rather than decrease, the chance of serious injuries. Because the ability to predict the time of a fall-related injuries is imprecise, I consent to be restrained long durations when I will not be falling. Being restrained will cause physical deconditioning and may decrease my functional ability and independence; it, may predispose me to pneumonia and aggravate bedsores. Research suggests that people who are restrained often receive sedating medicines to treat restraint-induced agitation, and that the use of these drugs, and exposure to their potentially harmful effects, decreases when restraint use is decreased. Confused or frail persons' efforts to escape restraints have caused skin injuries, nerve damage, gangrene of the limbs, falls while escaping from a restraints and death from positional asphyxia.

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.

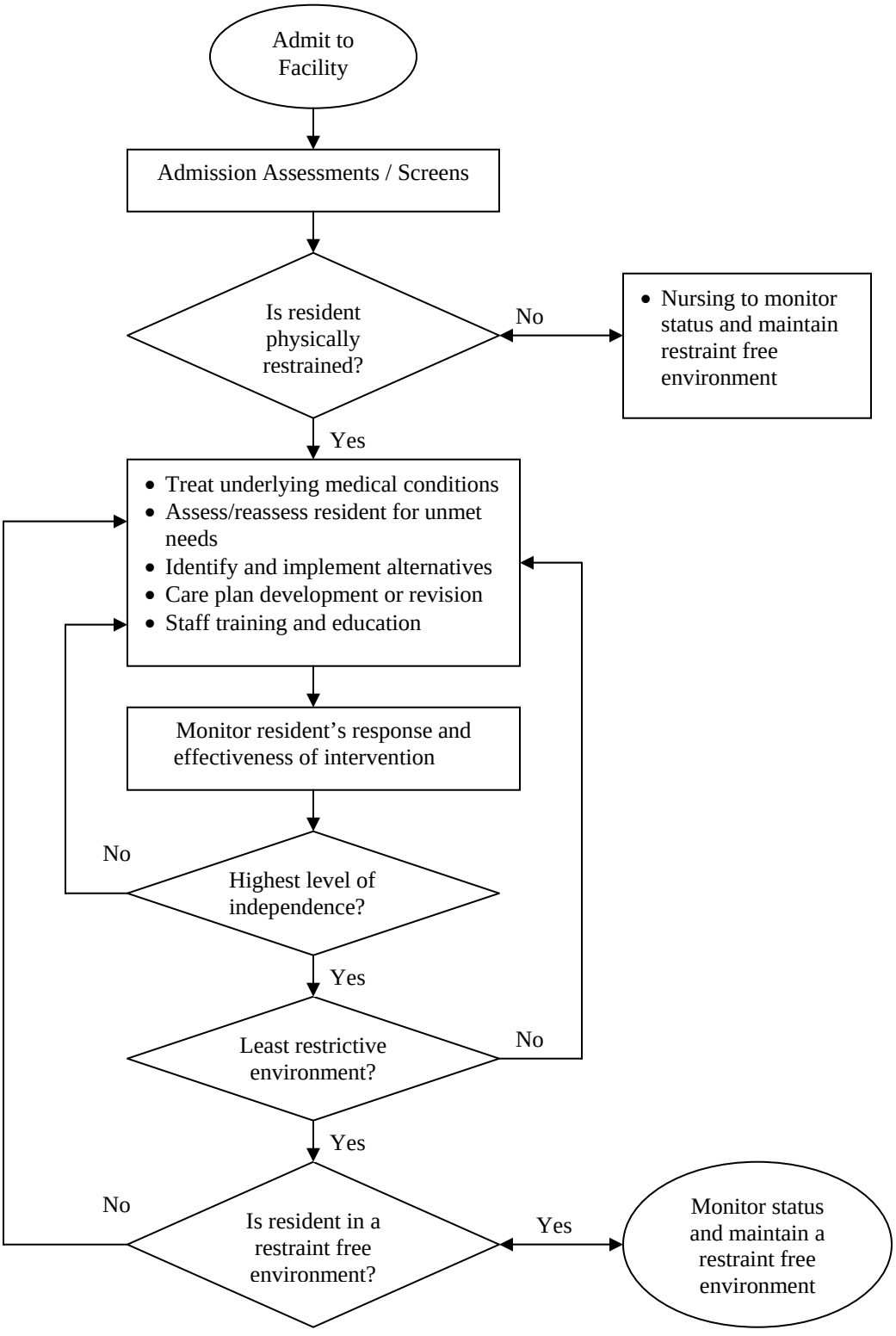
_____ Date

Signature

[1] This consent form does not apply to instances where a restraint is used to hold a person in proper alignment for life support or for immobilization to allow healing of a fracture or as part of post-operative management.

[2] Dr. Steven Miles, M.D., Professor of Medicine, Geriatrics and Bioethics, University of Minnesota. Printed in *Quality Care Advocate/Special Report,* April- May,1996. Modified September 16, 2003.

Physical Restraints: Decision Tree



The following 4 charts have been excerpted from:

“Restraint Reduction: Assessment and Alternatives, Help Guide; Evaluation Trees; Assessment Log/Intervention Care Plan.”

Developed by Diane Carter, RN, MSN, CS, President and CEO, The American Association of Nurse Assessment Coordinators (AANAC).

Funding for this Skilled Nursing Facility Health Care Quality Improvement Project was provided by the Health Care Financing Administration, Contract #500-96-P611. These materials were prepared and assembled by the **Colorado Foundation for Medical Care** in collaboration with the **Colorado Department of Public Health and Environment, Health Facilities Division**, May 1998. The contents presented do not necessarily reflect HCFA policy.

Possible Areas for Evaluation: F A L L S

FALLS

FACTORS	COMMON CAUSES	DO INTERDISCIPLINARY ASSESSMENT/SELECT BEST INTERVENTION CONSULT PRIMARY CARE PROVIDER, AS APPROPRIATE
Physiological	Medication	◆Dosage - multiple dosages/multiple medications ◆Check drug substitution, interactions, side effects of psychotropics, diuretics, cardiovascular ◆Have any new medications been added to regimen which may increase falls? ◆Tegretol level ◆Neurological checks ◆Frequent toileting assist if on diuretics ◆Dilantin level ◆Electrolytes, BUN, creatinine ◆Limit long-acting benzodiazapines ◆Depakote level ◆Void before tranquilizers/sedatives ◆Administer pain meds before transfer & ROM
	Unstable gait	◆Restorative nursing program ◆Evaluate hearing and vision ◆Evaluate clothing for size & length ◆Physical therapy--weight bearing ◆Gait training, muscle strengthing for ADL training ◆Walker, cane, merry walker ◆Fracture, arthritis, TIAs, seizures, Parkinson's, hypothyroidism, anemia ◆Shoe assessment
	Cardiovascular insufficiency Syncope - orthostatic, TIA, arrhythmia, hypotension	◆Auscultate sitting and walking ◆EKG, 24 hr. Holter monitor, O_2 saturation, CXR, electrolytes, BUN, ◆Teach to change position slowly creatinine, orthostatic BP, heart rate, digitalis level ◆Use elastic stockings ◆Check pacemaker
	Infection	◆Upper respiratory infection ◆Urinary tract infection ◆Fever - frequently afebrile, lung sounds, CBC, CXR, UA-C&S, O_2 saturation
	Hyperglycemia/Hypoglycemia	◆Check blood sugar
	Dehydration Constipation	◆Provide 1.5 to 2 qts. of water per day unless otherwise restricted ◆Change in mental status ◆Check bowel sounds, abdominal distention, impaction
	Pain	◆History of pain ◆Quality ◆Medications - try pain medications ◆Massage ◆Location ◆Onset, duration ◆Transcutaneous nerve stimulation ◆Heat ◆Intensity ◆Ability to express pain ◆Physical therapy ◆Cold
	Sleep	◆Sleep/wake patterns ◆Diet effects ◆Maintain regular schedule ◆Deep gentle exercise ◆Bedtime routines/rituals ◆Physiologic ◆Limit caffeine, cigarettes, etc. ◆Avoid napping ◆Medications ◆Illness ◆Avoid hypnotics ◆Avoid stimulating drugs ◆Room - quiet, cool, no noise
Psycho-social	Dementia/cognitive disorders Denial of impairment/depression	◆Attitude/approach ◆Distraction evaluation ◆Hearing/vision ◆Verbal approaches ◆Structured ADL schedules ◆Locate near nurses' station ◆Geriatric Depression Scale
Environ-mental	Physical surroundings	◆Bedrails ◆Bathroom ◆Noise ◆TV-remote control ◆Accessible call light ◆Furniture ◆Lighting ◆Floor ◆Stairs
Family		◆Involve family in care planning ◆Teach about current condition and interventions ◆Teach about predicted course of illness, as appropriate, behavior changes that result from cognitive loss

Adapted from *Rehabilitation Nursing,*
15 (1), 22-25, 1990, with permission from the Association of Rehabilitation Nurses.

Possible Areas for Evaluation: Behavior Symptoms

Behavior Symptoms

FACTORS	COMMON CAUSES	DO INTERDISCIPLINARY ASSESSMENT/SELECT BEST INTERVEN- CONSULT PRIMARY CARE PROVIDER, AS APPROPRI-
Physical	Medication	◆Dosage - multiple dosages/multiple medications ◆Check drug substitution, interactions, side effects of psychotropics, diuretics, cardiovascular ◆Have any new medications been added to regimen which may increase falls? ◆Tegretol level ◆Neurological checks ◆Frequent toileting assist if on diuretics ◆Dilantin level ◆Electrolytes, BUN, creatinine ◆Limit long-acting benzodiazapines ◆Depakote level ◆Void before tranquilizers/sedatives ◆Administer pain meds before transfer & ROM
	Cardiovascular insufficiency Syncope - orthostatic, TIA, arrhythmia, hypotension	◆Auscultate sitting and walking ◆EKG, 24 hr. Holter monitor, O_2 saturation, CXR, electrolytes, BUN, creatinine, orthostatic BP, heart rate, digitalis level ◆Teach to change position slowly ◆Use elastic stockings ◆Check pacemaker
	Infection	◆Upper respiratory infection ◆Urinary tract infection ◆Fever - frequently afebrile, lung sounds, CBC, CXR, UA-C&S, O_2 saturation
	Hyperglycemia/Hypoglycemia	◆Check blood sugar
	Dehydration Constipation	◆Provide 1.5 to 2 qts. of water per day unless otherwise restricted ◆Change in mental status ◆Check bowel sounds, abdominal distention, impaction
	Pain	◆History of pain ◆Quality ◆Medications - try pain medications ◆Massage ◆Location ◆Onset, duration ◆Transcutaneous nerve stimulation ◆Heat ◆Intensity ◆Ability to express pain ◆Physical therapy ◆Cold
	Sleep	◆Sleep/wake patterns ◆Diet effects ◆Maintain regular schedule ◆Deep gentle exercise ◆Bedtime routines/rituals ◆Physiologic ◆Limit caffeine, cigarettes, etc. ◆Avoid napping ◆Avoid hypnotics ◆Avoid stimulating drugs ◆Room - quiet, cool, no noise
Psychosocial	Delusions Hallucinations Depression	◆Assess agressive behavior ◆Contract with patient ◆Behavior modification ◆Assess psychoactive medications ◆Cognitive therapy
	Dementia Alzheimer's Disease	◆Attitude/approach - calm, flexible, guiding (not controlling) ◆Verbal approaches - concrete, validate feeling, task segmentation, avoid excess disability ◆Non-verbal approaches - attitude contagious, equal/lower position, therapeutic touch ◆Music therapy ◆Distraction therapy ◆Recreation ◆Exercise ◆Remotivation
Environmental	Physical surroundings	◆Call light ◆Rocking chair ◆Night-time activities ◆Avoid sensory overload ◆Roommate ◆Personalize room ◆Assess interpersonal preferences ◆Staff: street clothes, decrease turnover, resident chooses caregiver, permanent assignments, use non-nursing as much as possible, consistent scheduling

Adapted from *Rehabilitation Nursing*, 15 (1), 22-25, 1990, with permission from the Association of Rehabilitation Nurses.

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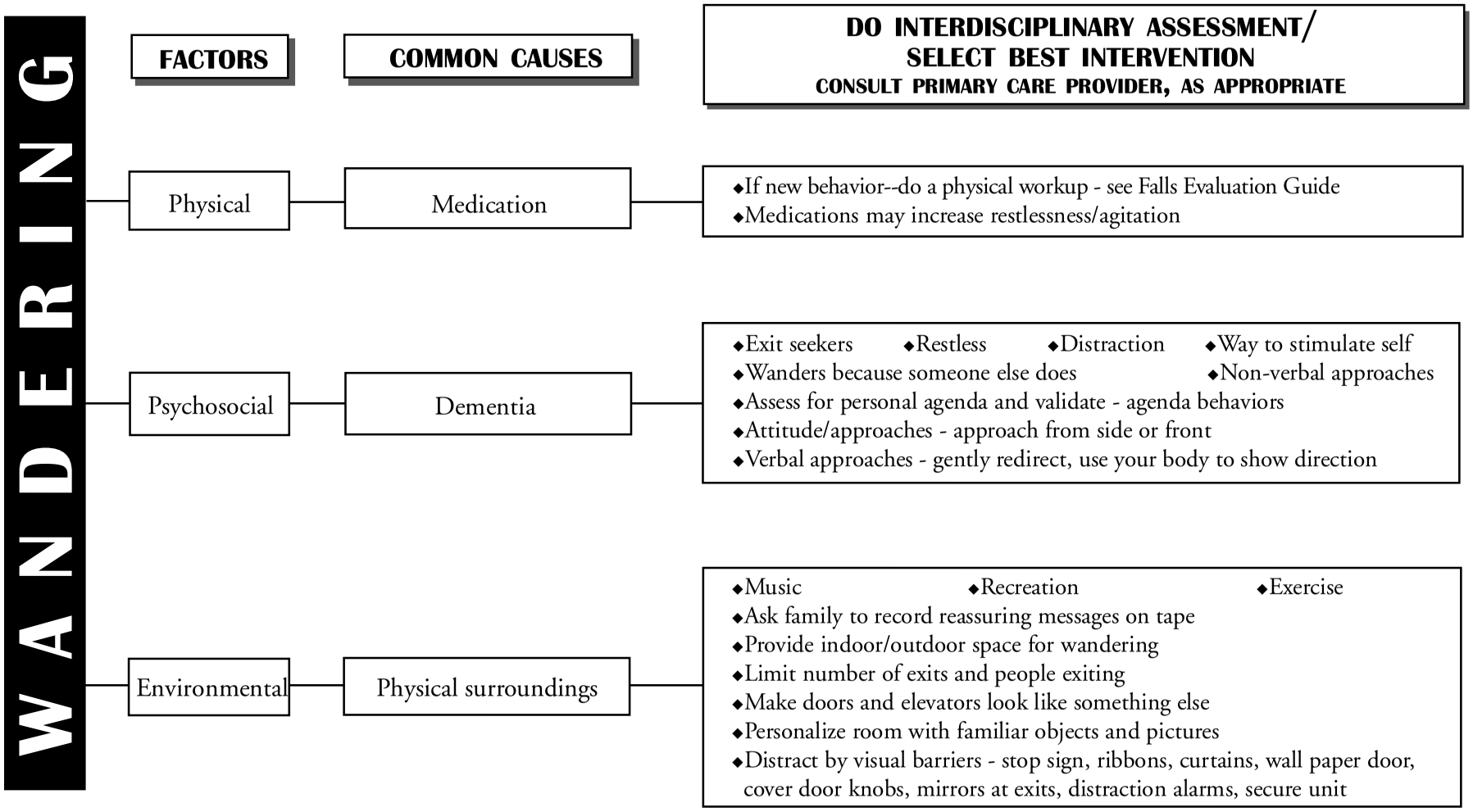
POSSIBLE AREAS FOR EVALUATION: WANDERING



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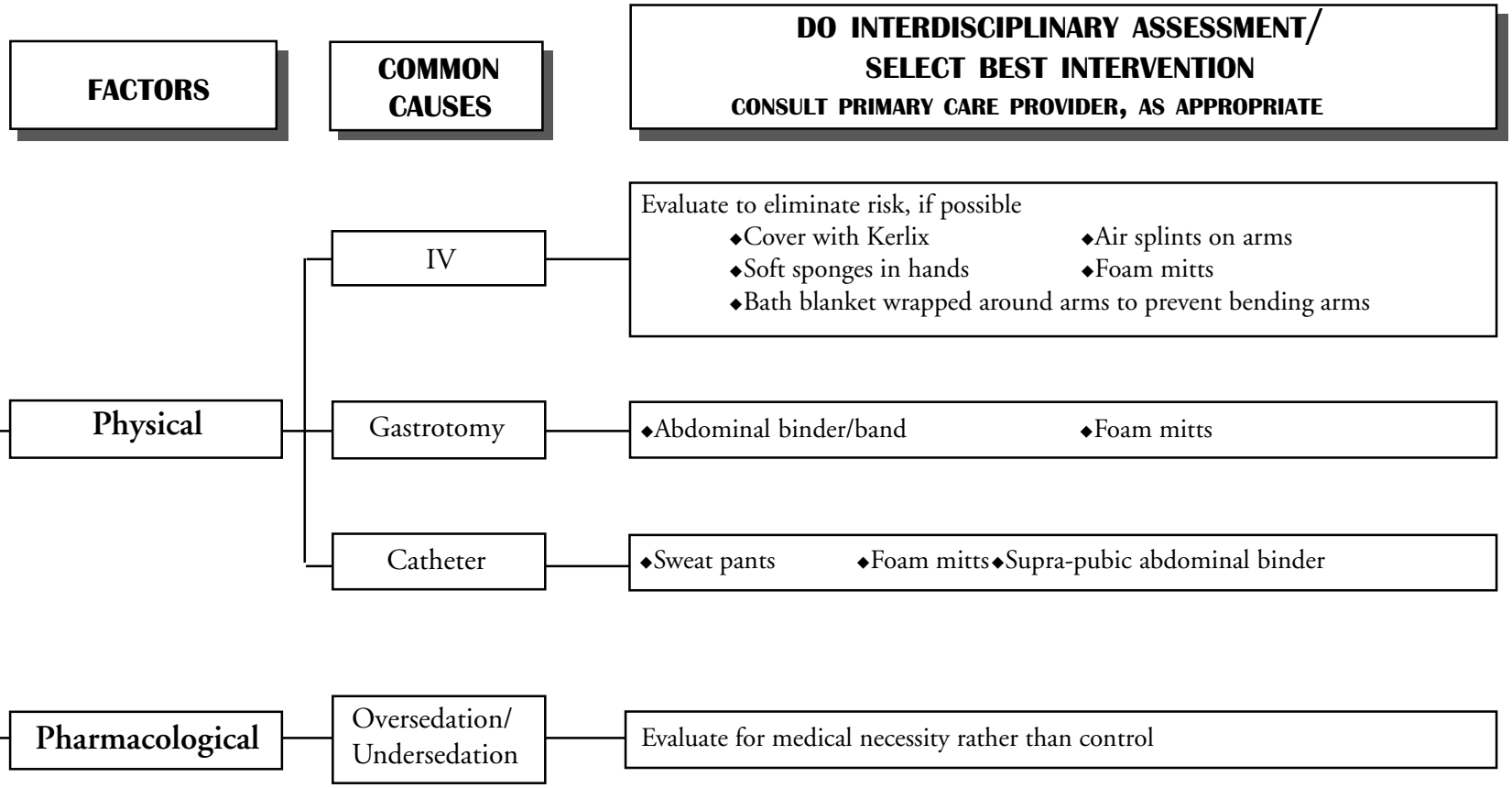
MEDICAL NECESSITY

POSSIBLE AREAS FOR EVALUATION: MEDICAL NECESSITY



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- The facility informs the resident and the resident's representative in advance that this is not a covered service to allow them to make an informed choice regarding the fee; and

- The resident's admission or continued stay is not conditioned on the resident's requesting and receiving that service.

Procedures §483.12(d)(3)

Review State covered services. Compare with the list of items for which the facility charges to determine if the facility is charging for covered services.

Determine if the facility requires deposits from residents. If you identify potential problems with discrimination, review the files of one or more residents selected for a focused or comprehensive review to determine if the facility requires residents to submit deposits as a precondition of admission besides what may be paid under the State plan.

If interviews with residents suggest that the facility may have required deposits from Medicaid recipients at admission, except those admitted when Medicaid eligibility is pending, corroborate by, for example, reviewing the facility's admissions documents or interviewing family members.

§483.12(d)(4) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

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§483.13 Resident Behavior and Facility Practices

F221

Use Tag F221 for deficiencies concerning **physical** restraints.

USE GUIDANCE UNDER TAG F222

F222

Use Tag F222 for deficiencies concerning **chemical** restraints.

§483.13(a) 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.

Intent §483.13(a)

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.

Interpretive Guidelines §483.13(a)

Definitions of Terms

"Physical Restraints" are defined 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.

"Chemical Restraints" is defined as any drug that is used for discipline or convenience and not required to treat medical symptoms.

"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 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" is defined as an indication or characteristic of a physical or psychological condition.

"Convenience" is defined as 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.

Restraints may not be used for staff convenience. However, if the resident needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed unless the facility has a notice indicating that the resident has previously made a valid refusal of the treatment in question. If a resident's unanticipated violent or aggressive behavior places him/her or others in imminent danger, the resident does not have the right to refuse the use of restraints. In this situation, the use of restraints is a measure of last resort to protect the safety of the resident or others and must not extend beyond the immediate episode. The resident's right to participate in care planning and the right to refuse treatment are addressed at §§483.20(k)(2)(ii) and 483.10(b)(4), respectively, and include the right to accept or refuse restraints.

Physical Restraints are defined 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.

"Physical restraints" include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions, and lap trays the resident cannot remove easily. Also included as restraints are facility practices that meet the definition of a restraint, such as:

- Using side rails that keep a resident from voluntarily getting out of bed;
- Tucking in or using velcro to hold a sheet, fabric, or clothing tightly so that a resident's movement is restricted;
- Using devices in conjunction with a chair, such as trays, tables, bars or belts, that the resident can not remove easily, that prevent the resident from rising;
- Placing a resident in a chair that prevents a resident from rising; and
- Placing a chair or bed so close to a wall that the wall prevents the resident from rising out of the chair or voluntarily getting out of bed.

Side rails sometimes restrain residents. The use of side rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms. Residents who attempt to exit a bed through, between, over or around side rails are at risk of injury or death. The potential for serious injury is more likely from a fall from a bed with raised side rails than from a fall from a bed where side rails are not used. They also potentially increase the likelihood that the resident will spend more time in bed and fall when attempting to transfer from the bed.

As with other restraints, for residents who are restrained by side rails, it is expected that the process facilities employ to reduce the use of side rails as restraints is systematic and gradual to ensure the resident's safety while treating the resident's medical symptom.

The same device may have the effect of restraining one individual but not another, depending on the individual resident's condition and circumstances. For example, partial rails may assist one resident to enter and exit the bed independently while acting as a restraint for another.

Orthotic body devices may be used solely for therapeutic purposes to improve the overall functional capacity of the resident.

An enclosed framed wheeled walker, with or without a posterior seat, would not meet the definition of a restraint if the resident could easily open the front gate and exit the device.

If the resident cannot open the front gate (due to cognitive or physical limitations that prevent him or her from exiting the device or because the device has been altered to prevent the resident from exiting the device), the enclosed framed wheeled walker would meet the definition of a restraint since the device would restrict the resident's freedom of movement (e.g. transferring to another chair, to the commode, or into the bed). The decision on whether framed wheeled walkers are a restraint must be made on an individual basis.

"Medical Symptom" is defined as an indication or characteristic of a physical or psychological condition.

The resident's medical symptoms should not be viewed in isolation, rather the symptoms should be viewed in the context of the resident's condition, circumstances and environment. Objective findings derived from clinical evaluation and the resident's subjective symptoms should be considered to determine the presence of the medical symptom. The resident's subjective symptoms may not be used as the sole basis for using a restraint. Before a resident is restrained, the facility must determine the presence of a specific medical symptom that would require the use of restraints, and how the use of restraints would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being.

Medical symptoms that warrant the use of restraints must be documented in the resident's medical record, ongoing assessments, and care plans. While there must be a physician's order reflecting the presence of a medical symptom, CMS will hold the facility ultimately accountable for the appropriateness of that determination. The physician's order alone is not sufficient to warrant the use of the restraint. It is further expected, for those residents whose care plans indicate the need for restraints, that the facility engage in a systematic and gradual process toward reducing restraints (e.g., gradually increasing the time for ambulation and muscle strengthening activities). This systematic process would also apply to recently admitted residents for whom restraints were used in the previous setting.

Consideration of Treatment Plan

In order for the resident to be fully informed, the facility must explain, in the context of the individual resident's condition and circumstances, the potential risks and benefits of all options under consideration including using a restraint, not using a restraint, and alternatives to restraint use. Whenever restraint use is considered, the facility must explain to the resident how the use of restraints would treat the resident's medical symptoms and assist the resident in attaining or maintaining his/her highest practicable level of physical or psychological well-being. In addition, the facility must also explain the potential negative outcomes of restraint use which include, but are not limited to, declines in the resident's physical functioning (e.g., ability to ambulate) and muscle condition, contractures, increased incidence of infections and development of pressure sores/ulcers, delirium, agitation, and incontinence. Moreover, 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 (e.g., strangulation, entrapment). Finally, residents who are restrained may face a loss of autonomy, dignity and self respect, and may show symptoms of withdrawal, depression, or reduced social contact. In effect, restraint use can reduce independence, functional capacity, and quality of life. Alternatives to restraint use should be considered and discussed with the resident. Alternatives to restraint use might include modifying the resident's environment and/or routine.

In the case of a resident who is incapable of making a decision, the legal surrogate or representative may exercise this right based on the same information that would have been provided to the resident. (See §483.10(a)(3) and (4).) However, the legal surrogate or representative cannot 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.

Assessment and Care Planning for Restraint Use

There are instances where, after assessment and care planning, a least restrictive restraint may be deemed appropriate for an individual resident to attain or maintain his or her highest practicable physical and psychosocial well-being. This does not alter the facility's responsibility to assess and care plan restraint use on an ongoing basis.

Before using a device for mobility or transfer, assessment should include a review of the resident's:

- Bed mobility (e.g., would the use of a device assist the resident to turn from side to side? Is the resident totally immobile and unable to change position without assistance?); and

- Ability to transfer between positions, to and from bed or chair, to stand and toilet (e.g., does the raised side rail add risk to the resident's ability to transfer?).

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.

- Interventions that the facility might incorporate in care planning include:

    - Providing restorative care to enhance abilities to stand, transfer, and walk safely;

    - Providing a device such as a trapeze to increase a resident's mobility in bed;

- Placing the bed lower to the floor and surrounding the bed with a soft mat;

- Equipping the resident with a device that monitors his/her attempts to arise;

- Providing frequent monitoring by staff with periodic assisted toileting for residents who attempt to arise to use the bathroom;

- Furnishing visual and verbal reminders to use the call bell for residents who are able to comprehend this information and are able to use the call bell device; and/or

- Providing 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.

Procedures: §483.13(a)

Determine if the facility follows a systematic process of evaluation and care planning prior to using restraints. Since continued restraint use is associated with a potential for a decline in functioning if the risk is not addressed, determine if the interdisciplinary team addressed the risk of decline at the time restraint use was initiated and that the care plan reflected measures to minimize a decline. Also determine if the plan of care was consistently implemented. Determine whether the decline can be attributed to a disease progression or inappropriate use of restraints.

For sampled residents observed as physically restrained during the survey or whose clinical records show the use of physical restraints within 30 days of the survey, determine whether the facility used the restraint for convenience or discipline, or a therapeutic intervention for specific periods to attain and maintain the resident's highest practicable physical, mental, or psychosocial well-being.

Probes: §483.13(a)

This systematic approach should answer these questions:

1. What are the medical symptoms that led to the consideration of the use of restraints?

2. Are these symptoms caused by failure to:

    a. Meet individual needs in accordance with the resident assessments including, but not limited to, section III of the MDS, Customary Daily Routines (MDS Version 2.0, section AC), in the context of relevant

information in sections I and II of the MDS (MDS Version 2.0, sections AA and AB)?

b. Use rehabilitative/restorative care?

c. Provide meaningful activities?

d. Manipulate the resident's environment, including seating?

3. Can the cause(s) of the medical symptoms be eliminated or reduced?

4. If the cause(s) cannot be eliminated or reduced, then has the facility attempted to use alternatives in order to avoid a decline in physical functioning associated with restraint use? (See Physical Restraints Resident Assessment Protocol (RAP), paragraph I).

5. If alternatives have been tried and deemed unsuccessful, does the facility use the least restrictive restraint for the least amount of time? Does the facility monitor and adjust care to reduce the potential for negative outcomes while continually trying to find and use less restrictive alternatives?

6. Did the resident or legal surrogate make an informed choice about the use of restraints? Were risks, benefits, and alternatives explained?

7. Does the facility use the Physical Restraints RAP to evaluate the appropriateness of restraint use?

8. Has the facility re-evaluated the need for the restraint, made efforts to eliminate its use and maintained residents' strength and mobility?

F223

§483.13(b) Abuse

The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

Intent §483.13(b)

Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.

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The statute mandates preadmission screening for all individuals with mental illness (MI) or mental retardation (MR) who apply to NFs, regardless of the applicant's source of payment, except as provided below. (See §1919(b)(3)(F).) Residents readmitted and individuals who initially apply to a nursing facility directly following a discharge from an acute care stay are exempt if:

- They are certified by a physician prior to admission to require a nursing facility stay of less than 30 days; and
- They require care at the nursing facility for the same condition for which they were hospitalized.

The State is responsible for providing specialized services to residents with MI/MR residing in Medicaid-certified facilities. The facility is required to provide all other care and services appropriate to the resident's condition. Therefore, if a facility has residents with MI/MR, do not survey for specialized services, but survey for all other requirements, including resident rights, quality of life, and quality of care.

If the resident's PAS report indicates that he or she needs specialized services but the resident is not receiving them, notify the Medicaid agency. NF services ordinarily are not of the intensity to meet the needs of residents with MI or MR.

Probes §483.20(m):

If sampled residents have MI or MR, did the State Mental Health or Mental Retardation Authority determine:

- Whether the residents needed the services of a NF?
- Whether the residents need specialized services for their MR or MI?

F309

§483.25 Quality of Care

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Use F309 for quality of care deficiencies not covered by §483.25(a)-(m).

Intent: §483.25

The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process.

Definitions: §483.25

- "Highest practicable" is defined as the highest level of functioning and well-being possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline. Highest practicable is determined through the comprehensive resident assessment by competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

- "Skin Ulcer/Wound"

  NOTE: Skin ulcer definitions are included to clarify clinical terms related to skin ulcers. At the time of the assessment and diagnosis, the clinician is expected to document the clinical basis (e.g., underlying condition contributing to the ulceration, ulcer edges and wound bed, location, shape, condition of surrounding tissues) which permit differentiating the ulcer type, especially if the ulcer has characteristics consistent with a pressure ulcer, but is determined not to be one.

  - "Arterial Ulcer" is ulceration that occurs as the result of arterial occlusive disease when non-pressure related disruption or blockage of the arterial blood flow to an area causes tissue necrosis.

    Inadequate blood supply to the extremity may initially present as intermittent claudication. Arterial/Ischemic ulcers may be present in individuals with moderate to severe peripheral vascular disease, generalized arteriosclerosis, inflammatory or autoimmune disorders (such as arteritis), or significant vascular disease elsewhere (e.g., stroke or heart attack). The arterial ulcer is characteristically painful, usually occurs in the distal portion of the lower extremity and may be over the ankle or bony areas of the foot (e.g., top of the foot or toe, outside edge of the foot). The wound bed is frequently dry and pale with minimal or no exudate. The affected foot may exhibit: diminished or absent pedal pulse, coolness to touch, decreased pain when hanging down (dependent) or increased pain when elevated, blanching upon elevation, delayed capillary fill time, hair loss on top of the foot and toes, toenail thickening.

  - "Diabetic neuropathic ulcer" requires that the resident be diagnosed with diabetes mellitus and have peripheral neuropathy. The diabetic ulcer characteristically occurs on the foot, e.g., at mid-foot, at the ball of the

foot over the metatarsal heads, or on the top of toes with Charcot deformity.

- "Pressure ulcer". See Guidance at 42 CFR 483.25(c)-F314.

- "Venous insufficiency ulcer" (previously known as "stasis ulcer") is an open lesion of the skin and subcutaneous tissue of the lower leg, usually occurring in the pretibial area of the lower leg or above the medial ankle. Venous ulcers are reported to be the most common vascular ulceration and may be difficult to heal, may occur off and on for several years, and may occur after relatively minor trauma. The ulcer may have a moist, granulating wound bed, may be superficial, and may have minimal to copious serous drainage unless the wound is infected. The resident may experience pain which may be increased when the foot is in a dependent position, such as when a resident is seated with her or his feet on the floor. Recent literature implicates venous hypertension as a causative factor. Earlier, the ulceration was believed to be due to the pooling of blood in the veins.

  Venous hypertension may be caused by one (or a combination of) factor(s) including: loss of (or compromised) valve function in the vein, partial or complete obstruction of the vein (e.g., deep vein thrombosis, obesity, malignancy), and/or failure of the calf muscle to pump the blood (e.g., paralysis, decreased activity). Venous insufficiency may result in edema and induration, dilated superficial veins, cellulitis in the lower third of the leg or dermatitis (typically characterized by change in skin pigmentation). The pigmentation may appear as darkening skin, tan or purple areas in light skinned residents and dark purple, black or dark brown in dark skinned residents.

Interpretive Guidelines §483.25

Use F309 when the survey team determines there are quality of care deficiencies not covered by §§483.25(a)-(m). "Highest practicable" is defined as the highest level of functioning and well-being possible, limited only by the individual's presenting functional status and potential for improvement or reduced rate of functional decline. Highest practicable is determined through the comprehensive resident assessment by competently and thoroughly addressing the physical, mental or psychosocial needs of the individual.

The facility must ensure that the resident obtains optimal improvement or does not deteriorate within the limits of a resident's right to refuse treatment, and within the limits of recognized pathology and the normal aging process.

In any instance in which there has been a lack of improvement or a decline, the survey team must determine if the occurrence was unavoidable or avoidable. A determination of

unavoidable decline or failure to reach highest practicable well-being may be made only if all of the following are present:

- An accurate and complete assessment (see §483.20);
- A care plan which is implemented consistently and based on information from the assessment;
- Evaluation of the results of the interventions and revising the interventions as necessary.

Determine if the facility is providing the necessary care and services based on the findings of the RAI. If services and care are being provided, determine if the facility is evaluating the outcome to the resident and changing the interventions if needed. This should be done in accordance with the resident's customary daily routine. Use Tag F309 to cite quality of care deficiencies that are not explicit in the quality of care regulations.

Procedures §483.25

Assess a facility's compliance with these requirements by determining if the services noted in the plan of care, based on a comprehensive and accurate functional assessment of the resident's strengths, weaknesses, risk factors for deterioration and potential for improvement, is continually and aggressively implemented and updated by the facility staff. In looking at assessments, use both the MDS and RAPs information, any other pertinent assessments, and resulting care plans.

If the resident has been in the facility for less than 14 days (before completion of all the RAI is required), determine if the facility is conducting ongoing assessment and care planning, and, if appropriate, care and services are being provided.

If quality of care problems are noted in areas of nurse aide responsibility, review nurse aide competency requirements at §483.75(e).

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§483.25(a) Activities of Daily Living.

Based on the comprehensive assessment of a resident, the facility must ensure that

Intent §483.25(a)

The intent of this regulation is that the facility must ensure that a resident's abilities in ADLs do not deteriorate unless the deterioration was unavoidable.

F310

§483.25(a)(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to --

(i) Bathe, dress, and groom;
(ii) Transfer and ambulate;
(iii) Toilet;
(iv) Eat; and
(v) Use speech, language, or other functional communication systems.

Interpretive Guidelines §483.25(a)

The mere presence of a clinical diagnosis, in itself, justify a decline in a resident's ability to perform ADLs. Conditions which may demonstrate unavoidable diminution in ADLs include:

- The natural progression of the resident's disease;

- Deterioration of the resident's physical condition associated with the onset of a physical or mental disability while receiving care to restore or maintain functional abilities; and

- The resident's or his/her surrogate's or representative's refusal of care and treatment to restore or maintain functional abilities after aggressive efforts by the facility to counsel and/or offer alternatives to the resident, surrogate, or representative. Refusal of such care and treatment should be documented in the clinical record. Determine which interventions were identified on the care plan and/or could be in place to minimize or decrease complications. Note also that depression is a potential cause of excess disability and, where appropriate, therapeutic interventions should be initiated.

Appropriate treatment and services includes all care provided to residents by employees, contractors, or volunteers of the facility to maximize the individual's functional abilities. This includes pain relief and control, especially when it is causing a decline or a decrease in the quality of life of the resident.

If the survey team identifies a pattern of deterioration in ADLs, i.e., a number of residents have deteriorated in more than one ADL or a number of residents have deteriorated in only one ADL (one in bathing, one in eating, one in toileting) and it is determined there is deficient practice, cite at F310.

For evaluating a resident's ADLs and determining whether a resident's abilities have declined, improved or stayed the same within the last twelve months, use the following definitions as specified in the State's RAI:

1. **Independent** - No help or staff oversight; or staff help/oversight provided only 1 or 2 times during prior 7 days.

2. **Supervision** - Oversight encouragement or cuing provided 3 or more times during the last 7 days, or supervision plus physical assistance provided only 1 or 2 times during the last 7 days.

3. **Limited Assistance** - Resident highly involved in activity, received physical help in guided maneuvering of limbs, and/or other non-weight bearing assistance 3 or more times; or more help provided only 1 or 2 times over 7-day period.

4. **Extensive Assistance** - While resident performed part of activity, over prior 7-day period, help of following type(s) was provided 3 or more times;

    a. Weight-bearing support; or

    b. Full staff performance during part (but not all) of week.

5. **Total Dependence** - Full staff performance of activity over entire 7-day period.

§483.25(a)(1)(i) Bathing, Dressing, Grooming

Interpretive Guidelines §483.25(a)(1)(i)

This corresponds to MDS section E; version 2.0, section G, when specified for use by the State.

"Bathing" means how resident takes full-body bath, sponge bath, and transfers in/out of tub/shower. Exclude washing of back and hair.

"Dressing" means how resident puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis.

"Grooming" means how resident maintains personal hygiene, including preparatory activities, combing hair, brushing teeth, shaving, applying make-up, washing/drying face, hands and perineum. Exclude baths and showers.

BATHING, DRESSING, GROOMING

Procedures: §483.25(a)(1)(i)

For each sampled resident selected for the comprehensive review or the focused review, as appropriate, determine:

1. Whether the resident's ability to bathe, dress and/or groom has changed since admission, or over the past 12 months;

2. Whether the resident's ability to bathe, dress and groom has improved, declined or stayed the same;

3. Whether any deterioration or lack of improvement was avoidable or unavoidable by:

4. Identifying if resident triggers RAPs for ADL functional/rehabilitation potential.

    a. What risk factors for decline of bathing, dressing, and/or grooming abilities did the facility identify?

    b. What care did the resident receive to address unique needs to maintain his/her bathing, dressing, and/or grooming abilities (e.g., resident needs a button hook to button his shirt; staff teaches the resident how to use it; staff provides resident with dementia with cues that allow him/her to dress him or herself)?

    c. Were individual objectives of the plan of care periodically evaluated, and if the objectives were not met, were alternative approaches developed to encourage maintenance of bathing, dressing, and/or grooming abilities (e.g., resident now unable to button dress, even with encouragement; will ask family if we may use velcro in place of buttons so resident can continue to dress herself)?

Probes: §483.25(a)(1)(i)

If the resident's abilities in bathing, dressing, and grooming have been maintained, what evidence is there that the resident could have improved if appropriate treatment and services were provided:

- Identify relevant sections of the MDS and consider whether assessment triggers the RAPs and the RAPs were followed.

- Are there physical and psychosocial deficits that could affect improvement in functional abilities?

- Was the care plan driven by resident strengths identified in the comprehensive assessment?

- Was the care plan consistently implemented?

- What changes were made in treatment if the resident failed to progress or when initial rehabilitation goals were achieved, but additional progress might have been possible?

TRANSFER AND AMBULATION

§483.25(a)(1)(ii)

Interpretive Guidelines: §483.25(a)(1)(ii)

This corresponds to MDS section E; MDS 2.0 section G when specified for use by the State.

"Transfer" means how resident moves between surfaces - to/from: bed, chair, wheelchair, standing position. (Exclude to/from bath/toilet.)

"Ambulation" means how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair.

Procedures: §483.25(a)(1)(ii)

Determine for each resident selected for a comprehensive review, or a focused review as appropriate, whether the resident's ability to transfer and ambulate has declined, improved or stayed the same and whether any deterioration or decline in function was avoidable or unavoidable.

Probes: §483.25(a)(1)(ii)

If the resident's transferring and ambulating abilities have declined, what evidence is there that the decline was unavoidable:

- What risk factors for decline of transferring or ambulating abilities did the facility identify (e.g., necrotic area of foot ulcer becoming larger, postural hypotension)?

- What care did the resident receive to address risk factors and unique needs to maintain transferring or ambulating abilities (e.g., a transfer board is provided to maintain ability to transfer from bed to wheelchair and staff teaches the resident how to use it)?

- What evidence is there that sufficient staff time and assistance are provided to maintain transferring and ambulating abilities?

- Has resident been involved in activities that enhance mobility skills?

- Were individual objectives of the plan of care periodically evaluated, and if goals were not met, were alternative approaches developed to encourage maintenance of transferring and ambulation abilities (e.g., resident remains unsteady when using a cane, returns to walker, with staff encouraging the walker's consistent use)?

- Identify if resident triggers RAPs for ADL functional/rehabilitation potential, psychosocial well-being, or mood state and the RAPs are followed.

If the resident's abilities in transferring and ambulating have been maintained, is there evidence that the resident could have improved if appropriate treatment and services were provided?

- Are there physical and psychosocial deficits that could affect improvement in functional abilities?

- Was the care plan driven by resident strengths identified in the comprehensive assessment?

- Was the care plan consistently implemented? What changes were made in treatment if the resident failed to progress or when initial rehabilitation goals were achieved, but additional progress seemed possible?

TOILETING

§483.25(a)(1)(ii)

Interpretive Guidelines: §483.25(a)(1)(iii)

This corresponds to MDS sections E; MDS 2.0 sections G and H when specified for use by the State.

"Toilet use" means how the resident uses the toilet room (or commode, bedpan, urinal); transfers on/off the toilet, cleanses self, changes pad, manages ostomy or catheter, adjusts clothes.

Procedures: §483.25(a)(1)(iii)

Determine for each resident selected for a comprehensive review, or focused review as appropriate, whether the resident's ability to use the toilet has improved, declined or

stayed the same and whether any deterioration or decline in improvement was avoidable or unavoidable.

Probes: §483.25(a)(1)(iii)

If the resident's toilet use abilities have declined, what evidence is there that the decline was unavoidable.

- What risk factors for the decline of toilet use abilities did the facility identify (e.g., severe arthritis in hands makes use of toilet paper difficult)?

- What care did resident receive to address risk factors and unique needs to maintain toilet use abilities (e.g., assistive devices to maintain ability to use the toilet such as using a removable elevated toilet seat or wall grab bar to facilitate rising from seated position to standing position)?

- Is there sufficient staff time and assistance provided to maintain toilet use abilities (e.g., allowing residents enough time to use the toilet independently or with limited assistance)?

- Were individual objectives of the plan of care periodically evaluated, and if objectives were not met, were alternative approaches developed to encourage maintaining toilet use abilities (e.g., if resident has not increased sitting stability, seek occupational therapy consult to determine the need for therapy to increase sitting balance, ability to transfer safely and manipulate clothing during the toileting process. For residents with dementia, remind periodically to use the toilet)?

- Identify if resident triggers RAPs for urinary incontinence, and ADL functional/rehabilitation potential and the RAPs were used to assess causal factors for decline or potential for decline or lack of improvement.

If the resident's toilet use abilities have been maintained, what evidence is there that the resident could have improved if appropriate treatment and services were provided?

- Are there physical and psychosocial deficits that could affect improvement in functional abilities?

- Was the care plan driven by resident strengths identified in the comprehensive assessment?

- Was the care plan consistently implemented? What changes were made to treatment if the resident failed to progress or when initial rehabilitation goals were achieved, but additional progress seemed possible?

- Identify if resident triggers RAPs for mood state and psychosocial well-being.

EATING

§483.25(a)(1)(iv)

Interpretive Guidelines: §483.25(a)(1)(iv)

This corresponds to MDS sections E, L1 and MI; MDS 2.0, sections G and K when specified for use by the State.

"Eating" means how resident ingests and drinks (regardless of self-feeding skill).

Procedures: §483.25(a)(1)(iv)

Determine for each resident selected for a comprehensive review, or focused review, as appropriate, whether the resident's ability to eat or eating skills has improved, declined, or stayed the same and whether any deterioration or lack of improvement was avoidable or unavoidable.

If the resident's eating abilities have declined, is there any evidence that the decline was unavoidable?

1. What risk factors for decline of eating skills did the facility identify?

    a. A decrease in the ability to chew and swallow food

    b. Deficit in neurological and muscular status necessary for moving food onto a utensil and into the mouth

    c. Oral health status affecting eating ability

    d. Depression or confused mental state

2. What care did the resident receive to address risk factors and unique needs to maintain eating abilities?

    a. Assistive devices to improve resident's grasp or coordination;

    b. Seating arrangements to improve sociability;

    c. Seating in a calm, quiet setting for residents with dementia.

3. Is there sufficient staff time and assistance provided to maintain eating abilities (e.g., allowing residents enough time to eat independently or with limited assistance)?

4. Identify if resident triggers RAPs for ADL functional/rehabilitation potential, feeding tubes, and dehydration/fluid maintenance, and the RAPs were used to assess causal reasons for decline, potential for decline or lack of improvement.

5. Were individual objectives of the plan of care periodically evaluated, and if the objectives were not met, were alternative approaches developed to encourage maintaining eating abilities?

Probes: §483.25(a)(1)(iv)

If the resident's eating abilities have been maintained, what evidence is there that the resident could have improved if appropriate treatment and services were provided:

- Are there physical and psychosocial deficits that could affect improvement in functional abilities?

- Was the care plan driven by resident strengths identified in the comprehensive assessment?

- Was the care plan consistently implemented? What changes are made to treatment if the resident failed to progress or when initial rehabilitation goals were achieved, but additional progress seemed possible?

Interpretive Guidelines: §483.25(a)(1)(v)

This corresponds to MDS, section C; MDS 2.0 sections B and C when specified for use by the State.

"Speech, language or other functional communication systems" is defined as the ability to effectively communicate requests, needs, opinions, and urgent problems; to express emotion, to listen to others and to participate in social conversation whether in speech, writing, gesture or a combination of these (e.g., a communication board or electronic augmentative communication device).

USE OF SPEECH, LANGUAGE, OR OTHER FUNCTIONAL COMMUNCATION SYSTEMS

§483.25(a)(1)(v)

Procedures: §483.25(a)(1)(v)

Determine for each resident selected for a comprehensive review, or focused review, as appropriate, if resident's ability to communicate has declined, improved or stayed the same and whether any deterioration or lack of improvement was avoidable or unavoidable.

Identify if resident triggers RAPs for communication, psychosocial well-being, mood state, and visual function, and if the RAPs were used to assess causal factors for decline, potential for decline or lack of improvement.

Probes: §483.25(a)(1)(v)

If the resident's communication abilities have diminished, is there any evidence that the decline was unavoidable:

- What risk factors for decline of communication abilities did the facility identify and how did they address them (e.g., dysarthria, poor fitting dentures, few visitors, poor relationships with staff, Alzheimer's disease)?

- Has the resident received audiologic and vision evaluation? If not, did the resident refuse such services? (See also §483.10(b)(4).)

- What unique resident needs and risk factors did the facility identify (e.g., does the resident have specific difficulties in transmitting messages, comprehending messages, and/or using a variety of communication skills such as questions and commands; does the resident receive evaluation and training in the use of assistive devices to increase and/or maintain writing skills)?

- What care does the resident receive to improve communication abilities (e.g.,nurse aides communicate in writing with deaf residents or residents with severe hearing problems; practice exercises with residents receiving speech-language pathology services; increase number of resident's communication opportunities; non-verbal means of communication; review of the effect of medications on communication ability)?

- Is there sufficient staff time and assistance provided to maintain communication abilities?

- Were individual objectives of the plan of care periodically evaluated, and if the objectives were not met, were alternative approaches developed to encourage maintenance of communication abilities (e.g., if drill-oriented therapy is frustrating the resident, a less didactic approach should be attempted)?

Probes: §483.25(a)(1)(v)

If the resident's speech, language, and other communication abilities have been maintained, what evidence is there that the resident could have improved if appropriate treatment and services were provided:

- Are there physical and psychosocial deficits that could affect improvement in functional abilities?
- Was the care plan driven by resident strengths identified in the comprehensive assessment?
- Was the care plan consistently implemented?
- What changes were made to treatment if the resident failed to progress or when initial rehabilitation goals were achieved, but additional progress seemed possible?

F311

§483.25(a)(2)

(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and

Intent §483.25(a)(2)

The intent of this regulation is to stress that the facility is responsible for providing maintenance and restorative programs that will not only maintain, but improve, as indicated by the resident's comprehensive assessment to achieve and maintain the highest practicable outcome.

Procedures §483.25(a)(2)

Use the survey procedures and probes at §483.25(a)(1)(i) through (v) to assist in making this determination

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F312

§483.25(a)(3)

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

Intent: §483.25(a)(3)

The intent of this regulation is that the resident receives the care and services needed because he/she is unable to do their own ADL care independently.

22 CA ADC § 72527

Term

22 CCR s 72527

Cal. Admin. Code tit. 22, s 72527

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS
TITLE 22. SOCIAL SECURITY
DIVISION 5. LICENSING AND CERTIFICATION OF HEALTH FACILITIES, HOME HEALTH AGENCIES, CLINICS, AND REFERRAL AGENCIES
CHAPTER 3. SKILLED NURSING FACILITIES
ARTICLE 5. ADMINISTRATION
This database is current through 5/18/07, Register 2007, No. 20

s 72527. Patients' Rights.

(a) Patients have the rights enumerated in this section and the facility shall ensure that these rights are not violated. The facility shall establish and implement written policies and procedures which include these rights and shall make a copy of these policies available to the patient and to any representative of the patient. The policies shall be accessible to the public upon request. Patients shall have the right:

(1) To be fully informed, as evidenced by the patient's written acknowledgement prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct.

(2) To be fully informed, prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate or not covered under Titles XVIII or XIX of the Social Security Act.

(3) To be fully informed by a physician of his or her total health status and to be afforded the opportunity to participate on an immediate and ongoing basis in the total plan of care including the identification of medical, nursing and psychosocial needs and the planning of related services.

(4) To consent to or to refuse any treatment or procedure or participation in experimental research.

(5) To receive all information that is material to an individual patient's decision concerning whether to accept or refuse any proposed treatment or procedure. The disclosure of material information for administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability to regain use of a normal bodily function shall include the disclosure of information listed in Section 72528(b).

(6) To be transferred or discharged only for medical reasons, or the patient's welfare or that of other patients or for nonpayment for his or her stay and to be given reasonable advance notice to ensure orderly transfer or discharge. Such actions shall be documented in the patient's health record.

(7) To be encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end to voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal.

(8) To manage personal financial affairs, or to be given at least a quarterly accounting of financial transactions made on the patient's behalf should the facility accept written delegation of this responsibility subject to the provisions of Section 72529.

(9) To be free from mental and physical abuse.

(10) To be assured confidential treatment of financial and health records and to approve or refuse their release, except as authorized by law.

(11) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.

(12) Not to be required to perform services for the facility that are not included for therapeutic purposes in the patient's plan of care.

(13) To associate and communicate privately with persons of the patient's choice, and to send and receive personal mail unopened.

(14) To meet with others and participate in activities of social, religious and community groups.

(15) To retain and use personal clothing and possessions as space permits, unless to do so would infringe upon the health, safety or rights of the patient or other patients.

(16) If married, to be assured privacy for visits by the patient's spouse and if both are patients in the facility, to be permitted to share a room.

(17) To have daily visiting hours established.

(18) To have visits from members of the clergy at any time at the request of the patient or the patient's representative.

(19) To have visits from persons of the patient's choosing at any time if the patient is critically ill, unless medically contraindicated.

(20) To be allowed privacy for visits with family, friends, clergy, social workers or for professional or business purposes.

(21) To have reasonable access to telephones and to make and receive confidential calls.

(22) To be free from any requirement to purchase drugs or rent or purchase medical supplies or equipment from any particular source in accordance with the provisions of Section 1320 of the Health and Safety Code.

(23) To be free from psychotherapeutic drugs and physical restraints used for the purpose of patient discipline or staff convenience and to be free from psychotherapeutic drugs used as a chemical restraint as defined in Section 72018, except in an emergency which threatens to bring immediate injury to the patient or others. If a chemical restraint is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient and used only for a specified and limited period of time.

(24) Other rights as specified in Health and Safety Code, Section 1599.1.

(25) Other rights as specified in Welfare and Institutions Code, Sections 5325 and 5325.1, for persons admitted for psychiatric evaluations or treatment.

(26) Other rights as specified in Welfare and Institutions Code Sections 4502, 4503 and 4505 for patients who are developmentally disabled as defined in Section 4512 of the Welfare and Institutions Code.

(b) A patient's rights, as set forth above, may only be denied or limited if such denial or limitation is otherwise authorized by law. Reasons for denial or limitation of such rights shall be documented in the patient's health record.

(c) If a patient lacks the ability to understand these rights and the nature and consequences of proposed treatment, the patient's representative shall have the rights specified in this section to the extent the right may devolve to another, unless the representative's authority is otherwise limited. The patient's incapacity shall be determined by a court in accordance with state law or by the patient's physician unless the physician's determination is disputed by the patient or patient's representative.

(d) Persons who may act as the patient's representative include a conservator, as authorized by Parts 3 and 4 of Division 4 of the Probate Code (commencing with Section 1800), a person designated as attorney in fact in the patient's valid durable power of attorney for health care, patient's next of kin, other appropriate surrogate decisionmaker designated consistent with statutory and case law, a person appointed by a court authorizing treatment pursuant to Part 7 (commencing with Section 3200) of Division 4 of the Probate Code, or, if the patient is a minor, a person lawfully authorized to represent the minor.

(e) Patients' rights policies and procedures established under this section concerning consent, informed consent and refusal of treatments or procedures shall include, but not be limited to the following:

(1) How the facility will verify that informed consent was obtained or a treatment or procedure was refused pertaining to the administration of psychotherapeutic drugs or physical restraints or the prolonged use of a device that may lead to the inability of thepatient to regain the use of a normal bodily function.

(2) How the facility, in consultation with the patient's physician, will identify consistent with current statutory case law, who may serve as a patient's representative when an incapacitated patient has no conservator or attorney in fact under a valid Durable Power of Attorney for Health Care.

<General Materials (GM) - References, Annotations, or Tables>

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276, 1320, 1599, 1599.1, 1599.2 and 1599.3, Health and Safety Code; and Cobbs v. Grant (1972) 8 Cal.3d 229.

HISTORY

1. Amendment of subsections (a) and (b), repealer of subsection (c), and new subsections (c), (d), and (e) filed 5-27-92; operative 5-27-92 (Register 92, No. 22).

22 CCR s 72527, 22 CA ADC s 72527
1CAC

22 CA ADC s 72527

END OF DOCUMENT

Term

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22 CA ADC § 72528

Term

22 CCR s 72528

Cal. Admin. Code tit. 22, s 72528

BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS
TITLE 22. SOCIAL SECURITY
DIVISION 5. LICENSING AND CERTIFICATION OF HEALTH FACILITIES, HOME HEALTH AGENCIES, CLINICS, AND REFERRAL AGENCIES
CHAPTER 3. SKILLED NURSING FACILITIES
ARTICLE 5. ADMINISTRATION
This database is current through 5/18/07, Register 2007, No. 20

s 72528. Informed Consent Requirements.

(a) It is the responsibility of the attending physician to determine what information a reasonable person in the patient's condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure. Information that is commonly appreciated need not be disclosed. The disclosure of the material information and obtaining informed consent shall be the responsibility of the physician.

(b) The information material to a decision concerning the administration of a psychotherapeutic drug or physical restraint, or the prolonged use of a device that may lead to the inability of the patient to regain use of a normal bodily function shall include at least the following:

(1) The reason for the treatment and the nature and seriousness of the patient's illness.

(2) The nature of the procedures to be used in the proposed treatment including their probable frequency and duration.

(3) The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment.

(4) The nature, degree, duration and probability of the side effects and significant risks, commonly known by the health professions.

(5) The reasonable alternative treatments and risks, and why the health professional is recommending this particular treatment.

(6) That the patient has the right to accept or refuse the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time.

(c) Before initiating the administration of psychotherapeutic drugs, or physical restraints, or the prolonged use of 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. The facility shall also ensure that all decisions concerning the withdrawal or withholding of life sustaining treatment are documented in the patient's health record.

(d) This section shall not be construed to require obtaining informed consent each time a treatment or procedure is administered unless material circumstances or risks change.

(e) There shall be no violation for initiating treatment without informed consent if there is documentation within the patient's health record that an emergency exists where there is an unanticipated condition in which immediate action is necessary for preservation of life or the prevention of serious bodily harm to the patient or others or to alleviate severe physical pain, and it is impracticable to obtain the required consent, and provided that the action taken is within the customary practice of physicians of good standing in similar circumstances.

(f) Notwithstanding Sections 72527(a)(5) and 72528(b)(4), disclosure of the risks of a proposed treatment or procedure may be withheld if there is documentation of one of the following in the patient's health record:

(1) That the patient or patient's representative specifically requested that he or she not be informed of the risk of the recommended treatment or procedure. This request does not waive the requirement for providing the other material information concerning the treatment or procedure.

(2) That the physician relied upon objective facts, as documented in the health record, that would demonstrate to a reasonable person that the disclosure would have so seriously upset the patient that the patient would not have been able to rationally weigh the risks of refusing to undergo the recommended treatment and that, unless inappropriate, a patient's representative gave informed consent as set forth herein.

(g) A general consent provision in a contract for admission shall only encompass consent for routine nursing care or emergency care. Routine nursing care, as used in this section, means a treatment or procedure that does not require informed consent as specified in Section 72528(b)(1) through (6) or that is determined by the physician not to require the disclosure of information material to the individual patient. Routine nursing care includes, but is not limited to, care that does not require the order of a physician. This section does not preclude the use of informed consent forms for any specific treatment or procedure at the time of admission or at any other time. All consent provisions or forms shall indicate that the patient or incapacitated patient's representative may revoke his or her consent at any time.

(h) If a patient or his or her representative cannot communicate with the physician because of language or communication barriers, the facility shall arrange for an interpreter.

(1) An interpreter shall be someone who is fluent in both English and the language used by the patient and his or her legal representative, or who can communicate with a deaf person, if deafness is the communication barrier.

(2) When interpreters are used, documentation shall be placed in the patient's health record indicating the name of the person who acted as the interpreter and his or her relationship to the patient and to the facility.

<General Materials (GM) - References, Annotations, or Tables**>**

Note: Authority cited: Sections 208(a) and 1275, Health and Safety Code. Reference: Sections 1276 and 1599.72, Health and Safety Code; and Cobbs v. Grant (1972) 8 Cal.3d 229.

HISTORY

1. New section filed 5-27-92; operative 5-27-92 (Register 92, No. 22).

22 CCR s 72528, 22 **CA ADC s 72528**
1CAC

22 **CA ADC s 72528**

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Handouts

Topic: GOOD CARE PRACTICES PRECLUDE RESTRAINTS

GUIDE WITH VIDEO:
EVERYONE WINS! THE FAMILY GUIDE TO RESTRAINT FREE CARE

Before the Video

Hi! Welcome and thank you for joining us for this very important presentation about restraints.

I am _____ and I am your Ombudsman. I am an independent advocate for your family members while they are residents in (this nursing home).

Why am I here? As advocates, we are supporting a statewide effort to reduce or even eliminate restraints in nursing homes. Restraints are any object or device that restricts movement or the ability to get to a part of the body. Usually a specialty device is used. Examples include vest or jacket restraints, waist belts, geri-chairs, hand mitts, and lap pillows.

Did you fall when you were a child? When you were learning to walk, did you fall? Of course!

After you fell, did your parents carry you all the time or push you back down so you wouldn't fall again? No. Why?

It was important for you to learn to walk. Why? Because as people, we walk.

So, do we all need to be able to move freely? Yes, that's the ideal. Why?

Because:

- *that is the way we become independent*
- *taking risks helps us to increase our skills and capabilities*
- *that is the way we explore and learn about our world*
- *because movement allows our minds to wonder and experience new things*

I'm going to show you a short video about the importance of restraint reduction. Afterwards, we can talk about the video and what steps you can take to help keep your family member safe and restraint free.

After the Video

I know that some of you might feel the same way that Jack Chekhov originally felt about keeping his wife Emma in restraints. People have long believed restraints help protect family members from injury.

In reality, the video was completely truthful when it talked about how restraints often create more harm than good. Restraints aren't a guarantee against falls. They put people at risk for poor circulation, weak muscles, loss in appetite, bedsores, and

even death.
Out of restraints, residents can participate more in their community and have a better quality of life while they live here. This is their home now. (Distribute and discuss *Restraint Risks and Alternatives to Restraints* sheets).

Why am I here? As families and friends, every one of you wants the very best care for your loved one. The Ombudsman program is also committed to helping your loved ones have the best care possible and the highest quality of life. We believe that reducing restraints is an important part of achieving a better quality of life.

[Talk about the progress at this nursing home. Did the administration call you (the Ombudsman) in? Is the family council supporting this new initiative? Has staff been trained? Has the administration committed to reduce restraints? You will need to verify the answers to these questions with the facility.]

This is not a process that occurs over night. Like in Emma's case, each restraint reduction is done with careful progress and the participation of the family and friends is crucial in making it a success. You know your loved one the best and need to share with the staff what is working and what is not. Talk about habits, likes and dislikes, shifts in behaviors. Together, we can find alternatives. The video only briefly discussed alternatives such as the education of staff to behavior and personal needs, but other alternatives can involve equipment such as modified chairs, lower beds, bed and chair alarms, cushions and boosters. I have a handout you can use to help staff get to know your loved one. When staff know the individual resident, they can find answers for care (Distribute and discuss *Resident Information* sheet).

By working together we, the staff, the resident, family and friends, and the Ombudsman, we can all make sure the resident is safe.

We have many resources to help everyone in this process, or we can access what may be needed. So please ask. I would like to be of assistance. Do you have any questions?

Removal of restraints has been taking place for some time all over the country. Over and over we hear success stories and we are encouraged and excited to be a part of making life better for residents. Thank you so much for letting me share your time. Again, talk with me anytime. Here is my contact information. (Distribute *Restraint Reduction* sheet and business cards.)

CALIFORNIA DEPARTMENT OF AGING
OFFICE OF THE STATE LONG-TERM CARE OMBUDSMAN
1300 National Drive, Suite 200
Sacramento, California 95834
916-419-7510
www.aging.ca.gov

Based on materials developed by the Texas Office of the State Long-Term Care Ombudsman

THAT'S GREAT FOR OTHER FAMILIES BUT…

When a family considers the prospects of removing restraints, commonly held concerns and beliefs may arise. The following is clarifying information for each concern based on recent studies.

It is not safe to remove restraints.

Safety is important. Residents free of restraints are less likely to sustain a serious injury. Quality of life, choice, freedom from restraint and dignity are more important than perceived safety. The process of removing restraints includes looking at how residents can be kept safe and restraint free.

Serious injuries will increase.

Several studies have shown that restraint-free care does NOT increase the rate of serious injuries fractures, lacerations requiring stitches or visits to the emergency room. Indeed, many studies have shown that injuries decrease in both numbers and severity when restraints are removed.

My family member is too sick and too frail to remove restraints.

There are many options for residents of all ages and health conditions. When families and staff work together, they find ways to provide successful, safe restraint-free care for your loved ones.

Doctor/Facility recommends that we use restraints.

Although restraints are necessary in very few cases, there aren't many restrained residents who have a medically appropriate need for restraints. Don't be afraid to question the doctor's or facility's orders. It is important for family members to be active in the resident's care. If you make it clear that you are in full support of restraint-free care for your family member, you can discuss possible alternatives with the doctors and the facility staff.

There isn't enough staff to protect my family member without restraints.

Restraint-free care does not require extra staff. The ratio of care receivers to caregivers has no bearing on a facility's rate of restraint use.

My family member has never raised complaints about the restraints.

Often residents worry about raising concerns or complaints for fear of retaliation. Although it is crucial to talk with your loved ones about how they are feeling, silence about restraints doesn't mean consent or contentment with their current situation. Try to observe agitation, body posture, attitude toward life, and possible feelings of hopelessness or helplessness that often accompany residents in restraints.

I can't tell facility administration how to run their nursing home.

The most important thing is your loved one's care. Facilities are open to family members' suggestions to improve the quality of care for their residents. Care is always changing for residents because the resident is always changing. Flexibility and openness in care is crucial to good quality of care and life. The work of the nursing home staff, doctors, and administration relies on the input from family members and friends who know the resident the best.

Maybe the facility is too big (too small) to become restraint-free.

Large facilities may take longer to train staff, educate families and complete a restraint reduction project than smaller facilities.

The facility is in the city/country and that might make it harder for them to take off the restraints.

There are restraint-free facilities in rural, suburban and urban areas -- it makes no difference.

None of the other families with residents in the nursing home seem concerned about restraints.

Many families may not know about the current information on restraint reduction and in many cases, care is varied between residents. What is right for someone else doesn't translate to the best quality of life and care for your loved one. Don't let the status quo stop YOU from questioning practices or raising concerns.

How do we get started? Are the restraints just taken off in one day?

The most common alternative involves temporarily untying the older adult -- at mealtimes, when families and friends visit and when a staff person is close by. Other commonly used alternatives involve wheelchair cushions and adaptations, and individualized napping, toileting and exercise schedules. Be part of a team including staff and medical professionals to assess your loved one's status and alternatives. This isn't an overnight decision, but a gradual process to analyze and meet your needs and concerns on every level.

There is no one right alternative to restraint use, especially for those who are agitated, wander or fall repeatedly. There may be as many options as there are nursing home residents. The important thing is to be an active participant in your loved one's care.

OFFICE OF THE STATE LONG-TERM CARE OMBUDSMAN
CALIFORNIA DEPARTMENT OF AGING
1300 National Drive, Suite 200
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916-419-7510
www.aging.ca.gov

Based on materials developed by the Texas Office of the State Long-Term Care Ombudsman

RESIDENT INFORMATION

Ideally, this form is completed by the resident. If the resident cannot complete this form, it should be completed by the resident's family or close friends.

Resident's Name _____

1) By what name do you prefer to be addressed?

2) What language do you prefer to speak?

3) What was your occupation/job?

4) What family members and friends are important to you? What are their names?

5) What objects brought from home could have particular meaning? What could be brought that would provide comfort?

6) Do/did you have a pet? Pet's name? What kind is/was it?

7) What was a typical (daily) routine?

- Sleeping pattern: awaken, nap, bedtime? What hours?
- Meal times?
- Bath or shower? When?
- Did you spend time out-of-doors?
- Special hobbies, membership organizations
- Religious activities or other interests?

8) Favorite foods?

9) Food allergies/dislikes?

10) How will staff know when you have to use the bathroom?

11) How did you/do you handle stress? How did you react when you were asked to do something that you did not want to do?

12) What might cause agitation or anxiety?

13) What has a calming or reassuring effect on you?

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Restraint Risks

Individuals that are restrained are at risk of suffering a variety of results.

DEATH by

- Strangulation
- Suffocation
- Broken neck
- Pneumonia subsequent to chest compression and reduced air exchange due to any restraint that goes around chest
- Sepsis (severe illness caused by infection) infected lungs, skin abrasion, dehydration, urinary tract infection

PHYSIOLOGICAL

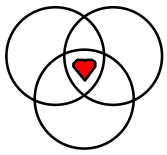
- Loss of muscle tone
- Pressure sores even in low risk individuals
- Decreased mobility – inability to stand, walk, turn, etc.
- Reduced bone mass from lack of pressure on long bones which leads to greater risk of breaks both pathogenic and subsequent to fall
- Stiffness
- Incontinence
- Dehydration
- Constipation / fecal impaction

PSYCHOLOGICAL

- Depression
- Agitation
- Frustration
- Loss of dignity
- Loss of self-esteem
- Loss of confidence
- Thoughts of suicide
- Increased boredom
- Increased feelings of loneliness
- Increased feelings of helplessness
- Feelings of confusion related to being punished
- Loss of willingness or drive to be involved in life

SOURCE: Diana Waugh, BSN, RN
Waugh Consulting, 419.351.7654

Care Practice
Work Place Practice
Environment



Change Ideas for Creating Pleasant Bathing

Typical issues & evidence of discordance:

- Resident displays anxiety, anguish, and combative behavior
- Injuries to both staff and resident

Barriers:

- Bathing is considered a private experience – why is this a barrier?
- The bathing experience is physically and emotionally cold
- Sterile, institutional, and functional environment

Goals:

- A positive, pleasant, individualized bathing experience, shifting from facility-directed to person-directed bathing and assistance with hygiene.
- To reduce injuries to residents and staff caused by the current facility-centered bathing routine

Infrastructure helpful to support the change:

- A team empowered to change practices. Team members include staff members who are directly affected by current bathing practices, with participation from residents and families.
- Adequate supplies for bed baths, showers (particularly enough linen)
- Adequate supplies and accessories for making bathing rooms more private, warm and comfortable
- Routines built around individualized bathing
- Adequate and consistent supply for warm water

Measurement possibilities:

- Number of residents screaming, calling out, vocally or nonverbally registering their disapproval
- Number of incident reports related to bathing, including possible injuries to residents and staff
- Number of bathing refusals
- Number of early identification of skin problems
- Number of residents who have individualized methods and schedules for bathing or assisting with hygiene.

Questions to consider:

- Would you take a bath here?
- How close is our bathing process to the process that you yourself use in your home?
- Is it functional or personal?
- What would be the benefits of changing the process?
- What would you change?

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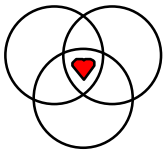

Change Ideas for Creating Pleasant Bathing

PDSA Cycle:

PLAN: Engage a team of interested and committed people including residents, staff and family members to make bathing a pleasant, less stressful and less traumatic event for all.
DO: A bathroom beautification/deinstitutionalization initiative based on data collected that tracked resident discomfort during bathing.
Check with direct care worker to see if there is enough linen available to keep people warm during bathing
Have maintenance fix fluctuations in water temperature and pressure in the showers
Provide ways to pad seats and support feet during showers
STUDY: The number of agitated residents and/or the number of incident reports related to bathing
ACT: Continue to evaluate and explore other potentially comforting change ideas.

Change Ideas:

- Ascertain that all residents receive interventions to help them feel warm and covered regardless of what method of bathing is utilized.
- Ascertain that direct caregivers and supervisors recognize that forced bathing is no longer acceptable and that resistance always triggers an assessment and intervention.
- Ascertain the residents former preferred behaviors, needs and schedule related to bathing.
- Ask the residents a series of questions about routines before moving to the nursing home or talking to family/friends of the resident.
- Does the resident need assistance with bathing? If not, resident can bathe on his/her own.
- Establish previous preference for bath or shower, time of day, leisurely activity (cup of coffee, relaxing music) vs. functional routine.
- Residents should be bathed in accordance with their response. A resident may enjoy bathing while enjoying drinking a cup of coffee or listening to their favorite type of music The bathing experience should be duplicated as closely as possible.
- Create an environment that contains distractions that are pleasant. Ask the residents what they would like to see in the bathroom. Resident responses may include plants, music and other pleasantries.
- Take strides to create a more familiar and friendly environment by asking the residents what their bathrooms were like at their own

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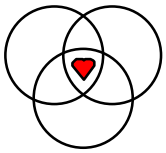

Change Ideas for Creating Pleasant Bathing

homes before moving into the nursing home.

- Consider personal items that can be used in the tub with residents to make the process more pleasant. Examples include bubble bath, bath salts and bath pillow.
- Consider warming lights to avoid residents being chilly when getting out of the tub or shower
- Consider what items could make the experience more comfortable, for example warm/soft/fluffy towel and caring conversation on favorite topics from a trusted, consistent caregiver.
- Provide as private an experience as possible by eliminating supplies and equipment storage in the shower area that will be needed by other staff.
- Provide a buffer curtain that will protect privacy.
- If at all possible, have only one person in the bathing area at a time
- Have consistent caregivers assist with bathing, minimizing the number of caregivers involved, to establish trust and knowledge about what works best.

Associated principles:

- **Primary**: Create systems within which individual preference is honored and defended
- **Secondary**: Commit to de-institutionalize, wherever possible, the current setting providing personal living accommodations, a sense of peace, safety and community

Resources:

1. Barrick, AL, Rader J, Hoeffer B, Sloane PD. Bathing Without a Battle: Personal Care of Individuals with Dementia. New York, New York: Springer Publishing Company. 2001.
2. Sloane, P. D., Hoeffer, B., Mitchell, C. M., McKenzie, D. A., Barrick, A. L., Rader, J., Stewart, B. J., Talerico, K. A., Rasin, J., Zink, R. C., Koch, G. G. (2004). Effect of person-centered showering and the towel bath on bathing-associated aggression, agitation and discomfort in nursing home residents with dementia: A randomized, controlled trial. *Journal of the American Geriatrics Society*, 52:1795-1804.

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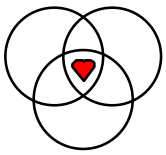
Care practice
Work Place Practice
Environment



Change Ideas for Sleeping and Waking

Typical issues and evidence of discordance:

Residents are awakened and put to bed according to the facility's schedule. To ease the burden on the in-coming day staff, the night shift awakens some residents. Sleeping residents are awakened during the night to take temperatures, give medications, monitor for incontinence, insert suppositories, or even to hydrate them. Some homes have gone so far as to have the night staff provide care such as clipping toenails. Sleep, for many residents, is compromised by bed alarms. Facility floors are cleaned and shined with noisy machinery during the night when hallways are clear.

Residents who are sleep deprived experience a range of typical effects of sleep deprivation: lethargy, loss of appetite, depression, anxiety, agitation, combative behavior, and other declines. Medications given in response to these effects, or to help residents sleep, often times exacerbate the situation.

Barriers:

The facility's care routines unwittingly deprive residents of deep restful sleep. These care routines are at the heart of the nursing home's culture. All work and assignments are organized around these routines. To change them will have an impact on the facility as a whole. The care routines continue because staff is not aware of the iatrogenic affects of sleep deprivation.

Goal:

To support residents' health and well-being by helping them have deep sleep through the night, by shifting from institutionally driven routines to routines that follow people's natural rhythms of sleeping and waking. Another goal is to support better relationships between residents and their caregivers by allowing caregivers to respect people's individual routines and set their care giving schedules around what works for each resident.

Infrastructure helpful to support the change:

Establish a work group with staff from all departments to identify and implement the changes needed in order for residents to return to their natural patterns for sleeping and waking. Adjust clinical care, staffing schedules, and routines for food service, housekeeping and maintenance to accommodate individual residents' needs and preferences related to sleeping and waking routines. Establish a system for learning about people's patterns as part of the welcoming in to the nursing home for new residents.

Measurement possibilities:

- Number of residents who sleep through the night.
- Number of residents who wake of their own accord.
- Pre and post data on agitated behavior; anxiety meds; bowel and bladder continence; UTI's; skin care; weight change; mobility; social engagement;

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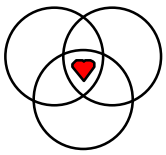

Change Ideas for Sleeping and Waking

staff-resident relationships; staff workload.

PDSA Cycles:

PLAN: Engage a committed group of people to consider, discuss and explore better sleep hygiene for residents based on residents obvious sleep deprivation and associated problems.
DO: Track the sleep of five resident volunteers who have minimal medical, hydration or treatment needs. These volunteers will be given the opportunity to awaken by their own natural body clock for two weeks.
STUDY: What time they awaken over the two weeks, mood, and appetite using simple tools. Determine if residents have a greater sense of rest and peace.
ACT: Consider a small group of people who have incontinence to initiate the next cycle. Explore how to maintain skin integrity while allowing for better sleep.

Questions to consider:

- Would you be comfortable sleeping here? With this bed and pillow?
- How can sleep be made comfortable?
- What could be improved in the following: lighting, noise, bed comfort, privacy, and clinical care to help with sleep?
- What is the importance of sleep hygiene for physical and mental well being?
- What negative outcomes are we causing by constantly interrupting the sleep of our residents?
- What are the medical consequences of sleep deprivation on health and well being?
- What evening activity and food do people who like to stay up want available?
- What are all the factors that must be considered from each department in order to make this change?
- Where could you start your change process?

Change Ideas:

- Ascertain the resident's preferred patterns, needs and schedule related to waking and sleeping.
- Take the time to allow the resident's own inner clock to be re-set. If a resident has been awakened every day at 5:30 for the past two years it will take a couple of weeks for the residents own internal clock to be re-set.
- Figure out with each resident what would be needed for comfortable sleep.
- Create an environment that is soothing and conducive to good sleep

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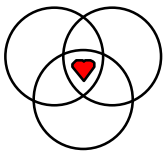

Change Ideas for Sleeping and Waking

hygiene. Think about lighting and noise. Bright hallway lights can be dimmed and floor cleaning can be completed during the day.

- Chart all the factors that interrupt each resident's sleep.
- Assess which clinical routines can be easily completed at another time. Start with the easiest situations to change and progress to the more clinically complex situations as you gain experience.
- Work with staffing patterns to adjust to the changes in workload.
- Explore ways to ensure skin integrity, continence, and other clinical needs without compromising sleep.
- Seek an interdisciplinary approach to residents' healthy sleeping, and to contribute to positive clinical outcomes. For example, instead of suppositories during the night shift, provide bran muffins, prunes, fluids, exercise opportunities throughout the day, and reduce medications that may cause constipation.

Resources:

1. Cruise PA, Schnelle JF, Alessi CA, Simmons SF, Ouslander JG. The nighttime environment and incontinence care practices in nursing homes. *J Am Geriatr Soc* 1998 Feb; 46 (2): 181-6.
2. Esser S, Wiles A, Taylor H, et al. The sleep of older people in hospital and nursing homes. *J Clin Nurs* 1999; 8: 360-8.
3. O'Rourke DJ, Klaasen KS, Sloan JA. Redesigning nighttime care for personal care residents. *J Gerontol Nurs* 2001 Jul; 27 (7): 30-7.

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Guidelines for Placing Mattress on Low Platform

Being restricted in bed by a tie-on restraint or siderail is a source of distress and agitation, yet many residents are at risk if they attempt to get out of bed on their own. Many lack the memory or judgment to call for assistance. A successful safety intervention is placing the person's mattress on a low platform (14-18 inches from the floor). This platform may be a Hollywood-style metal bed frame with a sheet of plywood cut to fit in the frame or a wooden futon frame to support the mattress from a regular bed. Metal frames can often be obtained at secondhand stores. Be sure to round off the corners of the plywood platform so that they do not extend and create a hazard. It costs approximately $30 to put the metal frame and plywood together; the cost of futon frames vary. Sometimes lowering the bed allows the resident better traction because the feet touch the floor. Sometimes the bed may need to be lowered so that he would not be at risk for a fall. Another reason to lower the bed is to shorten the distance if he rolls out of bed. If the floor is vinyl linoleum and the person's feet slide, a beveled-edge, rubber backed, low pile rug can be placed next to the bed to improve traction. This is also a useful intervention if the person is incontinent of urine because it ensures better footing. If the person is no longer able to stand but is at risk for rolling out of bed, in addition to lowering the bed you may "bring the floor up" and cushion the floor by placing a thick mat or foam egg crate mattress by the side of the bed. This can be slipped under the bed or rolled up out of the way when the person is not in bed.

Here are some useful questions to ask when considering lowering the bed:

1. Have all possible reasons why the person is at risk for falls been evaluated (medication, illness)?
2. Would the bed create other risks if positioned low (e.g., following hip surgery flexion greater than 90^0)?
3. Have all the other ways to minimize risk that could be used in place of or in addition to placing the bed lower been considered, e.g., would the use of a position-change alarm increase the safety margin? This may be useful even when the bed is on a low platform.
4. Are there any additional interventions necessary to increase the resident's comfort and safety (e.g., rug or mat next to bed)?
5. Is the person's weight, weight-bearing status, and care needs such that a low bed will not place an undue burden on the caregivers?
6. Is any in-service required so that caregivers will be aware of how to care for and transfer the person in the safest way possible?
7. Have the person and family been consulted and have they agreed to this safety-intervention?
8. Has the assessment and intervention selection process been documented in the chart?

9. Are there other safety factors to consider in the room with the bed on the floor (e.g., need to put safety plugs in outlets or need to move bedside stand to prevent patient from pulling up on it)?

If these questions have been addressed and the assessment indicates that the person would benefit from placing the bed nearer the floor, lower the bed. Generally, caregivers have found that it is easier to utilize a low bed when it is on wheels.

Caution: this intervention may not be appropriate for people if they are very heavy, require frequent, complex care in bed, and/or are able to bear weight. Persons with some or all these characteristics may pose too great a risk of caregiver injury. This possibility would need to be included in the assessment process.

Caregivers are often very clever and creative and can find ways to care for people in low beds that are safe and convenient for them. For example, they might get the person up in a wheelchair and wash them at the sink rather than doing so in the low bed.

For the few people for whom the low bed is not appropriate, because of their weight or heavy care needs, there are high-low beds that have the capacity to be lowered for safety and raised when care is given.

Here are some useful questions to ask when considering lowering the bed:

10. Have all possible reasons why the person is at risk for falls been evaluated (medication, illness)?
11. Would the bed create other risks if positioned low (e.g., following hip surgery flexion greater than 90^0)?
12. Have all the other ways to minimize risk that could be used in place of or in addition to placing the bed lower been considered, e.g., would the use of a position-change alarm increase the safety margin? This may be useful even when the bed is on a low platform.
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From: Individualized Wheelchair Seating: For Older Adults, Part I: A Guide for Caregivers, Joanne Rader, RN, MN, FAAN; Debbie Jones, PT and Lois Miller, RN PhD. Shared with Quality Partner of Rhode Island.

The following 8 slides have been excerpted from:

“Individualized Care: Wheelchair Seating as a Road to Restraint-Free Care”

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

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

www.fda.gov/cdrh/beds/

- For reporting:
- 1-800-FDA-1088

Getting Funding for wheelchairs

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

Sometimes restraint free care is not “pretty”

Body pillow

INDIVIDUALIZED WHEELCHAIR SEATING: FOR OLDER ADULTS

Part I: A Guide for Caregivers

Joanne Rader, RN, MN, FAAN
Debbie Jones, PT
and
Lois Miller, RN, PhD

Benedictine Institute for Long Term Care
980 S. Main St.
Mt. Angel, OR 97362

This material was designed by Joanne Rader, RN, MSN, Debbie Jones, PT and Lois Miller, RN, PhD, 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

INDIVIDUALIZED SEATING WORKS

How people sit is fundamental to their health. The standard sling seat, sling-back, collapsible wheelchair was designed to transport people short distances, for short amounts of time, to assist the person pushing the chair, and to make storage easy. The chair works for the caregiver, but very poorly for the person in it, particularly if it is used for long periods of time and as the primary seating system for the individual. When frail elders are properly seated in chairs designed to meet their particular needs, improvements can occur in:

- Posture
- Comfort and wheelchair tolerance
- Skin condition
- Ability to care for self
- Efficient use of limited energy and endurance
- Socialization
- Quality of life
- Caregiver burden

Improved Posture

Improving posture can enhance a number of functions in the elderly; however, as a result of illness or orthopedic changes many elders have postures that cannot be corrected and can only be supported. The first step in achieving proper seating is a seating assessment. A seating assessment by a physical or occupational therapist is required to determine if the person needs accommodation of fixed posture and/or support of flexible posture. The assessment should include a physical evaluation, in which the person is transferred out of the chair or wheelchair and onto a mat or hard surface. This allows the therapist to evaluate the person both lying down and in a seated position for fixed joints, spasticity, pain, and skin problems.

With better positioning and/or support through proper seating, physiologic functions such as breathing, swallowing, digestion and elimination are improved. Respiratory function improves in several ways. The chest cavity more easily expands if the person is not slumped forward. Many frail elders have a delayed swallow that places them at risk for choking or aspirating (taking food or fluid into the lungs). It is essential that the person sit upright for meals so that food and particularly liquids can be better controlled and to aid the normal gravitational flow into stomach. Needless to say, if a person is constantly choking, food may often be refused. The ability to move the bolus of food in the mouth may be improved if the person with a normal swallow and kyphotic or curved back (resulting in a forward head and neck position) is properly supported and positioned so that gravity can assist in getting the food to the back of the mouth. Also, elongating the abdominal region through proper positioning allows food to

move more easily through the digestive tract and better utilize gravity to facilitate digestion and elimination.

Good positioning can also improve eye gaze, that is, the visual field created by the position of one's head. If older persons have stooped posture, the eyes naturally fall lower, sometimes to the floor, requiring a considerable effort to raise the eyes or head to see what is in front of them. Even if the posture is fixed, as with a kyphotic or curved spine, improvements can occur. For example, positioning the wheelchair at even a 15 degree recline may bring the eye gaze level, making it easier for the person to attend to what is going on around him and socialize (see Chapter 2).

Improved Comfort and Wheelchair Tolerance

Comfort is an important concern of frail elders. Comfort is achieved or improved through proper support and positioning. Wheelchair tolerance or the amount of time the person feels able to be up in the chair can be used as a practical indicator of comfort. That is, comfort is directly related to wheelchair tolerance. If the person is uncomfortable in the wheelchair or gerichair, he will often ask to go to bed sooner and refuse to become more involved in activities.

Older adults experience more pain than younger people, for many reasons. They often suffer from arthritis or other chronic illnesses that have pain associated with them. Often pain is unidentified or under treated in the frail elderly. Many frail elders have diagnosed or undiagnosed spinal fractures that can be a source of pain. Often with proper positioning and support, this type of pain can be dramatically reduced.

Persons with dementia may not have the verbal or cognitive ability to express their pain in words or even respond appropriately when asked if they are in pain. However, their behavior is often a good indicator of pain. One nurse clinician working in a large Midwest teaching hospital found that out of 18 nursing home residents referred to an outpatient clinic, inpatient medical unit or inpatient psychiatric unit for screaming/yelling behaviors, 15 had undiagnosed or unstable fractures (Geri Hall, personal communications, August 8, 1997).

Prevention of Skin Breakdown

Proper cushions and support prevent skin and tissue breakdown by more evenly distributing pressure, thus allowing the individual to be up for longer periods without causing damage. Some fabric cushion covers wick away moisture/fluid from the skin. Heat may also contribute to skin breakdown, and some cushion materials (air, fluid) are cooler than foam (see Chapter 6).

Improved Ability to Care for Self

A properly fitted wheelchair can improve the person's ability to care for himself in many ways. For example, correct arm rest length and height allow the chair to get under the table so that at meals the person can be close enough to reach the food and feed himself. It gives the person a level eye gaze so he can see in the mirror for grooming. Further, with the proper chair many people can wheel themselves from place to place.

Better Use of Limited Energy and Endurance

Frail elders often have limited stamina, endurance and energy. When one is not positioned properly, energy is required simply to remain upright. When properly equipped, the ability to self propel is enhanced and requires less expenditure of energy. The standard wheelchair weighs between 40-50 pounds, a lightweight chair weighs 24-28 pounds, and an ultralight chair can weigh even less (18-21 pounds). Choosing a lighter weight chair can save energy for use with other activities. Having the seat low enough so that the person who ambulates with his feet can get a good heel strike (connection of the foot to the floor) also improves efficiency. Providing a chair with the proper width so that the person can easily access the hand rims on the wheels is another way to better conserve limited energy. Being comfortably seated and positioned for eating may mean that the person will eat more because he is not too fatigued to finish the meal. With proper support, the person can relax and focus on other activities such as eating or conversing.

Improved Socialization

Improved socialization can result from a combination of the factors already mentioned such as level eye gaze, the ability to move oneself in and out of social situations, and increased comfort. Improved socialization may also be related to eliminating restraints. Individuals often find restraints uncomfortable, humiliating and degrading, causing them to shrink from social situations.

Improved Quality of Life

It goes without saying that if a person is more comfortable, more independent, and has better physiologic function, that person will have improved quality of life and self-esteem.

Easing of Caregiver Burden

When properly seated, frail elders may be easier to transfer, or able to transfer themselves, and able to feed or toilet themselves; they may require less repositioning (creating less back and shoulder stress for the caregiver), tolerate

being up for longer periods, and have fewer behavioral problems. All these ease the caregiver's burden.

CASE EXAMPLES OF BENEFITS OF PROPER SEATING

The following case examples illustrate many of the benefits of proper seating.

Case 1 – Marguerite Parker

Ninety-seven year old Marguerite Parker was in the typical wheelchair with a sling back and a sling seat with an inexpensive foam cushion. Her thighs were rolled inward and her pelvis was in a posterior pelvic tilt, which made her trunk collapse and her movements limited, affecting her breathing and circulation. Consequently, Mrs. Parker suffered from considerable back pain, making her irritable, as manifested by crying, angry outbursts and refusing all activities. A physical therapist conducted an evaluation, including a physical assessment on the mat to assess her needs. She discovered that Marguerite had:

- A fixed posterior pelvic tilt or forward thrust of pelvis;
- Hip range of motion limited to 90 degrees;
- Shortened hamstring muscles;
- A fixed thoracic, kyphotic spine causing her head to be positioned forward

The therapist recommended a smaller, lightweight chair and a solid, contoured back and seat system. Putting Mrs. Parker in a wheelchair with smaller diameter (20-inch) wheels provided her with enough range of motion to bring her elbows back far enough to have full excursion on the wheel so she could more easily propel her wheelchair. The stability and contoured support that Mrs. Parker received from the new seating system also protected her skin with better distribution of pressure. Finally, the system stabilized her pelvis, allowing elongation of her trunk and resulting in better upright sitting, energy conservation and comfort.

The overall results were dramatic. Before, because of her pain, Mrs. Parker had been very withdrawn, not talking to people or attending activities. Following the improvements in her seating, she became clearer cognitively and moved easily through the facility talking to others. She was more comfortable, aware and pleasant. Her son was amazed and pleased with the differences. Mrs. Parker lived another four years, continuing to use her individualized wheelchair and maintaining her improved comfort and mobility (Pitts, 1995).

Case 2 – Art Solum

Art Solum, 75, had been residing in a nursing home for several years due to progressive gait instability and dementia. He was placed in a gerichair with a soft, tie-on restraint because he was sliding out of his facility-issued wheelchair,

even with a restraint. He continued to sit in this gerichair for two years. Like many gerichair users, during this time Mr. Solum's ability to perform daily care activities slowly declined, until he was totally fed and groomed by others. In addition, his wife and staff members had difficulty pushing and maneuvering the gerichair because it was designed mainly for lounging, not mobility. Because of the difficulty of maneuvering the chair, as well as his low interest, Mr. Solum rarely participated in facility activities.

The nursing staff were also concerned that his position in the chair posed a risk of aspiration during mealtime; and further, his transfers were becoming more difficult. At the time, the facility was working on eliminating the use of restraints and Mr. Solum had two devices in place that restricted his mobility: the recliner and a tie-on waist restraint.

The facility's rehab team, including an occupational therapist, a physical therapist, and a speech pathologist, identified Mr. Solum as a candidate for restraint elimination and improved posture through proper wheelchair seating. During the observation process, the team noted that Mr. Solum spent most of his time lying in the gerichair outside his room. He had ample room to move in the gerichair because of his small body size, and he was frequently found lying at an angle and sliding down in the chair. The mat assessment revealed:

- A slight posterior tilt;
- Mild thoracic kyphosis;
- Bilateral hip range of motion limited to 90 degrees of flexion;
- Fair trunk balance

Mr. Solum's knees were a little stiff but within normal limits for sitting, and his ankles were extended in slight plantar flexion with foot drop. His skin did not appear to have any redness or blanching and he had no previous history of skin breakdown.

Therefore, the initial equipment recommendation was a solid seat with contours to support and protect his pelvis and a solid contoured back that could recline slightly to accommodate his limited hip flexion, posterior pelvic tilt and thoracic kyphosis. The seat cushion needed enough length and padding to firmly support his thighs. He also needed the proper footrest height to secure his position in the wheelchair. Due to his slight frame, a 16-inch-wide wheelchair was also recommended.

Mr. Solum had only Medicare coverage and was not eligible for wheelchair and seating equipment through Medicaid because he was living in a nursing home. However, the facility had recently received a 16-inch-wide lightweight chair as a donation and the administration agreed to let him have the chair if it would improve his situation. In addition, the team selected a cushion and back to implement the recommendations from the assessment.

The results were again dramatic. With a few minor adjustments to the seat-to-back angle, foot rests and arm rests, Mr. Solum was able to sit upright in the wheelchair without sliding. At this point, the speech pathologist wanted to see if he could manage eating an ice cream sandwich. He not only opened the wrapper by himself but also was able to take a bite and swallow appropriately. When the occupational therapist wheeled him to the sink in his room, he washed his hands with little prompting. Although Mr. Solum still required assistance with his transfer, they were accomplished more easily from his upright seated position than from the gerichair. With his upright sitting posture in the wheelchair, he seemed more approachable and experienced more social interaction with other residents and staff members.

Mr. Solum's improved upright posture also led the restorative staff to begin a strengthening program with the goal of self-mobilization and increased strength for self-care. As he became stronger, the nursing staff recommended that the physical therapist see him for transfer training and possible gait training. He was fitted with an ankle-foot brace and could ambulate with assistance in the parallel bars. He continued a weightlifting and walking program. He managed his meals independently with some assistance in cutting up meat and opening packages. The staff and his wife found it easier to push the lightweight wheelchair than the gerichair (Jones, 1995). Mr. Solum was even able to enjoy a fishing trip to a local trout pond with the activities department.

The people in these two cases are representative of those who can benefit from individualized seating. There are many persons in care facilities and in the community with the same types of problems who could experience similar improvements. As caregivers, it is our job to identify who these people are and being the process of improving their lives through better seating.

In the last 10 years, there have been dramatic improvements in the types and costs of products available to meet needs for better seating. Chapter 4 discusses how some of the newer devices are more effective than the older ones. The fact is our population is aging and a market is developing for better seating.

Physical Restraints: Essential Systems for Quality Care

The following information suggests areas to focus on while evaluating facility processes for reducing physical restraint use.

Systems to Review	Key Interventions to Reduce Physical Restraint Use
Organizational Commitment	▪ Establish a facility wide commitment to developing and maintaining a restraint free environment. ▪ Identify key staff members to form an interdisciplinary restraint elimination team. ▪ Implement a no-restraint policy. ▪ Analyze current clinical practices such as screening, assessing, use of restraints, documentation and interventions. ▪ Educate staff, family and residents on the dangers of physical restraints and how to implement less restrictive alternatives. ▪ Assess and treat underlying conditions precipitating the use of physical restraints. ▪ Consider environmental modifications to promote safety and decrease use of restraints. ▪ Celebrate restraint reduction/elimination success stories, reward caregivers and family member for positive attitudes and assistance in creating a restraint-free environment. ▪ Provide appropriate resources such as adequate staffing, continuing education, strong communication systems, standardized tools, environmental modifications and necessary equipment. ▪ Evaluate the outcome of restraint elimination programs and revise as needed.

Assessment	• Develop systems for interdisciplinary team members to perform basic assessments, including medical history review and physical examination, to rule out acute illness for residents currently using restraint devices, being considered for devices, or had incident or event requiring assessment for restraint or newly admitted residents.
	• Involve the resident and family/caregivers if available and if resident wants family to be involved.
	• Obtain information from resident, family, or caregivers regarding the resident's previous life experiences, interests, social patterns in order to provide an individualized approach to restraint-free care.
	• Analyze the context or circumstances surrounding the precipitating events to determine the meaning of the behavior.
	• Assess and treat underlying medical conditions precipitating the use of physical restraints:
	  • Gait: stability, clothing size, strength, range of motion, balance, hearing/vision, shoes, assistive devices, fractures/precautions, and fall risk assessment.
	  • Medications: dosage, multiple medications, side effects, medications increasing potential for falls, frequent toileting for residents on diuretics, pain medications, or sedatives causing fatigue/drowsiness.
	  • Cardiovascular: elastic stockings, oxygen saturation, blood pressure, heart rate, and energy conservation.
	  • Infections: urinary tract infections, fever, or upper respiratory infections.
	  • Dehydration: bowel sounds, impaction/constipation, change in mental status, and skin turgor.
	  • Pain: location, intensity, medications, onset, duration, and ability to express.
	  • Sleep: patterns, routines, caffeine intake, noise level, napping, medications, and exercise levels.
	  • Cognition: depression, hallucinations, delirium, aggressive behaviors, psychoactive medications, dementia, confusion, wandering, orientation, and response to verbal cues.
	  ▪ Environment: call light location, roommate situation, adequate lighting, access to bathroom, water at bedside

Physical Restraints: Essential Components for Quality Care

The following information suggests five areas to focus on while evaluating current facility interventions for Physical Restraints.

Systems to Review	Key Interventions to Facilitate Physical Restraint Elimination
Assessment (cont.)	table, noise levels, clutter, bedrails, furniture and access to T.V. / remote control. ▪ If a restraint must be used, document all other possible interventions that have been attempted, resident's response and if the intervention succeeded or failed and why. ▪ Reassess residents with physical restraints as needed (at least monthly) until the resident is achieving the highest level of functioning in the least restrictive environment. ▪ Document clinical findings, including: medical necessity, tests, response to activity, safety awareness, education, family/caregiver involvement, plan of care, interventions, frequency/duration and referrals.
Care Planning	• If a restraint needs to be used as a last resort, include on the care plan the reason, type, location, in what circumstances the device is implemented, what period of time/situation device is used for the resident. • Develop individualized interventions and goals related to providing the highest functional status and least restrictive environment. • Include approaches for restraint elimination, prevention of complications (i.e. contractures, skin breakdown and incontinence). • Document the person(s) responsible for implementing and achieving the goal on the care plan. ▪ Update and revise the plan of care as required. ▪ Ensure the relevant disciplines involved in facilitation of the care plan have documented the interventions that have been attempted and the results. ▪ Involve the resident and family in development of the care plan at the discretion of the resident.
Training & Education	▪ Develop orientation and ongoing in-service programs for staff, families and residents that address types of physical restraints, goals of restraint elimination, adverse effects and regulations regarding use. • Provide documentation that reflects staff training and understanding of roles and responsibilities of restraint elimination programs. • Educate employees on referring a resident to the restraint team if restraints are being considered. • If a restraint must be used for a limited time period, include education regarding restraint application, when it should be released, obtaining appropriate physician's orders, and documenting resident and/or legal guardian consent. • Educate the resident and family regarding predicted course of illness, current conditions, and interventions. • Develop philosophy of restraint-free care and provide educational programs on how to achieve a restraint-free environment.

Physical Restraints: Essential Components for Quality Care

The following information suggests five areas to focus on while evaluating current facility interventions for Physical Restraints.

Systems to Review	Key Interventions to Facilitate Physical Restraint Elimination
Restraint Elimination	▪ Implement a system for tracking and identifying residents appropriate for assessment or reassessment by the interdisciplinary restraint team. ▪ Identify what type of restraint is used, during what time of the day, where the resident is restrained, for how long, under what circumstance and who implemented the restraint. ▪ Determine reason and precipitating factors for restraint application. Potential reasons: risk of falls, behavioral symptoms, inability to treat a medical condition. ▪ Assess and treat underlying conditions (see Assessment section). ▪ Evaluate effectiveness of interventions and resident's response. ▪ Reassess for elimination or least restrictive alternative devices. ▪ Provide continual reassessment and revisions to plan of care until the restraint is safely eliminated.

Restraint Reduction Resource List

Guides on Restraint Reduction

Burger, Sarah G. et al, *Nursing Homes Getting Good Care* There, 2d Edition, NCCNHR, 2002.

Burger, Sarah G., *Avoiding Physical Restraint Use: New Standards in Care, A Guide for Residents, Families, Friends, and Caregivers*. NCCNHR, 1993.

Everyone Wins! Quality Care Without Restraints
The Resident Care Library: Six 12-14 minute videos, an in-service training manual, plus handouts. The six units are: 1) The New Resident, 2) Up and About: Minimizing the Risk of Fall Injuries, 3) Working With Residents Who Wander, 4) Getting Hit, Grabbed, and Threatened: What it Means, What to do, 5) Staying Restraint-free Evenings, Nights, and Weekends, and 6) Now That the Restraints Are Off, What Do We Do?
The Management Perspective: A 16-minute video with viewing and resource guide; the topics include: Why Opt for Restraint-Free Care?, Setting the Stage, and Keeping it Going.
The Family Guide to Restraint-free Care: A 12-minute video plus a pamphlet for families. The video features a man who resisted when the nursing home approached him about removing his wife's restraint and the way everyone worked together to eliminate her restraint safely.
Available at the *Untie the Elderly* website: www.ute.kendal.org.

Everyone Wins! A Family Guide to Restraint-Free Care
A documentary that follows a husband who needed significant support before he could accept restraint-free care for his wife. Available at the *Kendal Outreach* website: http://kendaloutreach.org/.

Fall Management Guidelines. Health Care Association of New Jersey (HCANJ), Best Practice Committee. Adopted 9/2003, Revised 2/2005. Available online at: http://www.tmf.org/nursinghomes/restraint/Falls%20Management.pdf

NCCNHR Consumer Fact Sheets, free at the NCCNHR website: www.nccnhr.org. Physical Restraint Free Care Fact Sheet to be available June 2007.

"*Nursing Counts: Delirium, Depression Often Overlooked,"* John A. Hartford Institute for Geriatric Nursing, NYU at: www.Hartfordign.org**.**

Rader, Joanne et al., *Bathing Without a Battle: Personal Care of Individuals with Dementia*, Springer Publishing, 2002.

Rader, Joanne, *Individualized Dementia Care: Creative, Compassionate Approaches*, Springer Publishing, 1995.

Untie the Elderly Film Series:
Philosophy of care, the change process, and Environmental and Program Alternatives to Care. Go to the UTE website: www.ute.kendal.org

Untie the Elderly Newsletter provides ongoing information on restraint reduction. Go to the website: www.ute.kendal.org.

QIO Websites

Colorado Foundation for Medical Care
http://www.cfmc.org/nh/nh_restraints.htm
Colorado Foundation for Medical Care, in collaboration with AANAC, provides excellent assessment and alternatives materials. One page decision trees for wandering, falls, behavior symptoms, and emergency care.

Quality Improvement Organization Websites
http://www.tmf.org/nursinghomes/restraint/indes.htm
A very complete and simple program from start to finish. Information available for the whole interdisciplinary team as well as families and ombudsman. It assumes restraint free nursing homes are the goal!

Quality Partners of Rhode Island
http://www.riqualitypartners.org
Click on "nursing homes," then "organizational culture," then "module 4," and finally "restraints." This website has all Joanne Rader's slides on it. She did the California physical restraint training for CA in 2007 in seven sites across the state. They can be copied and used. It is very complete training program used by QIOs. This is also the site for the Advancing Excellence in America's Nursing Homes Campaign, including restraint and consistent assignment information.

Other Websites

The American Geriatrics Society
http://www.americangeriatrics.org/
The American Geriatrics Society with British Geriatrics Society and American Academy of Orthopedic Surgeons Panel on Falls Prevention. Guideline for the prevention of falls in older persons. Also published in the JAGS 49(5): 664-72, 2001, May.

American Medical Directors Association
http://www.amda.com/

Using an interdisciplinary process, the American Medical Directors Association developed process guidelines for treatment of depression in nursing home residents. Also includes guidelines for chronic pain management. Undiagnosed chronic and acute pain in demented people often leads to behavioral symptoms, which are then treated with an inappropriate psychoactive drug rather than a medication to control pain. The Agency for Health care Research and Quality (AHRQ) has these guidelines.

Center for Gerontology and Health Care Research at the Brown Medical School
http://www.chcr.brown.edu/dying/severepain.htm
Brown University study on untreated pain in nursing home residents.

Hartford Institute for Geriatric Nursing
http://www.hartfordign.org
Includes Nursing Counts series. Also has Beers medication and the elderly criteria in the clinical section of the geriatric nursing self instructional course.

The Pioneer Network
http://www.pioneernetwork.org
Creating an environment for residents that has stable staff is key to good care. The vision to do this and the accompanying approach to individualized care are keys to restraint elimination. In fact, the pioneer network grew out of the restraint reduction movement.

Untie the Elderly
http://www.ute.kendal.org
The best ongoing information about reduction of physical restraints in nursing homes. Jill Blakeslee and Beryl Goldman helped to transform this county's thinking about restraint use. While Jill unfortunately has died, her good work continues in Beryl's capable hands. Visit the website or email them at info@ute.kendal.org. In addition to having resources such as films available, there are questions and answers, resources and other help available. Download the FDA bedrail guidance from the Hospital Bed Safety Workgroup (HBSW) at this site. Order the HBSW film on bed safety entitled, "Do No Harm."

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality
http://www.ahrq.gov
University of California at San Francisco-Stanford University Evidence-based Practice Center Subchapter 26.2. Interventions that Decrease the Use of Physical Restraints of the Evidence Report/technology Assessment, No. 43 entitled "Making Health Care Safer: A Critical analysis of Patient Safety Practices." The full report can be accessed at http://www.ahrq.gov/qual/errorsix.htm.

U.S. Department of Health and Human Services, Office of Inspector General
http://www.oig.hhs.gov
OIG nursing home reports. Many good ones on staffing, which is directly related to restraint reduction.

U.S. Food and Drug Administration
http://www.fda.gov
Download the Guidance from the Hospital Bed Safety Workgroup. This guidance details the risks, evidence, how to assess for a safe bed environment, provides a decision tree, and makes recommendations about using low beds and safety mats. Also download the consumer information flyer on bedrails. Report bedrail deaths at 1-800-FDA-1088.

Physical Restraints: Annotated Guidelines

Guideline				
Guideline	*Overview*	*Source*	*Address*	*Cost*
Restraints 1996 and updated 1997. 83 pages. As of July 2002 a revision is in progress.	This physical and chemical restraint protocol includes an initial section with definitions, information on patient risk factors for restraint use, assessment for restraint use with a decision tree, protocols, interventions, and outcomes of restraint use. This protocol features appendices containing assessment and documentation tools, a restraint knowledge test, outcome monitoring forms, process evaluation monitoring forms, and a model consent form. A section is dedicated to reducing restraints; among the topics covered are strategies for the care of persons at risk of falling, persons with agitated/restless behavior and persons who wander. Includes a laminated "Restraint Use Algorithm". The final section is a "Quick Reference Guide".	University of Iowa Gerontological Nursing Intervention Research Center.	University of Iowa, College of Nursing Research Dissemination Core 4118 Westlawn Iowa City, IA 52242 (319) 384-4429 http://www.nursing.uiowa.edu/gnirc	$9.00. These materials are copyrighted and permission must be obtained to duplicate. (A permission form accompanies the protocols)
Guidelines for Restraint Use. Last updated January 1, 1997. 3 pages.	A succinct guideline containing an introduction, background information emphasizing regulations, and guidelines for restraint use. Includes references.	American Geriatrics Society	American Geriatrics Society The Empire State Building 350 Fifth Avenue, Suite 801 New York, NY 10118 (212) 308-1414 http://www.americangeriatrics.org/products/positionpapers/restrain.shtml	Available online
Untie the Elderly, The Kendal Corporation: Steps to Restraint Reduction. December 1996; rev. 3/99.	Among the topics covered are letters to staff and residents/families/physicians with suggestions for content, and advice for selecting Restraint Reduction Committee members. Tasks of the Restraint Reduction Committee and the Committee process are outlined.	The Kendal Corporation	The Kendal Corporation P.O. Box 100 Kennett Square, PA 19348-0100 (610) 388-5580 www.ute.kendal.org/index6.htm	Available online

Literature	
Literature	*Synopsis*
Risks Associated with Physical Restraint Use	
Capezuti E, Evans L, Strumpf NE, Maislin G. Physical Restraint Use and Falls in Nursing Home Residents. *Journal of the American Geriatrics Society* . 1996;44:627-633.	The relationship between restraint use and falls was examined while controlling for the effect of psychoactive drug use among nursing home residents. There was no evidence that the effect of restraint use on fall risk depended upon the use of psychoactive drugs. Restraints were not associated with a significantly lower risk of falls or injuries in subgroups of residents likely to be restrained. These findings support individualized assessment of fall risk rather than routine use of physical restraints for fall prevention.
Miles SH, Irvine P. Deaths Caused by Physical Restraints. *Journal of the American Geriatrics Society* . 1997; July; 45 (7): 797-802.	This article provides information on 74 deaths identified from "files of the United Consumer Product Safety Commission Death Certificate File and its Reported Incidents File and its National Injury Information Clearinghouse Accident Investigations." The authors point out that "bedrails are an unvalidated treatment" and the article contains graphic depictions of how bedrails can cause deaths. Clinical and design recommendations to prevent bedrail-related deaths are provided.
Tinetti ME, Liu WL, Ginter SF. Mechanical Restraint Use and Fall-Related Injuries Among Residents of Skilled Nursing Facilities. *Annals of Internal Medicine* . 1992;116(5):369-74.	These researchers performed a prospective observational cohort study involving 12 skilled nursing facilities and 397 nursing home residents. "Mechanical restraints were associated with continued, and perhaps increased, occurrence of serious fall-related injuries after controlling for other injury risk factors."
Williams CC, Finch CE. Physical Restraints: Not Fit for Woman, Man, or Beast. *Journal of the American Geriatrics Society* . 1997;45:773-775.	This article describes the conclusion found in both researching human and animals: "physical restraint places highly destructive, measurable stress on people and animals". The undesirable psychological and physical effects of stress are described. The author suggests three factors contributing to the continued use of physical restraints: the failure to appreciate the dangers and destructiveness of stress associated with restraint use; lack of comprehension of the paradigm shift necessary for restraint-free care; and failure of nursing home leadership at the facility level.

Benefits of Restraint Reduction	
Capezuti E, Strumpf NE, Evans LK, Grisso JA, Maislin G. The Relationship Between Physical Restraint Removal and Falls and Injuries Among Nursing Home Residents. *Journal of Gerontology: Medical Sciences* . 1998;53A(1):M47-M52.	This study represents an analysis of data collected in a clinical trial of interventions aimed at reducing the use of restraints in nursing homes. There was no indication of increased risk of falls or injuries with restraint removal. Moreover, restraint removal significantly decreased the chance of minor injuries due to falls. This study demonstrates that physical restraint removal does not lead to increases in falls or subsequent fall-related injury in older nursing home residents.
Neufeld RR, Libow LS, Foley WJ, Dunbar JM, Cohen C, Breuer B. Restraint Reduction Reduces Serious Injuries Among Nursing Home Residents. *Journal of the American Geriatrics Society* . 1999;47(10):1202-1207.	These researchers performed a 2 year prospective study involving 16 nursing homes in 4 states. All nursing homes participated in an educational program followed by quarterly consultation. Restraint use declined from 41% to 4% without a concomitant increase in serious injuries.
Reducing restraints in nursing homes	
Evans LK. Knowing the Patient: The Route to Individualized Care. *Journal of Gerontological Nursing* . 1996;22(3):15-9.	"Provision of individualized care is dependent on knowing the patient as a person. Three factors contributed to individualized care: congruent societal and health care values; commonalities of patient needs in all settings; and primacy of caring through knowing the patient. Role modeling by mature nurses appears to have been of prime importance in the transmission of this way of nursing."
Evans LK, Strumpf NE, Allen-Taylor SL, Capezuti E, Maislin G, Jacobsen B. A Clinical Trial to Reduce Restraints in Nursing Homes. *Journal of the American Geriatrics Society* . 1997;45(6):675-81.	These investigators performed a prospective 12 month clinical trial, involving 3 nursing homes and 643 residents. The 3 nursing homes were randomly assigned to restraint education, restraint education with 12 hours/week consultation, or control. A statistically significant reduction in restraint use was noted in the restraint education-with-consultation nursing home; restraint reduction occurred without increasing staff, serious fall-related injuries, or psychoactive drug use.
Happ MB, Williams CC, Strumpf NE, Burger SG. Individualized Care for Frail Elders: Theory and Practice. *Journal of Gerontolological Nursing* . 1996;22(3):6-14.	"Individualized care for frail elders is defined as an interdisciplinary approach which acknowledges elders as unique persons and is practiced through consistent caring relationships. The four critical attributes of individualized care for frail elders are: 1) knowing the person, 2) relationship, 3) choice, and 4) participation in and direction of care. Cognitively impaired elders can direct their care through the staff's knowledge of individual past patterns and careful observation of behavior for what is pleasing and comfortable to each resident."

Rantz MJ, Popejoy L, Petroski GF, Madsen RW, Mehr DR, Zwygart-Stauffacher M, Hicks LL, Grando V, Wipke-Tevis DD, Bostick J, Porter R, Conn VS, Maas M. Randomized clinical trial of a quality improvement intervention in nursing homes. *The Gerontologist.* 2001 Aug; 41 (4): 525-38	These investigators performed a 12-month randomized clinical trial involving 113 nursing facilities. The facilities were randomly assigned to 1) workshop and comparative performance feedback reports, or 2) workshop and comparative performance feedback reports with the availability of clinical consultation by a gerontological clinical nurse specialist, or 3) control group. A non-significant decrease in restraint use was seen in the two intervention groups.
Schnelle JF, Newman DR, White M, Volner TR, Burnett J, Cronqvist A, Ory M. Reducing and Managing Restraints in Long-Term-Care Facilities. *Journal of the American Geriatrics Society* . 1992;40(4):381-85.	These investigators performed "a delayed intervention, controlled, cross-over design with 3 phases" involving 63 physically restrained residents in 2 long-term care facilities. A management system, using colored pads as an environmental cue, is described for improving staff adherence with federal regulations requiring restraint release every two hours. The intervention resulted in a significant reduction in the percentage of residents restrained for greater than 2 hours.
Siegler EL, Capezuti E, Maislin G, Baumgarten M, Evans L, Strumpf N. Effects of a Restraint Reduction Intervention and OBRA '87 Regulations on Psychoactive Drug Use in Nursing Homes. *Journal of the American Geriatrics Society* . 1997;45:791-796.	"The objective of this study was to describe the changes in psychoactive drug use in nursing homes after implementation of physical restraint reduction interventions and mandates of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87)" and "Interventions to reduce physical restraint did not lead to an increase in psychoactive drug use; further, reduction in both can occur simultaneously. OBRA mandates regarding psychoactive drug use were not uniformly effective, but appear, at minimum, to have increased awareness of the indications for neuroleptics."
Sullivan-Marx EM. Achieving Restraint-Free Care of Acutely Confused Older Adults *Journal of Gerontological Nursing* . 2001;27(4):56-61.	"The purpose of this article is to report findings from a descriptive study of restrained hip fracture patients, and discuss approaches to achieving restraint-free care. Clinically, restrained patients had a diagnosis of dementia, were noted to be confused or disoriented by nursing staff, and were dependent in activities of daily living. An individualized approach to care is the best method to avoid use of physical restraints for patients with acute confusion and cognitive impairment."
Walker L, Porter M, Gruman C, Michalski M. Developing Individualized Care in Nursing Homes: Integrating the Views of Nurses and Certified Nurse Aides. *Journal of Gerontological Nursing.* 1999;25(3):30-5;quiz 54-5.	This study reports findings from a comparative analysis conducted on a data set including quantitative and qualitative data from 289 CNAs and 245 nurses in Connecticut. Measures of obstacles to individualized care and needs for future supports were explored. A number of significant differences in perceptions of obstacles to providing individualized care were found. The nurses were significantly more likely to identify the following impediments to change: cost, concepts not integrated into work, lack of administrative support, and staff attitudes. The CNAs were significantly more likely to report inadequate staffing, lack of interdisciplinary teams, and resident and family attitudes as problematic. Such disparate perceptions pose challenges to nursing homes committed to the implementation of individualized care alternatives. Successful approaches must consider the various vantage points of caregivers and administrators.

Alternatives to restraint use	
Bryant H, Fernald L. Nursing Knowledge and Use of Restraint Alternatives: Acute and Chronic Care. *Geriatric Nursing* . 1997;18(2):57-60.	"This descriptive study compares the types of restraints and alternatives to restraints used by nurses in the acute and chronic care setting. Significant results showed that chronic care nurses used fewer restraints and more alternatives than nurses in acute care. It is suggested by the findings stated above that the need is significant for additional and continued education in the acute care setting regarding restraints and alternatives to restraints."
Cohen C, Neufeld R, Dunbar J, Pflug L, Breuer B. Old Problem, Different Approach: Alternatives to Physical Restraints. *Journal of Gerontological Nursing* . 1996;22(2):23-9.	This paper describes specific alternatives to physical restraints utilized in 16 high restraint-use nursing facilities in four states (see Neufeld reference).
Risk factors/predictors of physical restraint use	
Castle NG, Fogel B, Mor V. Risk Factors for Physical Restraint Use in Nursing Homes: Pre- and Post-Implementation of the Nursing Home Reform Act. *The Gerontologist* . 1997;37(6):737-47.	These investigators identified resident and facility risk factors for physical restraint use post-Nursing Home Reform Act (NHRA) implementation and compared these risk factors with pre-NHRA results, using data collected in 1990 and 1993. Age, more physical and cognitive impairment, taking anti-psychotic medications, a history of falls, and mobility problems were significantly associated with restraint use. They "propose that, to date, the NHRA may have been successful in reducing the use of physical restraints, but it appears to have had less impact on the types of residents who are restrained."
Sullivan-Marx EM, Strumpf NE, Evans LK, Baumgarten M, Maislin G. Initiation of Physical Restraint in Nursing Home Residents Following Restraint Reduction Efforts. *Research in Nursing & Health* . 1999;22:369-379.	Predictors of restraint initiation for older adults were examined using secondary analysis of an existing data set of nursing home residents who were subjected to a federal mandate and significant restraint reduction efforts. Lower cognitive status and a higher ratio of licensed nursing personnel were predictive of restraint initiation. Key findings suggest that restraint initiation occurs, despite significant restraint reduction efforts, when a nursing home resident is cognitively impaired or when more licensed nursing personnel are available for resident care.
Sullivan-Marx EM, Strumpf NE, Evans LE, Baumgarten M, Maislin G. Predictors of Continued Physical Restraint Use in Nursing Home Residents Following Restraint Reduction Efforts. *Journal of the American Geriatrics Society*. 1999; 47(3):342-48.	These researchers performed a secondary analysis of data from a clinical trial involving 3 nursing homes and 201 physically restrained residents. 135 residents remained in physical restraints after study restraint reduction efforts. "Severe cognitive impairment" and/or "fall risk as staff rationale for restraint use" were significantly associated with continued physical restraint use following restraint reduction efforts.

The role of nursing administrators	
Dunbar JM, Neufeld RR, Libow LS, Cohen CE, Foley WJ. Taking Charge. The Role of Nursing Administrators in Removing Restraints. *The Journal of Nursing Administration* . 1997;27(3):42-8.	"This article describes the role of nursing administrators in reducing the use of physical restraints as part of a 2-year, national nursing home restraint-reduction project." Concerns and benefits relating to restraint-free care are addressed. Among the topics covered are legal liabilities, compliance with OBRA, costs of staff time, and family attitudes and concerns.
Patterson JE, Strumpf NE, Evans LK. Nursing Consultation to Reduce Restraints in a Nursing Home. *Clinical Nurse Specialist* .1995;9(4):231-5.	These researchers describe the 6 phase consulting process utilized by a clinical nurse specialist as part of a clinical trial to decrease restraint use. Activities and roles of the clinical nurse specialist during each phase are reported.
Review articles	
Evans LK, Strumpf NE. Myths about Elder Restraint. *IMAGE: Journal of Nursing Scholarship* . 1990;22(2):124-128.	The following beliefs are examined as myths: "The old should be restrained because they are more likely to fall and seriously injure themselves", "It is a moral duty to protect patients from harm", "Failure to restraint puts individuals and facilities at risk for legal liablity", "It doesn't really bother old people to be restrained", "We have to restrain because of inadequate staffing", and lastly "Alternatives to physical restraint are unavailable". The author also recommends topics for future investigation.
Guttman R, Altman RD, Karlan MS. *Report of the Council on Scientific Affairs. Use of Restraints for Patients in Nursing Homes* . Council on Scientific Affairs, American Medical Association. *Archives of Family Medicine* . 1999;8(2):101-5.	A review of restraint use in nursing homes including information about regulations and the Interpretative Guidelines. This article updates information regarding restraint use in nursing homes since the publication of the 1989 AMA report "Guidelines for the Use of Restraints in Long-Term Care Facilities".
Siderails	
Capezuti E. Preventing Falls and Injuries While Reducing Siderail Use. *Annals of Long-Term Care* . 2000;8:57-63.	"This article describes a program of research that aims to prevent bed-related falls and injuries while minimizing use of both restraints and siderails." The authors conduct individualized interventions addressing problems often resulting in siderail use: impaired mobility, sleep disturbance, nocturia/incontinence, and injury risk. The author concludes that "there is no single solution to prevent bed-related falls. Use of siderails often replaces the assessment process of unraveling the complex etiology of a resident's fall risk. Effective fall reduction programs emphasize the importance of a comprehensive assessment process and often employ an individualized, multifactoral intervention".

Capezuti E, Maislin G, Strumpf N, Evans LE. Side Rail Use and Bed-Related Fall Outcomes Among Nursing Home Residents. *Journal of the American Geriatrics Society* . 2002;50(1):90-96.	This article analyzes the effects of "physical restraint reduction on nighttime side rail use" and examines "the relationship between bilateral side rail use and bed-related falls/injuries among nursing home residents". Three nursing homes were examined in the study with 463 residents. "Despite high usage of bilateral side rails, they do not appear to significantly reduce the likelihood of falls, recurrent falls, or serious injuries."
Capezuti E, Talerico KA, Cochran E, Becker H, Strumpf N, Evans L. Individualized Interventions to Prevent Bed-Related Falls and Reduce Siderail Use. *Journal of Gerontological Nursing* . 1999;25(11):26-34.	"Five categories of problems that often result in siderail use: memory disorder, impaired mobility, injury risk, nocturia/incontinence, and sleep disturbance. As nursing homes work toward meeting the Health Care Financing Administration's mandate to examine siderail use, administrators and staff need to implement interventions that support safety and individualize care for residents. While no one intervention represents a singular solution to siderail use, a range of interventions, tailored to individual needs, exist. This article describes the process of selecting individualized interventions to reduce bed-related falls."
Capezuti E, Talerico KA, Strumpf N, Evans L. Individualized Assessment and Intervention in Bilateral Siderail Use. *Geriatric Nursing* . 1998;19(6):322-330.	"The use of bilateral siderails, similar to physical restraints, can be safely reduced by a comprehensive assessment process. This article presents an individualized assessment for evaluating siderail use to guide nurses in managing resident characteristics for falling out of bed and intervening for high-risk residents. The individualized assessment is consistent with federal resident assessment instrument requirements and includes risk factors specific to falls from bed."
Miles SH. Deaths Between Bedrails and Air Pressure Mattresses. *Journal of the American Geriatrics Society* . 2002;50(6):1124-1125.	A retrospective review of all voluntary report of deaths in beds with air mattresses that can be found in the Food and Drug Administration's on-line databases from 1994 to 2001. There were 35 deaths involving many product lines. "Two patterns were seen. In one, the mattress bunched up behind a person who was lying on the side of the bed, pushing the neck against a bedrail. In the second type, a patient died after sliding off the bed and having the neck or chest compressed between the rail and bed. Manufacturers attributed the deaths to poor clinical decision-making or inadequate monitoring."

Alternatives to Restraints

Alternatives offer the opportunity to increase the quality of life for restraints.

PSYCHOSOCIAL

Play to the resident's strengths
Provide for sense of security
Wandering paths
Offer choices
Plants
Staff dress – encourage independence
Same caregiver
Apply the 5 Magic Tools (knowing what resident likes to *See, Smell, Taste, Touch, Hear*)
Know resident's agenda
Be calm and self-assured
Pets and children
Classes for Frequent Fallers
Volunteers

ACTIVITIES

Buddy system
Restorative care
TV, video, music, picture books
Punching bags
Art of Living programming
Distraction based on their "work/career"
Repeated activity

ENVIRONMENTAL

Non-wheeled chairs
Wing back chairs
Gliders
Use of tables
Couch for sleeping
Hand belts
Music
Floor patterns
Visual barriers, murals
Fence with bushes
Non-skid surface in bathrooms
Pad dangerous furniture corners
Dining room chairs
Easy chairs
Proper fit chairs
Bed placement
Recliner for sleeping
Tap belts
Lighting
Motion detectors
Notes with directions
Grab bars
Rest areas in halls
Room identifiers

PHYSICAL

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

SOURCE: Diana Waugh, BSN, RN
Waugh Consulting, 419.351.7654

Handouts

Topic: APPLY YOUR KNOWLEDGE to ASSIST RESIDENTS

Facts and Strategies: Restraint Free Care Is the Standard

Sarah Greene Burger with Alice H. Hedt and Jessica E. Brill

MRS. BETTS

A daughter calls and forcefully complains that her mother, Mrs. Betts, who has Parkinson's disease, is starting to fall, especially in the mornings, at Riverside Home in Sacramento. The facility will not restrain her even though she has been slightly injured. Staff use an alarm to monitor her both in and out of bed. She has talked with her mother's physician who agrees she is unsafe. Mrs. Betts, who is competent, can walk only with assistance, loves sleeping late,(but rarely is able to) moving from one part of the facility to another, eating, reading, and feeding birds.

Who is your client?

What would you want to know about Mrs. Betts' risk for falling? How would you gather that information?

What Environmental elements would you want to see in place in the facility to assure you that Mrs. Betts could be cared for without restraints?

What organizational systems and structures would support Mrs. Betts without restraints?

What might Mrs. Betts care plan for safety include in a staff directed facility?

How could you use this opportunity to move the facility toward resident directed care?

This training is made possible by the generous funding of the California HealthCare Foundation in the "Voices for Quality: *Strategies in the National Campaign for Excellence in America's Nursing Homes"* project which enables NCCNHR to provide training, consultation and support to the CA Ombudsman Program.

Facts and Strategies: Restraint Free Care Is the Standard

Sarah Greene Burger with Alice H. Hedt and Jessica E. Brill

MR. GONZALES

When you visit Starbright Nursing Home, Mr. Gonzales' daughter stops you in the hall to ask for help. She says staff have restrained her father in his wheelchair after he hit the aide who was bathing him. You go to him and he is pulling and tugging at his vest restraint, calling out loudly in Spanish, and the wheelchair is tipping dangerously as Mr. Gonzales struggles. Mr. Gonzales, was a master brick layer, is living with dementia and osteoarthritis. He is often agitated. He has been a patient in the home for six months. His family visits daily. The home has never been cited for restraint use by the surveyors.

Does Mr. Gonzales' striking the aid constitute a legitimate reason for restraint use? In the short term? In the long term?

What are his rights?

What would you want to ask staff about Mr. Gonzales to assess his need for a restraint? What environmental elements would support care without restraints?

What systems would help Mr. Gonzales decrease agitation?

Can you ever be assured that he will not strike again? What would have to be in place to give the greatest assurance?

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Facts and Strategies: Restraint Free Care Is the Standard

Sarah Greene Burger with Alice H. Hedt and Jessica E. Brill

MRS CHIN LING

Mrs. Chin Ling is a very old, tiny and frail woman living at a large facility near San Francisco. She has multiple chronic illnesses including COPD, heart disease and dementia. The facility over the last five years has become restraint free except for bedrail use. Mrs. Ling uses a bedrail. Her son, who was anxious about the restraint reduction, tells you that he is really concerned about the side rails coming off his mother's bed. He is relieved to know they will be starting at the other end of the nursing home from his mother's neighborhood.

Is there any immediate concern about Mr. Ling's relief that his mothers rails will not come off immediately?

How will you work with him on this issue?

How will you work with the facility staff?

What environmental elements would you expect to be in place?

What systems may already be in place to get the bedrails off?

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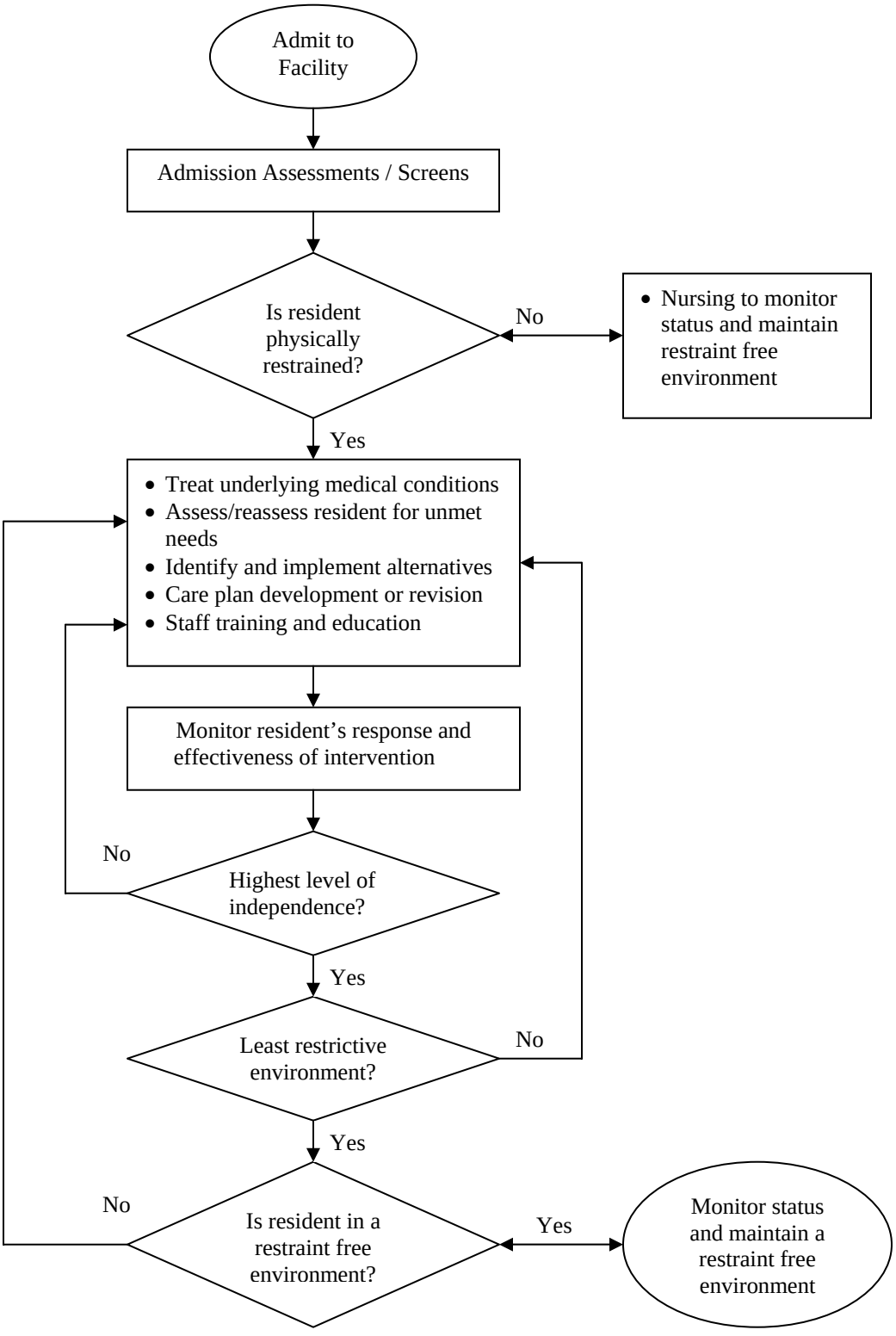
Physical Restraints: Decision Tree



The following 4 charts have been excerpted from:

“Restraint Reduction: Assessment and Alternatives, Help Guide; Evaluation Trees; Assessment Log/Intervention Care Plan.”

Developed by Diane Carter, RN, MSN, CS, President and CEO, The American Association of Nurse Assessment Coordinators (AANAC).

Funding for this Skilled Nursing Facility Health Care Quality Improvement Project was provided by the Health Care Financing Administration, Contract #500-96-P611. These materials were prepared and assembled by the **Colorado Foundation for Medical Care** in collaboration with the **Colorado Department of Public Health and Environment, Health Facilities Division**, May 1998. The contents presented do not necessarily reflect HCFA policy.

Possible Areas for Evaluation: F A L L S

FALLS

FACTORS	COMMON CAUSES	DO INTERDISCIPLINARY ASSESSMENT/SELECT BEST INTERVENTION CONSULT PRIMARY CARE PROVIDER, AS APPROPRIATE
Physiological	Medication	◆Dosage - multiple dosages/multiple medications ◆Check drug substitution, interactions, side effects of psychotropics, diuretics, cardiovascular ◆Have any new medications been added to regimen which may increase falls? ◆Tegretol level ◆Neurological checks ◆Frequent toileting assist if on diuretics ◆Dilantin level ◆Electrolytes, BUN, creatinine ◆Limit long-acting benzodiazapines ◆Depakote level ◆Void before tranquilizers/sedatives ◆Administer pain meds before transfer & ROM
	Unstable gait	◆Restorative nursing program ◆Evaluate hearing and vision ◆Evaluate clothing for size & length ◆Physical therapy--weight bearing ◆Gait training, muscle strengthing for ADL training ◆Walker, cane, merry walker ◆Fracture, arthritis, TIAs, seizures, Parkinson's, hypothyroidism, anemia ◆Shoe assessment
	Cardiovascular insufficiency Syncope - orthostatic, TIA, arrhythmia, hypotension	◆Auscultate sitting and walking ◆EKG, 24 hr. Holter monitor, O_2 saturation, CXR, electrolytes, BUN, ◆Teach to change position slowly creatinine, orthostatic BP, heart rate, digitalis level ◆Use elastic stockings ◆Check pacemaker
	Infection	◆Upper respiratory infection ◆Urinary tract infection ◆Fever - frequently afebrile, lung sounds, CBC, CXR, UA-C&S, O_2 saturation
	Hyperglycemia/Hypoglycemia	◆Check blood sugar
	Dehydration Constipation	◆Provide 1.5 to 2 qts. of water per day unless otherwise restricted ◆Change in mental status ◆Check bowel sounds, abdominal distention, impaction
	Pain	◆History of pain ◆Quality ◆Medications - try pain medications ◆Massage ◆Location ◆Onset, duration ◆Transcutaneous nerve stimulation ◆Heat ◆Intensity ◆Ability to express pain ◆Physical therapy ◆Cold
	Sleep	◆Sleep/wake patterns ◆Diet effects ◆Maintain regular schedule ◆Deep gentle exercise ◆Bedtime routines/rituals ◆Physiologic ◆Limit caffeine, cigarettes, etc. ◆Avoid napping ◆Medications ◆Illness ◆Avoid hypnotics ◆Avoid stimulating drugs ◆Room - quiet, cool, no noise
Psycho-social	Dementia/cognitive disorders Denial of impairment/depression	◆Attitude/approach ◆Distraction evaluation ◆Hearing/vision ◆Verbal approaches ◆Structured ADL schedules ◆Locate near nurses' station ◆Geriatric Depression Scale
Environ-mental	Physical surroundings	◆Bedrails ◆Bathroom ◆Noise ◆TV-remote control ◆Accessible call light ◆Furniture ◆Lighting ◆Floor ◆Stairs
Family		◆Involve family in care planning ◆Teach about current condition and interventions ◆Teach about predicted course of illness, as appropriate, behavior changes that result from cognitive loss

Adapted from *Rehabilitation Nursing,*
15 (1), 22-25, 1990, with permission from the Association of Rehabilitation Nurses.

Possible Areas for Evaluation: Behavior Symptoms

Behavior Symptoms

FACTORS	COMMON CAUSES	DO INTERDISCIPLINARY ASSESSMENT/SELECT BEST INTERVEN- CONSULT PRIMARY CARE PROVIDER, AS APPROPRI-
Physical	Medication	◆Dosage - multiple dosages/multiple medications ◆Check drug substitution, interactions, side effects of psychotropics, diuretics, cardiovascular ◆Have any new medications been added to regimen which may increase falls? ◆Tegretol level ◆Neurological checks ◆Frequent toileting assist if on diuretics ◆Dilantin level ◆Electrolytes, BUN, creatinine ◆Limit long-acting benzodiazapines ◆Depakote level ◆Void before tranquilizers/sedatives ◆Administer pain meds before transfer & ROM
	Cardiovascular insufficiency Syncope - orthostatic, TIA, arrhythmia, hypotension	◆Auscultate sitting and walking ◆EKG, 24 hr. Holter monitor, O_2 saturation, CXR, electrolytes, BUN, creatinine, orthostatic BP, heart rate, digitalis level ◆Teach to change position slowly ◆Use elastic stockings ◆Check pacemaker
	Infection	◆Upper respiratory infection ◆Urinary tract infection ◆Fever - frequently afebrile, lung sounds, CBC, CXR, UA-C&S, O_2 saturation
	Hyperglycemia/Hypoglycemia	◆Check blood sugar
	Dehydration Constipation	◆Provide 1.5 to 2 qts. of water per day unless otherwise restricted ◆Change in mental status ◆Check bowel sounds, abdominal distention, impaction
	Pain	◆History of pain ◆Quality ◆Medications - try pain medications ◆Massage ◆Location ◆Onset, duration ◆Transcutaneous nerve stimulation ◆Heat ◆Intensity ◆Ability to express pain ◆Physical therapy ◆Cold
	Sleep	◆Sleep/wake patterns ◆Diet effects ◆Maintain regular schedule ◆Deep gentle exercise ◆Bedtime routines/rituals ◆Physiologic ◆Limit caffeine, cigarettes, etc. ◆Avoid napping ◆Avoid hypnotics ◆Avoid stimulating drugs ◆Room - quiet, cool, no noise
Psychosocial	Delusions Hallucinations Depression	◆Assess agressive behavior ◆Contract with patient ◆Behavior modification ◆Assess psychoactive medications ◆Cognitive therapy
	Dementia Alzheimer's Disease	◆Attitude/approach - calm, flexible, guiding (not controlling) ◆Verbal approaches - concrete, validate feeling, task segmentation, avoid excess disability ◆Non-verbal approaches - attitude contagious, equal/lower position, therapeutic touch ◆Music therapy ◆Distraction therapy ◆Recreation ◆Exercise ◆Remotivation
Environmental	Physical surroundings	◆Call light ◆Rocking chair ◆Night-time activities ◆Avoid sensory overload ◆Roommate ◆Personalize room ◆Assess interpersonal preferences ◆Staff: street clothes, decrease turnover, resident chooses caregiver, permanent assignments, use non-nursing as much as possible, consistent scheduling

Adapted from *Rehabilitation Nursing*, 15 (1), 22-25, 1990, with permission from the Association of Rehabilitation Nurses.

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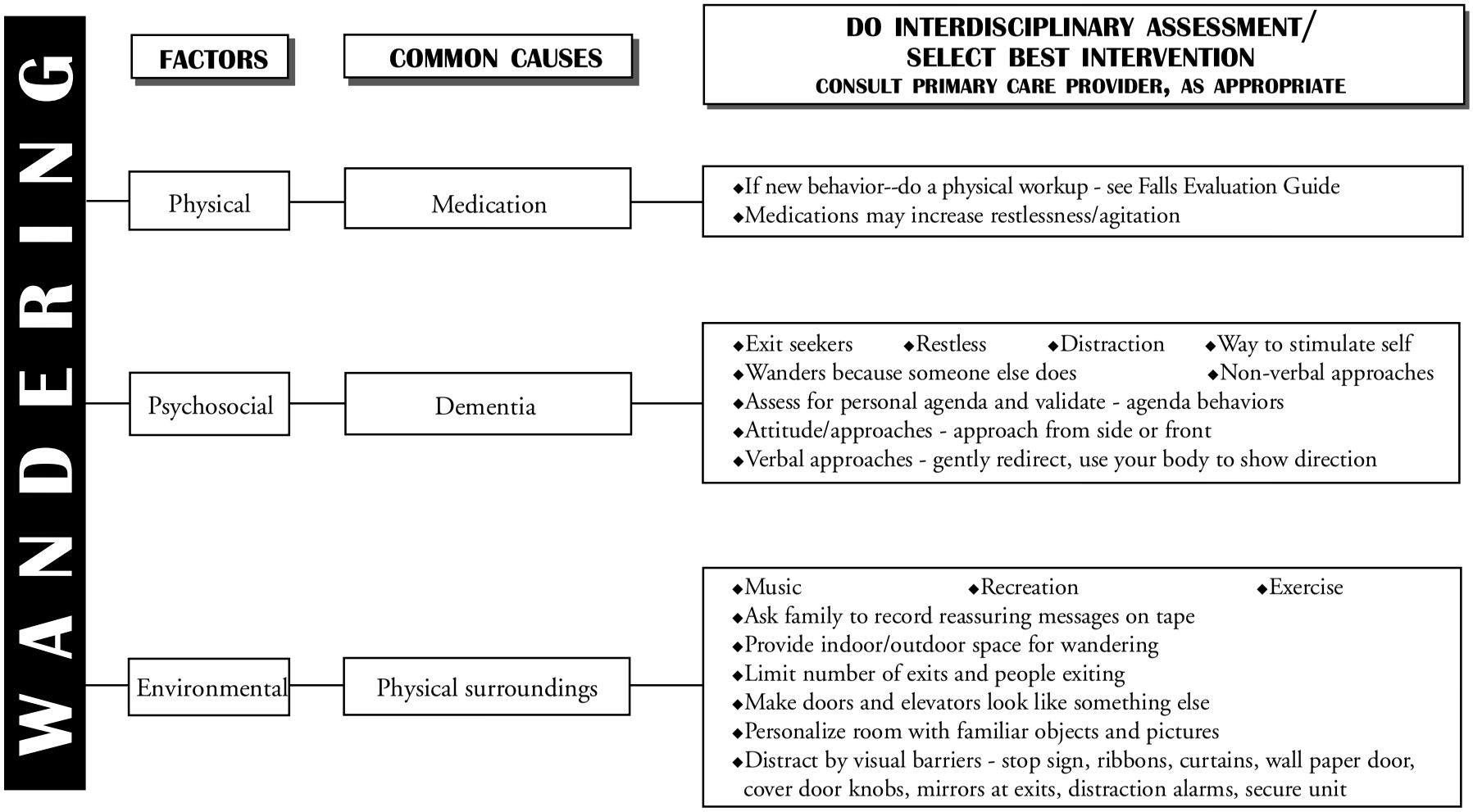
POSSIBLE AREAS FOR EVALUATION: WANDERING



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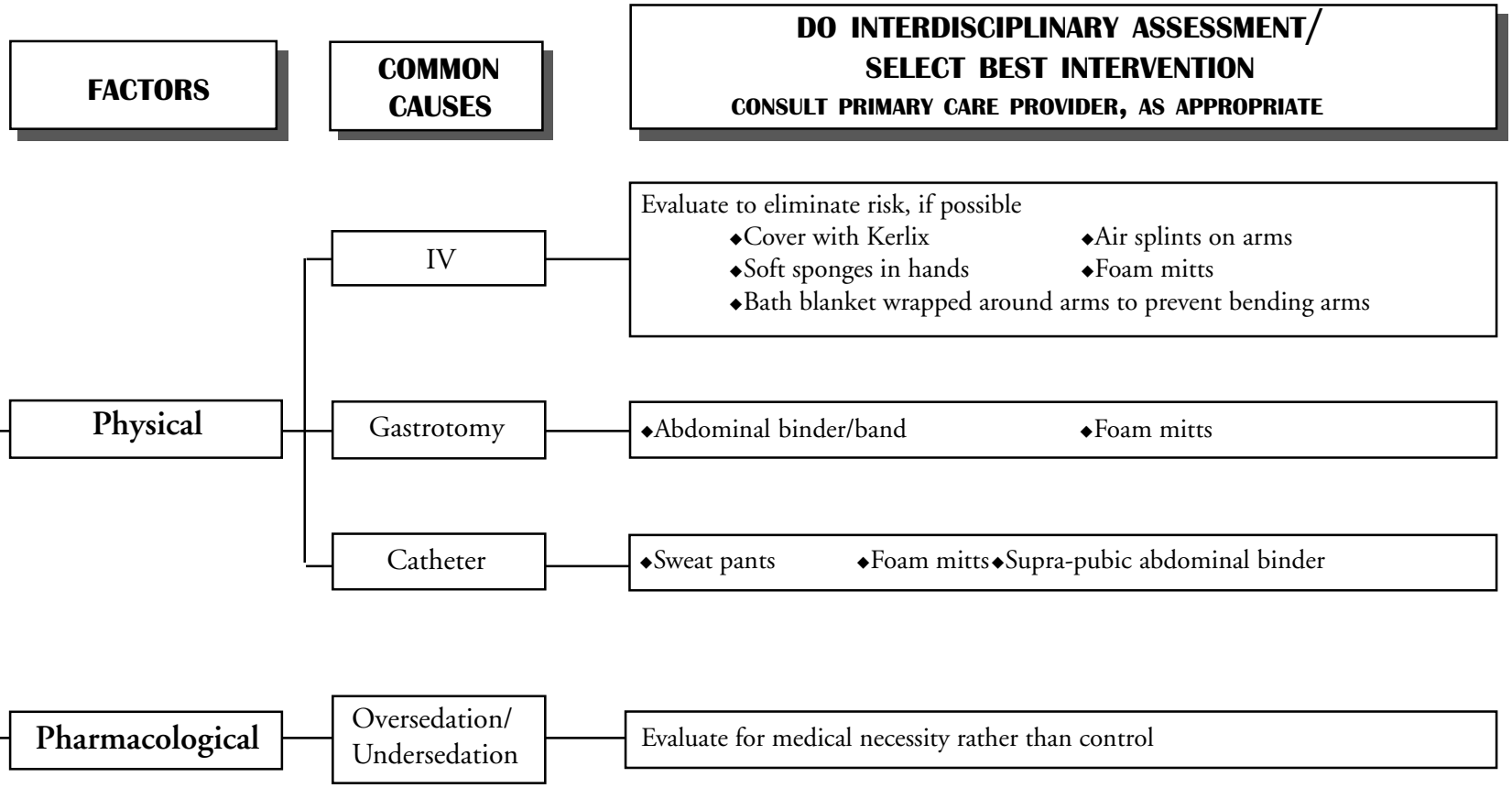
MEDICAL NECESSITY

POSSIBLE AREAS FOR EVALUATION: MEDICAL NECESSITY



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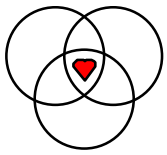
Care Practice
Work Place Practice
Environment



Change Ideas for Creating Pleasant Bathing

Typical issues & evidence of discordance:

- Resident displays anxiety, anguish, and combative behavior
- Injuries to both staff and resident

Barriers:

- Bathing is considered a private experience – why is this a barrier?
- The bathing experience is physically and emotionally cold
- Sterile, institutional, and functional environment

Goals:

- A positive, pleasant, individualized bathing experience, shifting from facility-directed to person-directed bathing and assistance with hygiene.
- To reduce injuries to residents and staff caused by the current facility-centered bathing routine

Infrastructure helpful to support the change:

- A team empowered to change practices. Team members include staff members who are directly affected by current bathing practices, with participation from residents and families.
- Adequate supplies for bed baths, showers (particularly enough linen)
- Adequate supplies and accessories for making bathing rooms more private, warm and comfortable
- Routines built around individualized bathing
- Adequate and consistent supply for warm water

Measurement possibilities:

- Number of residents screaming, calling out, vocally or nonverbally registering their disapproval
- Number of incident reports related to bathing, including possible injuries to residents and staff
- Number of bathing refusals
- Number of early identification of skin problems
- Number of residents who have individualized methods and schedules for bathing or assisting with hygiene.

Questions to consider:

- Would you take a bath here?
- How close is our bathing process to the process that you yourself use in your home?
- Is it functional or personal?
- What would be the benefits of changing the process?
- What would you change?

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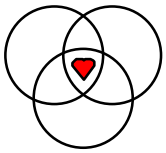

Change Ideas for Creating Pleasant Bathing

PDSA Cycle:

PLAN: Engage a team of interested and committed people including residents, staff and family members to make bathing a pleasant, less stressful and less traumatic event for all.
DO: A bathroom beautification/deinstitutionalization initiative based on data collected that tracked resident discomfort during bathing.
Check with direct care worker to see if there is enough linen available to keep people warm during bathing
Have maintenance fix fluctuations in water temperature and pressure in the showers
Provide ways to pad seats and support feet during showers
STUDY: The number of agitated residents and/or the number of incident reports related to bathing
ACT: Continue to evaluate and explore other potentially comforting change ideas.

Change Ideas:

- Ascertain that all residents receive interventions to help them feel warm and covered regardless of what method of bathing is utilized.
- Ascertain that direct caregivers and supervisors recognize that forced bathing is no longer acceptable and that resistance always triggers an assessment and intervention.
- Ascertain the residents former preferred behaviors, needs and schedule related to bathing.
- Ask the residents a series of questions about routines before moving to the nursing home or talking to family/friends of the resident.
- Does the resident need assistance with bathing? If not, resident can bathe on his/her own.
- Establish previous preference for bath or shower, time of day, leisurely activity (cup of coffee, relaxing music) vs. functional routine.
- Residents should be bathed in accordance with their response. A resident may enjoy bathing while enjoying drinking a cup of coffee or listening to their favorite type of music The bathing experience should be duplicated as closely as possible.
- Create an environment that contains distractions that are pleasant. Ask the residents what they would like to see in the bathroom. Resident responses may include plants, music and other pleasantries.
- Take strides to create a more familiar and friendly environment by asking the residents what their bathrooms were like at their own

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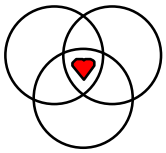

Change Ideas for Creating Pleasant Bathing

homes before moving into the nursing home.

- Consider personal items that can be used in the tub with residents to make the process more pleasant. Examples include bubble bath, bath salts and bath pillow.
- Consider warming lights to avoid residents being chilly when getting out of the tub or shower
- Consider what items could make the experience more comfortable, for example warm/soft/fluffy towel and caring conversation on favorite topics from a trusted, consistent caregiver.
- Provide as private an experience as possible by eliminating supplies and equipment storage in the shower area that will be needed by other staff.
- Provide a buffer curtain that will protect privacy.
- If at all possible, have only one person in the bathing area at a time
- Have consistent caregivers assist with bathing, minimizing the number of caregivers involved, to establish trust and knowledge about what works best.

Associated principles:

- **Primary**: Create systems within which individual preference is honored and defended
- **Secondary**: Commit to de-institutionalize, wherever possible, the current setting providing personal living accommodations, a sense of peace, safety and community

Resources:

1. Barrick, AL, Rader J, Hoeffer B, Sloane PD. Bathing Without a Battle: Personal Care of Individuals with Dementia. New York, New York: Springer Publishing Company. 2001.
2. Sloane, P. D., Hoeffer, B., Mitchell, C. M., McKenzie, D. A., Barrick, A. L., Rader, J., Stewart, B. J., Talerico, K. A., Rasin, J., Zink, R. C., Koch, G. G. (2004). Effect of person-centered showering and the towel bath on bathing-associated aggression, agitation and discomfort in nursing home residents with dementia: A randomized, controlled trial. *Journal of the American Geriatrics Society*, 52:1795-1804.

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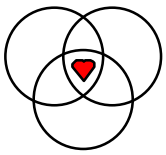
Care practice
Work Place Practice
Environment



Change Ideas for Sleeping and Waking

Typical issues and evidence of discordance:

Residents are awakened and put to bed according to the facility's schedule. To ease the burden on the in-coming day staff, the night shift awakens some residents. Sleeping residents are awakened during the night to take temperatures, give medications, monitor for incontinence, insert suppositories, or even to hydrate them. Some homes have gone so far as to have the night staff provide care such as clipping toenails. Sleep, for many residents, is compromised by bed alarms. Facility floors are cleaned and shined with noisy machinery during the night when hallways are clear.

Residents who are sleep deprived experience a range of typical effects of sleep deprivation: lethargy, loss of appetite, depression, anxiety, agitation, combative behavior, and other declines. Medications given in response to these effects, or to help residents sleep, often times exacerbate the situation.

Barriers:

The facility's care routines unwittingly deprive residents of deep restful sleep. These care routines are at the heart of the nursing home's culture. All work and assignments are organized around these routines. To change them will have an impact on the facility as a whole. The care routines continue because staff is not aware of the iatrogenic affects of sleep deprivation.

Goal:

To support residents' health and well-being by helping them have deep sleep through the night, by shifting from institutionally driven routines to routines that follow people's natural rhythms of sleeping and waking. Another goal is to support better relationships between residents and their caregivers by allowing caregivers to respect people's individual routines and set their care giving schedules around what works for each resident.

Infrastructure helpful to support the change:

Establish a work group with staff from all departments to identify and implement the changes needed in order for residents to return to their natural patterns for sleeping and waking. Adjust clinical care, staffing schedules, and routines for food service, housekeeping and maintenance to accommodate individual residents' needs and preferences related to sleeping and waking routines. Establish a system for learning about people's patterns as part of the welcoming in to the nursing home for new residents.

Measurement possibilities:

- Number of residents who sleep through the night.
- Number of residents who wake of their own accord.
- Pre and post data on agitated behavior; anxiety meds; bowel and bladder continence; UTI's; skin care; weight change; mobility; social engagement;

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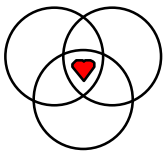

Change Ideas for Sleeping and Waking

staff-resident relationships; staff workload.

PDSA Cycles:

PLAN: Engage a committed group of people to consider, discuss and explore better sleep hygiene for residents based on residents obvious sleep deprivation and associated problems.
DO: Track the sleep of five resident volunteers who have minimal medical, hydration or treatment needs. These volunteers will be given the opportunity to awaken by their own natural body clock for two weeks.
STUDY: What time they awaken over the two weeks, mood, and appetite using simple tools. Determine if residents have a greater sense of rest and peace.
ACT: Consider a small group of people who have incontinence to initiate the next cycle. Explore how to maintain skin integrity while allowing for better sleep.

Questions to consider:

- Would you be comfortable sleeping here? With this bed and pillow?
- How can sleep be made comfortable?
- What could be improved in the following: lighting, noise, bed comfort, privacy, and clinical care to help with sleep?
- What is the importance of sleep hygiene for physical and mental well being?
- What negative outcomes are we causing by constantly interrupting the sleep of our residents?
- What are the medical consequences of sleep deprivation on health and well being?
- What evening activity and food do people who like to stay up want available?
- What are all the factors that must be considered from each department in order to make this change?
- Where could you start your change process?

Change Ideas:

- Ascertain the resident's preferred patterns, needs and schedule related to waking and sleeping.
- Take the time to allow the resident's own inner clock to be re-set. If a resident has been awakened every day at 5:30 for the past two years it will take a couple of weeks for the residents own internal clock to be re-set.
- Figure out with each resident what would be needed for comfortable sleep.
- Create an environment that is soothing and conducive to good sleep

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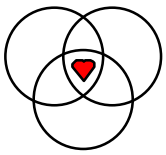

Change Ideas for Sleeping and Waking

hygiene. Think about lighting and noise. Bright hallway lights can be dimmed and floor cleaning can be completed during the day.

- Chart all the factors that interrupt each resident's sleep.
- Assess which clinical routines can be easily completed at another time. Start with the easiest situations to change and progress to the more clinically complex situations as you gain experience.
- Work with staffing patterns to adjust to the changes in workload.
- Explore ways to ensure skin integrity, continence, and other clinical needs without compromising sleep.
- Seek an interdisciplinary approach to residents' healthy sleeping, and to contribute to positive clinical outcomes. For example, instead of suppositories during the night shift, provide bran muffins, prunes, fluids, exercise opportunities throughout the day, and reduce medications that may cause constipation.

Resources:

1. Cruise PA, Schnelle JF, Alessi CA, Simmons SF, Ouslander JG. The nighttime environment and incontinence care practices in nursing homes. *J Am Geriatr Soc* 1998 Feb; 46 (2): 181-6.
2. Esser S, Wiles A, Taylor H, et al. The sleep of older people in hospital and nursing homes. *J Clin Nurs* 1999; 8: 360-8.
3. O'Rourke DJ, Klaasen KS, Sloan JA. Redesigning nighttime care for personal care residents. *J Gerontol Nurs* 2001 Jul; 27 (7): 30-7.

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Guidelines for Placing Mattress on Low Platform

Being restricted in bed by a tie-on restraint or siderail is a source of distress and agitation, yet many residents are at risk if they attempt to get out of bed on their own. Many lack the memory or judgment to call for assistance. A successful safety intervention is placing the person's mattress on a low platform (14-18 inches from the floor). This platform may be a Hollywood-style metal bed frame with a sheet of plywood cut to fit in the frame or a wooden futon frame to support the mattress from a regular bed. Metal frames can often be obtained at secondhand stores. Be sure to round off the corners of the plywood platform so that they do not extend and create a hazard. It costs approximately $30 to put the metal frame and plywood together; the cost of futon frames vary. Sometimes lowering the bed allows the resident better traction because the feet touch the floor. Sometimes the bed may need to be lowered so that he would not be at risk for a fall. Another reason to lower the bed is to shorten the distance if he rolls out of bed. If the floor is vinyl linoleum and the person's feet slide, a beveled-edge, rubber backed, low pile rug can be placed next to the bed to improve traction. This is also a useful intervention if the person is incontinent of urine because it ensures better footing. If the person is no longer able to stand but is at risk for rolling out of bed, in addition to lowering the bed you may "bring the floor up" and cushion the floor by placing a thick mat or foam egg crate mattress by the side of the bed. This can be slipped under the bed or rolled up out of the way when the person is not in bed.

Here are some useful questions to ask when considering lowering the bed:

1. Have all possible reasons why the person is at risk for falls been evaluated (medication, illness)?
2. Would the bed create other risks if positioned low (e.g., following hip surgery flexion greater than 90^0)?
3. Have all the other ways to minimize risk that could be used in place of or in addition to placing the bed lower been considered, e.g., would the use of a position-change alarm increase the safety margin? This may be useful even when the bed is on a low platform.
4. Are there any additional interventions necessary to increase the resident's comfort and safety (e.g., rug or mat next to bed)?
5. Is the person's weight, weight-bearing status, and care needs such that a low bed will not place an undue burden on the caregivers?
6. Is any in-service required so that caregivers will be aware of how to care for and transfer the person in the safest way possible?
7. Have the person and family been consulted and have they agreed to this safety-intervention?
8. Has the assessment and intervention selection process been documented in the chart?

9. Are there other safety factors to consider in the room with the bed on the floor (e.g., need to put safety plugs in outlets or need to move bedside stand to prevent patient from pulling up on it)?

If these questions have been addressed and the assessment indicates that the person would benefit from placing the bed nearer the floor, lower the bed. Generally, caregivers have found that it is easier to utilize a low bed when it is on wheels.

Caution: this intervention may not be appropriate for people if they are very heavy, require frequent, complex care in bed, and/or are able to bear weight. Persons with some or all these characteristics may pose too great a risk of caregiver injury. This possibility would need to be included in the assessment process.

Caregivers are often very clever and creative and can find ways to care for people in low beds that are safe and convenient for them. For example, they might get the person up in a wheelchair and wash them at the sink rather than doing so in the low bed.

For the few people for whom the low bed is not appropriate, because of their weight or heavy care needs, there are high-low beds that have the capacity to be lowered for safety and raised when care is given.

Here are some useful questions to ask when considering lowering the bed:

10. Have all possible reasons why the person is at risk for falls been evaluated (medication, illness)?
11. Would the bed create other risks if positioned low (e.g., following hip surgery flexion greater than 90^0)?
12. Have all the other ways to minimize risk that could be used in place of or in addition to placing the bed lower been considered, e.g., would the use of a position-change alarm increase the safety margin? This may be useful even when the bed is on a low platform.
13. Are there any additional interventions necessary to increase the resident's comfort and safety (e.g., rug or mat next to bed)?
14. Is the person's weight, weight-bearing status, and care needs such that a low bed will not place an undue burden on the caregivers?
15. Is any in-service required so that caregivers will be aware of how to care for and transfer the person in the safest way possible?
16. Have the person and family been consulted and have they agreed to this safety-intervention?
17. Has the assessment and intervention selection process been documented in the chart?

18. Are there other safety factors to consider in the room with the bed on the floor (e.g., need to put safety plugs in outlets or need to move bedside stand to prevent patient from pulling up on it)?

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From: Individualized Wheelchair Seating: For Older Adults, Part I: A Guide for Caregivers, Joanne Rader, RN, MN, FAAN; Debbie Jones, PT and Lois Miller, RN PhD. Shared with Quality Partner of Rhode Island.

The following 8 slides have been excerpted from:

“Individualized Care: Wheelchair Seating as a Road to Restraint-Free Care”

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

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

www.fda.gov/cdrh/beds/

- For reporting:
- 1-800-FDA-1088

Getting Funding for wheelchairs

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

Sometimes restraint free care is not “pretty”

Body pillow

INDIVIDUALIZED WHEELCHAIR SEATING: FOR OLDER ADULTS

Part I: A Guide for Caregivers

Joanne Rader, RN, MN, FAAN
Debbie Jones, PT
and
Lois Miller, RN, PhD

Benedictine Institute for Long Term Care
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Mt. Angel, OR 97362

This material was designed by Joanne Rader, RN, MSN, Debbie Jones, PT and Lois Miller, RN, PhD, 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

INDIVIDUALIZED SEATING WORKS

How people sit is fundamental to their health. The standard sling seat, sling-back, collapsible wheelchair was designed to transport people short distances, for short amounts of time, to assist the person pushing the chair, and to make storage easy. The chair works for the caregiver, but very poorly for the person in it, particularly if it is used for long periods of time and as the primary seating system for the individual. When frail elders are properly seated in chairs designed to meet their particular needs, improvements can occur in:

- Posture
- Comfort and wheelchair tolerance
- Skin condition
- Ability to care for self
- Efficient use of limited energy and endurance
- Socialization
- Quality of life
- Caregiver burden

Improved Posture

Improving posture can enhance a number of functions in the elderly; however, as a result of illness or orthopedic changes many elders have postures that cannot be corrected and can only be supported. The first step in achieving proper seating is a seating assessment. A seating assessment by a physical or occupational therapist is required to determine if the person needs accommodation of fixed posture and/or support of flexible posture. The assessment should include a physical evaluation, in which the person is transferred out of the chair or wheelchair and onto a mat or hard surface. This allows the therapist to evaluate the person both lying down and in a seated position for fixed joints, spasticity, pain, and skin problems.

With better positioning and/or support through proper seating, physiologic functions such as breathing, swallowing, digestion and elimination are improved. Respiratory function improves in several ways. The chest cavity more easily expands if the person is not slumped forward. Many frail elders have a delayed swallow that places them at risk for choking or aspirating (taking food or fluid into the lungs). It is essential that the person sit upright for meals so that food and particularly liquids can be better controlled and to aid the normal gravitational flow into stomach. Needless to say, if a person is constantly choking, food may often be refused. The ability to move the bolus of food in the mouth may be improved if the person with a normal swallow and kyphotic or curved back (resulting in a forward head and neck position) is properly supported and positioned so that gravity can assist in getting the food to the back of the mouth. Also, elongating the abdominal region through proper positioning allows food to

move more easily through the digestive tract and better utilize gravity to facilitate digestion and elimination.

Good positioning can also improve eye gaze, that is, the visual field created by the position of one's head. If older persons have stooped posture, the eyes naturally fall lower, sometimes to the floor, requiring a considerable effort to raise the eyes or head to see what is in front of them. Even if the posture is fixed, as with a kyphotic or curved spine, improvements can occur. For example, positioning the wheelchair at even a 15 degree recline may bring the eye gaze level, making it easier for the person to attend to what is going on around him and socialize (see Chapter 2).

Improved Comfort and Wheelchair Tolerance

Comfort is an important concern of frail elders. Comfort is achieved or improved through proper support and positioning. Wheelchair tolerance or the amount of time the person feels able to be up in the chair can be used as a practical indicator of comfort. That is, comfort is directly related to wheelchair tolerance. If the person is uncomfortable in the wheelchair or gerichair, he will often ask to go to bed sooner and refuse to become more involved in activities.

Older adults experience more pain than younger people, for many reasons. They often suffer from arthritis or other chronic illnesses that have pain associated with them. Often pain is unidentified or under treated in the frail elderly. Many frail elders have diagnosed or undiagnosed spinal fractures that can be a source of pain. Often with proper positioning and support, this type of pain can be dramatically reduced.

Persons with dementia may not have the verbal or cognitive ability to express their pain in words or even respond appropriately when asked if they are in pain. However, their behavior is often a good indicator of pain. One nurse clinician working in a large Midwest teaching hospital found that out of 18 nursing home residents referred to an outpatient clinic, inpatient medical unit or inpatient psychiatric unit for screaming/yelling behaviors, 15 had undiagnosed or unstable fractures (Geri Hall, personal communications, August 8, 1997).

Prevention of Skin Breakdown

Proper cushions and support prevent skin and tissue breakdown by more evenly distributing pressure, thus allowing the individual to be up for longer periods without causing damage. Some fabric cushion covers wick away moisture/fluid from the skin. Heat may also contribute to skin breakdown, and some cushion materials (air, fluid) are cooler than foam (see Chapter 6).

Improved Ability to Care for Self

A properly fitted wheelchair can improve the person's ability to care for himself in many ways. For example, correct arm rest length and height allow the chair to get under the table so that at meals the person can be close enough to reach the food and feed himself. It gives the person a level eye gaze so he can see in the mirror for grooming. Further, with the proper chair many people can wheel themselves from place to place.

Better Use of Limited Energy and Endurance

Frail elders often have limited stamina, endurance and energy. When one is not positioned properly, energy is required simply to remain upright. When properly equipped, the ability to self propel is enhanced and requires less expenditure of energy. The standard wheelchair weighs between 40-50 pounds, a lightweight chair weighs 24-28 pounds, and an ultralight chair can weigh even less (18-21 pounds). Choosing a lighter weight chair can save energy for use with other activities. Having the seat low enough so that the person who ambulates with his feet can get a good heel strike (connection of the foot to the floor) also improves efficiency. Providing a chair with the proper width so that the person can easily access the hand rims on the wheels is another way to better conserve limited energy. Being comfortably seated and positioned for eating may mean that the person will eat more because he is not too fatigued to finish the meal. With proper support, the person can relax and focus on other activities such as eating or conversing.

Improved Socialization

Improved socialization can result from a combination of the factors already mentioned such as level eye gaze, the ability to move oneself in and out of social situations, and increased comfort. Improved socialization may also be related to eliminating restraints. Individuals often find restraints uncomfortable, humiliating and degrading, causing them to shrink from social situations.

Improved Quality of Life

It goes without saying that if a person is more comfortable, more independent, and has better physiologic function, that person will have improved quality of life and self-esteem.

Easing of Caregiver Burden

When properly seated, frail elders may be easier to transfer, or able to transfer themselves, and able to feed or toilet themselves; they may require less repositioning (creating less back and shoulder stress for the caregiver), tolerate

being up for longer periods, and have fewer behavioral problems. All these ease the caregiver's burden.

CASE EXAMPLES OF BENEFITS OF PROPER SEATING

The following case examples illustrate many of the benefits of proper seating.

Case 1 – Marguerite Parker

Ninety-seven year old Marguerite Parker was in the typical wheelchair with a sling back and a sling seat with an inexpensive foam cushion. Her thighs were rolled inward and her pelvis was in a posterior pelvic tilt, which made her trunk collapse and her movements limited, affecting her breathing and circulation. Consequently, Mrs. Parker suffered from considerable back pain, making her irritable, as manifested by crying, angry outbursts and refusing all activities. A physical therapist conducted an evaluation, including a physical assessment on the mat to assess her needs. She discovered that Marguerite had:

- A fixed posterior pelvic tilt or forward thrust of pelvis;
- Hip range of motion limited to 90 degrees;
- Shortened hamstring muscles;
- A fixed thoracic, kyphotic spine causing her head to be positioned forward

The therapist recommended a smaller, lightweight chair and a solid, contoured back and seat system. Putting Mrs. Parker in a wheelchair with smaller diameter (20-inch) wheels provided her with enough range of motion to bring her elbows back far enough to have full excursion on the wheel so she could more easily propel her wheelchair. The stability and contoured support that Mrs. Parker received from the new seating system also protected her skin with better distribution of pressure. Finally, the system stabilized her pelvis, allowing elongation of her trunk and resulting in better upright sitting, energy conservation and comfort.

The overall results were dramatic. Before, because of her pain, Mrs. Parker had been very withdrawn, not talking to people or attending activities. Following the improvements in her seating, she became clearer cognitively and moved easily through the facility talking to others. She was more comfortable, aware and pleasant. Her son was amazed and pleased with the differences. Mrs. Parker lived another four years, continuing to use her individualized wheelchair and maintaining her improved comfort and mobility (Pitts, 1995).

Case 2 – Art Solum

Art Solum, 75, had been residing in a nursing home for several years due to progressive gait instability and dementia. He was placed in a gerichair with a soft, tie-on restraint because he was sliding out of his facility-issued wheelchair,

even with a restraint. He continued to sit in this gerichair for two years. Like many gerichair users, during this time Mr. Solum's ability to perform daily care activities slowly declined, until he was totally fed and groomed by others. In addition, his wife and staff members had difficulty pushing and maneuvering the gerichair because it was designed mainly for lounging, not mobility. Because of the difficulty of maneuvering the chair, as well as his low interest, Mr. Solum rarely participated in facility activities.

The nursing staff were also concerned that his position in the chair posed a risk of aspiration during mealtime; and further, his transfers were becoming more difficult. At the time, the facility was working on eliminating the use of restraints and Mr. Solum had two devices in place that restricted his mobility: the recliner and a tie-on waist restraint.

The facility's rehab team, including an occupational therapist, a physical therapist, and a speech pathologist, identified Mr. Solum as a candidate for restraint elimination and improved posture through proper wheelchair seating. During the observation process, the team noted that Mr. Solum spent most of his time lying in the gerichair outside his room. He had ample room to move in the gerichair because of his small body size, and he was frequently found lying at an angle and sliding down in the chair. The mat assessment revealed:

- A slight posterior tilt;
- Mild thoracic kyphosis;
- Bilateral hip range of motion limited to 90 degrees of flexion;
- Fair trunk balance

Mr. Solum's knees were a little stiff but within normal limits for sitting, and his ankles were extended in slight plantar flexion with foot drop. His skin did not appear to have any redness or blanching and he had no previous history of skin breakdown.

Therefore, the initial equipment recommendation was a solid seat with contours to support and protect his pelvis and a solid contoured back that could recline slightly to accommodate his limited hip flexion, posterior pelvic tilt and thoracic kyphosis. The seat cushion needed enough length and padding to firmly support his thighs. He also needed the proper footrest height to secure his position in the wheelchair. Due to his slight frame, a 16-inch-wide wheelchair was also recommended.

Mr. Solum had only Medicare coverage and was not eligible for wheelchair and seating equipment through Medicaid because he was living in a nursing home. However, the facility had recently received a 16-inch-wide lightweight chair as a donation and the administration agreed to let him have the chair if it would improve his situation. In addition, the team selected a cushion and back to implement the recommendations from the assessment.

The results were again dramatic. With a few minor adjustments to the seat-to-back angle, foot rests and arm rests, Mr. Solum was able to sit upright in the wheelchair without sliding. At this point, the speech pathologist wanted to see if he could manage eating an ice cream sandwich. He not only opened the wrapper by himself but also was able to take a bite and swallow appropriately. When the occupational therapist wheeled him to the sink in his room, he washed his hands with little prompting. Although Mr. Solum still required assistance with his transfer, they were accomplished more easily from his upright seated position than from the gerichair. With his upright sitting posture in the wheelchair, he seemed more approachable and experienced more social interaction with other residents and staff members.

Mr. Solum's improved upright posture also led the restorative staff to begin a strengthening program with the goal of self-mobilization and increased strength for self-care. As he became stronger, the nursing staff recommended that the physical therapist see him for transfer training and possible gait training. He was fitted with an ankle-foot brace and could ambulate with assistance in the parallel bars. He continued a weightlifting and walking program. He managed his meals independently with some assistance in cutting up meat and opening packages. The staff and his wife found it easier to push the lightweight wheelchair than the gerichair (Jones, 1995). Mr. Solum was even able to enjoy a fishing trip to a local trout pond with the activities department.

The people in these two cases are representative of those who can benefit from individualized seating. There are many persons in care facilities and in the community with the same types of problems who could experience similar improvements. As caregivers, it is our job to identify who these people are and being the process of improving their lives through better seating.

In the last 10 years, there have been dramatic improvements in the types and costs of products available to meet needs for better seating. Chapter 4 discusses how some of the newer devices are more effective than the older ones. The fact is our population is aging and a market is developing for better seating.

Physical Restraints: Essential Systems for Quality Care

The following information suggests areas to focus on while evaluating facility processes for reducing physical restraint use.

Systems to Review	Key Interventions to Reduce Physical Restraint Use
Organizational Commitment	▪ Establish a facility wide commitment to developing and maintaining a restraint free environment. ▪ Identify key staff members to form an interdisciplinary restraint elimination team. ▪ Implement a no-restraint policy. ▪ Analyze current clinical practices such as screening, assessing, use of restraints, documentation and interventions. ▪ Educate staff, family and residents on the dangers of physical restraints and how to implement less restrictive alternatives. ▪ Assess and treat underlying conditions precipitating the use of physical restraints. ▪ Consider environmental modifications to promote safety and decrease use of restraints. ▪ Celebrate restraint reduction/elimination success stories, reward caregivers and family member for positive attitudes and assistance in creating a restraint-free environment. ▪ Provide appropriate resources such as adequate staffing, continuing education, strong communication systems, standardized tools, environmental modifications and necessary equipment. ▪ Evaluate the outcome of restraint elimination programs and revise as needed.

Assessment	• Develop systems for interdisciplinary team members to perform basic assessments, including medical history review and physical examination, to rule out acute illness for residents currently using restraint devices, being considered for devices, or had incident or event requiring assessment for restraint or newly admitted residents.
	• Involve the resident and family/caregivers if available and if resident wants family to be involved.
	• Obtain information from resident, family, or caregivers regarding the resident's previous life experiences, interests, social patterns in order to provide an individualized approach to restraint-free care.
	• Analyze the context or circumstances surrounding the precipitating events to determine the meaning of the behavior.
	• Assess and treat underlying medical conditions precipitating the use of physical restraints:
	  • Gait: stability, clothing size, strength, range of motion, balance, hearing/vision, shoes, assistive devices, fractures/precautions, and fall risk assessment.
	  • Medications: dosage, multiple medications, side effects, medications increasing potential for falls, frequent toileting for residents on diuretics, pain medications, or sedatives causing fatigue/drowsiness.
	  • Cardiovascular: elastic stockings, oxygen saturation, blood pressure, heart rate, and energy conservation.
	  • Infections: urinary tract infections, fever, or upper respiratory infections.
	  • Dehydration: bowel sounds, impaction/constipation, change in mental status, and skin turgor.
	  • Pain: location, intensity, medications, onset, duration, and ability to express.
	  • Sleep: patterns, routines, caffeine intake, noise level, napping, medications, and exercise levels.
	  • Cognition: depression, hallucinations, delirium, aggressive behaviors, psychoactive medications, dementia, confusion, wandering, orientation, and response to verbal cues.
	  ▪ Environment: call light location, roommate situation, adequate lighting, access to bathroom, water at bedside

Physical Restraints: Essential Components for Quality Care

The following information suggests five areas to focus on while evaluating current facility interventions for Physical Restraints.

Systems to Review	Key Interventions to Facilitate Physical Restraint Elimination
Assessment (cont.)	table, noise levels, clutter, bedrails, furniture and access to T.V. / remote control. ▪ If a restraint must be used, document all other possible interventions that have been attempted, resident's response and if the intervention succeeded or failed and why. ▪ Reassess residents with physical restraints as needed (at least monthly) until the resident is achieving the highest level of functioning in the least restrictive environment. ▪ Document clinical findings, including: medical necessity, tests, response to activity, safety awareness, education, family/caregiver involvement, plan of care, interventions, frequency/duration and referrals.
Care Planning	• If a restraint needs to be used as a last resort, include on the care plan the reason, type, location, in what circumstances the device is implemented, what period of time/situation device is used for the resident. • Develop individualized interventions and goals related to providing the highest functional status and least restrictive environment. • Include approaches for restraint elimination, prevention of complications (i.e. contractures, skin breakdown and incontinence). • Document the person(s) responsible for implementing and achieving the goal on the care plan. ▪ Update and revise the plan of care as required. ▪ Ensure the relevant disciplines involved in facilitation of the care plan have documented the interventions that have been attempted and the results. ▪ Involve the resident and family in development of the care plan at the discretion of the resident.
Training & Education	▪ Develop orientation and ongoing in-service programs for staff, families and residents that address types of physical restraints, goals of restraint elimination, adverse effects and regulations regarding use. • Provide documentation that reflects staff training and understanding of roles and responsibilities of restraint elimination programs. • Educate employees on referring a resident to the restraint team if restraints are being considered. • If a restraint must be used for a limited time period, include education regarding restraint application, when it should be released, obtaining appropriate physician's orders, and documenting resident and/or legal guardian consent. • Educate the resident and family regarding predicted course of illness, current conditions, and interventions. • Develop philosophy of restraint-free care and provide educational programs on how to achieve a restraint-free environment.

Physical Restraints: Essential Components for Quality Care

The following information suggests five areas to focus on while evaluating current facility interventions for Physical Restraints.

Systems to Review	Key Interventions to Facilitate Physical Restraint Elimination
Restraint Elimination	▪ Implement a system for tracking and identifying residents appropriate for assessment or reassessment by the interdisciplinary restraint team. ▪ Identify what type of restraint is used, during what time of the day, where the resident is restrained, for how long, under what circumstance and who implemented the restraint. ▪ Determine reason and precipitating factors for restraint application. Potential reasons: risk of falls, behavioral symptoms, inability to treat a medical condition. ▪ Assess and treat underlying conditions (see Assessment section). ▪ Evaluate effectiveness of interventions and resident's response. ▪ Reassess for elimination or least restrictive alternative devices. ▪ Provide continual reassessment and revisions to plan of care until the restraint is safely eliminated.

Restraint Reduction Resource List

Guides on Restraint Reduction

Burger, Sarah G. et al, *Nursing Homes Getting Good Care* There, 2d Edition, NCCNHR, 2002.

Burger, Sarah G., *Avoiding Physical Restraint Use: New Standards in Care, A Guide for Residents, Families, Friends, and Caregivers*. NCCNHR, 1993.

Everyone Wins! Quality Care Without Restraints
The Resident Care Library: Six 12-14 minute videos, an in-service training manual, plus handouts. The six units are: 1) The New Resident, 2) Up and About: Minimizing the Risk of Fall Injuries, 3) Working With Residents Who Wander, 4) Getting Hit, Grabbed, and Threatened: What it Means, What to do, 5) Staying Restraint-free Evenings, Nights, and Weekends, and 6) Now That the Restraints Are Off, What Do We Do?
The Management Perspective: A 16-minute video with viewing and resource guide; the topics include: Why Opt for Restraint-Free Care?, Setting the Stage, and Keeping it Going.
The Family Guide to Restraint-free Care: A 12-minute video plus a pamphlet for families. The video features a man who resisted when the nursing home approached him about removing his wife's restraint and the way everyone worked together to eliminate her restraint safely.
Available at the *Untie the Elderly* website: www.ute.kendal.org.

Everyone Wins! A Family Guide to Restraint-Free Care
A documentary that follows a husband who needed significant support before he could accept restraint-free care for his wife. Available at the *Kendal Outreach* website: http://kendaloutreach.org/.

Fall Management Guidelines. Health Care Association of New Jersey (HCANJ), Best Practice Committee. Adopted 9/2003, Revised 2/2005. Available online at: http://www.tmf.org/nursinghomes/restraint/Falls%20Management.pdf

NCCNHR Consumer Fact Sheets, free at the NCCNHR website: www.nccnhr.org. Physical Restraint Free Care Fact Sheet to be available June 2007.

"*Nursing Counts: Delirium, Depression Often Overlooked,"* John A. Hartford Institute for Geriatric Nursing, NYU at: www.Hartfordign.org**.**

Rader, Joanne et al., *Bathing Without a Battle: Personal Care of Individuals with Dementia*, Springer Publishing, 2002.

Rader, Joanne, *Individualized Dementia Care: Creative, Compassionate Approaches*, Springer Publishing, 1995.

Untie the Elderly Film Series:
Philosophy of care, the change process, and Environmental and Program Alternatives to Care. Go to the UTE website: www.ute.kendal.org

Untie the Elderly Newsletter provides ongoing information on restraint reduction. Go to the website: www.ute.kendal.org.

QIO Websites

Colorado Foundation for Medical Care
http://www.cfmc.org/nh/nh_restraints.htm
Colorado Foundation for Medical Care, in collaboration with AANAC, provides excellent assessment and alternatives materials. One page decision trees for wandering, falls, behavior symptoms, and emergency care.

Quality Improvement Organization Websites
http://www.tmf.org/nursinghomes/restraint/indes.htm
A very complete and simple program from start to finish. Information available for the whole interdisciplinary team as well as families and ombudsman. It assumes restraint free nursing homes are the goal!

Quality Partners of Rhode Island
http://www.riqualitypartners.org
Click on "nursing homes," then "organizational culture," then "module 4," and finally "restraints." This website has all Joanne Rader's slides on it. She did the California physical restraint training for CA in 2007 in seven sites across the state. They can be copied and used. It is very complete training program used by QIOs. This is also the site for the Advancing Excellence in America's Nursing Homes Campaign, including restraint and consistent assignment information.

Other Websites

The American Geriatrics Society
http://www.americangeriatrics.org/
The American Geriatrics Society with British Geriatrics Society and American Academy of Orthopedic Surgeons Panel on Falls Prevention. Guideline for the prevention of falls in older persons. Also published in the JAGS 49(5): 664-72, 2001, May.

American Medical Directors Association
http://www.amda.com/

Using an interdisciplinary process, the American Medical Directors Association developed process guidelines for treatment of depression in nursing home residents. Also includes guidelines for chronic pain management. Undiagnosed chronic and acute pain in demented people often leads to behavioral symptoms, which are then treated with an inappropriate psychoactive drug rather than a medication to control pain. The Agency for Health care Research and Quality (AHRQ) has these guidelines.

Center for Gerontology and Health Care Research at the Brown Medical School
http://www.chcr.brown.edu/dying/severepain.htm
Brown University study on untreated pain in nursing home residents.

Hartford Institute for Geriatric Nursing
http://www.hartfordign.org
Includes Nursing Counts series. Also has Beers medication and the elderly criteria in the clinical section of the geriatric nursing self instructional course.

The Pioneer Network
http://www.pioneernetwork.org
Creating an environment for residents that has stable staff is key to good care. The vision to do this and the accompanying approach to individualized care are keys to restraint elimination. In fact, the pioneer network grew out of the restraint reduction movement.

Untie the Elderly
http://www.ute.kendal.org
The best ongoing information about reduction of physical restraints in nursing homes. Jill Blakeslee and Beryl Goldman helped to transform this county's thinking about restraint use. While Jill unfortunately has died, her good work continues in Beryl's capable hands. Visit the website or email them at info@ute.kendal.org. In addition to having resources such as films available, there are questions and answers, resources and other help available. Download the FDA bedrail guidance from the Hospital Bed Safety Workgroup (HBSW) at this site. Order the HBSW film on bed safety entitled, "Do No Harm."

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality
http://www.ahrq.gov
University of California at San Francisco-Stanford University Evidence-based Practice Center Subchapter 26.2. Interventions that Decrease the Use of Physical Restraints of the Evidence Report/technology Assessment, No. 43 entitled "Making Health Care Safer: A Critical analysis of Patient Safety Practices." The full report can be accessed at http://www.ahrq.gov/qual/errorsix.htm.

U.S. Department of Health and Human Services, Office of Inspector General
http://www.oig.hhs.gov
OIG nursing home reports. Many good ones on staffing, which is directly related to restraint reduction.

U.S. Food and Drug Administration
http://www.fda.gov
Download the Guidance from the Hospital Bed Safety Workgroup. This guidance details the risks, evidence, how to assess for a safe bed environment, provides a decision tree, and makes recommendations about using low beds and safety mats. Also download the consumer information flyer on bedrails. Report bedrail deaths at 1-800-FDA-1088.

Physical Restraints: Annotated Guidelines

Guideline				
Guideline	*Overview*	*Source*	*Address*	*Cost*
Restraints 1996 and updated 1997. 83 pages. As of July 2002 a revision is in progress.	This physical and chemical restraint protocol includes an initial section with definitions, information on patient risk factors for restraint use, assessment for restraint use with a decision tree, protocols, interventions, and outcomes of restraint use. This protocol features appendices containing assessment and documentation tools, a restraint knowledge test, outcome monitoring forms, process evaluation monitoring forms, and a model consent form. A section is dedicated to reducing restraints; among the topics covered are strategies for the care of persons at risk of falling, persons with agitated/restless behavior and persons who wander. Includes a laminated "Restraint Use Algorithm". The final section is a "Quick Reference Guide".	University of Iowa Gerontological Nursing Intervention Research Center.	University of Iowa, College of Nursing Research Dissemination Core 4118 Westlawn Iowa City, IA 52242 (319) 384-4429 http://www.nursing.uiowa.edu/gnirc	$9.00. These materials are copyrighted and permission must be obtained to duplicate. (A permission form accompanies the protocols)
Guidelines for Restraint Use. Last updated January 1, 1997. 3 pages.	A succinct guideline containing an introduction, background information emphasizing regulations, and guidelines for restraint use. Includes references.	American Geriatrics Society	American Geriatrics Society The Empire State Building 350 Fifth Avenue, Suite 801 New York, NY 10118 (212) 308-1414 http://www.americangeriatrics.org/products/positionpapers/restrain.shtml	Available online
Untie the Elderly, The Kendal Corporation: Steps to Restraint Reduction. December 1996; rev. 3/99.	Among the topics covered are letters to staff and residents/families/physicians with suggestions for content, and advice for selecting Restraint Reduction Committee members. Tasks of the Restraint Reduction Committee and the Committee process are outlined.	The Kendal Corporation	The Kendal Corporation P.O. Box 100 Kennett Square, PA 19348-0100 (610) 388-5580 www.ute.kendal.org/index6.htm	Available online

Literature	
Literature	*Synopsis*
Risks Associated with Physical Restraint Use	
Capezuti E, Evans L, Strumpf NE, Maislin G. Physical Restraint Use and Falls in Nursing Home Residents. *Journal of the American Geriatrics Society* . 1996;44:627-633.	The relationship between restraint use and falls was examined while controlling for the effect of psychoactive drug use among nursing home residents. There was no evidence that the effect of restraint use on fall risk depended upon the use of psychoactive drugs. Restraints were not associated with a significantly lower risk of falls or injuries in subgroups of residents likely to be restrained. These findings support individualized assessment of fall risk rather than routine use of physical restraints for fall prevention.
Miles SH, Irvine P. Deaths Caused by Physical Restraints. *Journal of the American Geriatrics Society* . 1997; July; 45 (7): 797-802.	This article provides information on 74 deaths identified from "files of the United Consumer Product Safety Commission Death Certificate File and its Reported Incidents File and its National Injury Information Clearinghouse Accident Investigations." The authors point out that "bedrails are an unvalidated treatment" and the article contains graphic depictions of how bedrails can cause deaths. Clinical and design recommendations to prevent bedrail-related deaths are provided.
Tinetti ME, Liu WL, Ginter SF. Mechanical Restraint Use and Fall-Related Injuries Among Residents of Skilled Nursing Facilities. *Annals of Internal Medicine* . 1992;116(5):369-74.	These researchers performed a prospective observational cohort study involving 12 skilled nursing facilities and 397 nursing home residents. "Mechanical restraints were associated with continued, and perhaps increased, occurrence of serious fall-related injuries after controlling for other injury risk factors."
Williams CC, Finch CE. Physical Restraints: Not Fit for Woman, Man, or Beast. *Journal of the American Geriatrics Society* . 1997;45:773-775.	This article describes the conclusion found in both researching human and animals: "physical restraint places highly destructive, measurable stress on people and animals". The undesirable psychological and physical effects of stress are described. The author suggests three factors contributing to the continued use of physical restraints: the failure to appreciate the dangers and destructiveness of stress associated with restraint use; lack of comprehension of the paradigm shift necessary for restraint-free care; and failure of nursing home leadership at the facility level.

Benefits of Restraint Reduction	
Capezuti E, Strumpf NE, Evans LK, Grisso JA, Maislin G. The Relationship Between Physical Restraint Removal and Falls and Injuries Among Nursing Home Residents. *Journal of Gerontology: Medical Sciences* . 1998;53A(1):M47-M52.	This study represents an analysis of data collected in a clinical trial of interventions aimed at reducing the use of restraints in nursing homes. There was no indication of increased risk of falls or injuries with restraint removal. Moreover, restraint removal significantly decreased the chance of minor injuries due to falls. This study demonstrates that physical restraint removal does not lead to increases in falls or subsequent fall-related injury in older nursing home residents.
Neufeld RR, Libow LS, Foley WJ, Dunbar JM, Cohen C, Breuer B. Restraint Reduction Reduces Serious Injuries Among Nursing Home Residents. *Journal of the American Geriatrics Society* . 1999;47(10):1202-1207.	These researchers performed a 2 year prospective study involving 16 nursing homes in 4 states. All nursing homes participated in an educational program followed by quarterly consultation. Restraint use declined from 41% to 4% without a concomitant increase in serious injuries.
Reducing restraints in nursing homes	
Evans LK. Knowing the Patient: The Route to Individualized Care. *Journal of Gerontological Nursing* . 1996;22(3):15-9.	"Provision of individualized care is dependent on knowing the patient as a person. Three factors contributed to individualized care: congruent societal and health care values; commonalities of patient needs in all settings; and primacy of caring through knowing the patient. Role modeling by mature nurses appears to have been of prime importance in the transmission of this way of nursing."
Evans LK, Strumpf NE, Allen-Taylor SL, Capezuti E, Maislin G, Jacobsen B. A Clinical Trial to Reduce Restraints in Nursing Homes. *Journal of the American Geriatrics Society* . 1997;45(6):675-81.	These investigators performed a prospective 12 month clinical trial, involving 3 nursing homes and 643 residents. The 3 nursing homes were randomly assigned to restraint education, restraint education with 12 hours/week consultation, or control. A statistically significant reduction in restraint use was noted in the restraint education-with-consultation nursing home; restraint reduction occurred without increasing staff, serious fall-related injuries, or psychoactive drug use.
Happ MB, Williams CC, Strumpf NE, Burger SG. Individualized Care for Frail Elders: Theory and Practice. *Journal of Gerontolological Nursing* . 1996;22(3):6-14.	"Individualized care for frail elders is defined as an interdisciplinary approach which acknowledges elders as unique persons and is practiced through consistent caring relationships. The four critical attributes of individualized care for frail elders are: 1) knowing the person, 2) relationship, 3) choice, and 4) participation in and direction of care. Cognitively impaired elders can direct their care through the staff's knowledge of individual past patterns and careful observation of behavior for what is pleasing and comfortable to each resident."

Rantz MJ, Popejoy L, Petroski GF, Madsen RW, Mehr DR, Zwygart-Stauffacher M, Hicks LL, Grando V, Wipke-Tevis DD, Bostick J, Porter R, Conn VS, Maas M. Randomized clinical trial of a quality improvement intervention in nursing homes. *The Gerontologist.* 2001 Aug; 41 (4): 525-38	These investigators performed a 12-month randomized clinical trial involving 113 nursing facilities. The facilities were randomly assigned to 1) workshop and comparative performance feedback reports, or 2) workshop and comparative performance feedback reports with the availability of clinical consultation by a gerontological clinical nurse specialist, or 3) control group. A non-significant decrease in restraint use was seen in the two intervention groups.
Schnelle JF, Newman DR, White M, Volner TR, Burnett J, Cronqvist A, Ory M. Reducing and Managing Restraints in Long-Term-Care Facilities. *Journal of the American Geriatrics Society* . 1992;40(4):381-85.	These investigators performed "a delayed intervention, controlled, cross-over design with 3 phases" involving 63 physically restrained residents in 2 long-term care facilities. A management system, using colored pads as an environmental cue, is described for improving staff adherence with federal regulations requiring restraint release every two hours. The intervention resulted in a significant reduction in the percentage of residents restrained for greater than 2 hours.
Siegler EL, Capezuti E, Maislin G, Baumgarten M, Evans L, Strumpf N. Effects of a Restraint Reduction Intervention and OBRA '87 Regulations on Psychoactive Drug Use in Nursing Homes. *Journal of the American Geriatrics Society* . 1997;45:791-796.	"The objective of this study was to describe the changes in psychoactive drug use in nursing homes after implementation of physical restraint reduction interventions and mandates of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87)" and "Interventions to reduce physical restraint did not lead to an increase in psychoactive drug use; further, reduction in both can occur simultaneously. OBRA mandates regarding psychoactive drug use were not uniformly effective, but appear, at minimum, to have increased awareness of the indications for neuroleptics."
Sullivan-Marx EM. Achieving Restraint-Free Care of Acutely Confused Older Adults *Journal of Gerontological Nursing* . 2001;27(4):56-61.	"The purpose of this article is to report findings from a descriptive study of restrained hip fracture patients, and discuss approaches to achieving restraint-free care. Clinically, restrained patients had a diagnosis of dementia, were noted to be confused or disoriented by nursing staff, and were dependent in activities of daily living. An individualized approach to care is the best method to avoid use of physical restraints for patients with acute confusion and cognitive impairment."
Walker L, Porter M, Gruman C, Michalski M. Developing Individualized Care in Nursing Homes: Integrating the Views of Nurses and Certified Nurse Aides. *Journal of Gerontological Nursing.* 1999;25(3):30-5;quiz 54-5.	This study reports findings from a comparative analysis conducted on a data set including quantitative and qualitative data from 289 CNAs and 245 nurses in Connecticut. Measures of obstacles to individualized care and needs for future supports were explored. A number of significant differences in perceptions of obstacles to providing individualized care were found. The nurses were significantly more likely to identify the following impediments to change: cost, concepts not integrated into work, lack of administrative support, and staff attitudes. The CNAs were significantly more likely to report inadequate staffing, lack of interdisciplinary teams, and resident and family attitudes as problematic. Such disparate perceptions pose challenges to nursing homes committed to the implementation of individualized care alternatives. Successful approaches must consider the various vantage points of caregivers and administrators.

Alternatives to restraint use	
Bryant H, Fernald L. Nursing Knowledge and Use of Restraint Alternatives: Acute and Chronic Care. *Geriatric Nursing* . 1997;18(2):57-60.	"This descriptive study compares the types of restraints and alternatives to restraints used by nurses in the acute and chronic care setting. Significant results showed that chronic care nurses used fewer restraints and more alternatives than nurses in acute care. It is suggested by the findings stated above that the need is significant for additional and continued education in the acute care setting regarding restraints and alternatives to restraints."
Cohen C, Neufeld R, Dunbar J, Pflug L, Breuer B. Old Problem, Different Approach: Alternatives to Physical Restraints. *Journal of Gerontological Nursing* . 1996;22(2):23-9.	This paper describes specific alternatives to physical restraints utilized in 16 high restraint-use nursing facilities in four states (see Neufeld reference).
Risk factors/predictors of physical restraint use	
Castle NG, Fogel B, Mor V. Risk Factors for Physical Restraint Use in Nursing Homes: Pre- and Post-Implementation of the Nursing Home Reform Act. *The Gerontologist* . 1997;37(6):737-47.	These investigators identified resident and facility risk factors for physical restraint use post-Nursing Home Reform Act (NHRA) implementation and compared these risk factors with pre-NHRA results, using data collected in 1990 and 1993. Age, more physical and cognitive impairment, taking anti-psychotic medications, a history of falls, and mobility problems were significantly associated with restraint use. They "propose that, to date, the NHRA may have been successful in reducing the use of physical restraints, but it appears to have had less impact on the types of residents who are restrained."
Sullivan-Marx EM, Strumpf NE, Evans LK, Baumgarten M, Maislin G. Initiation of Physical Restraint in Nursing Home Residents Following Restraint Reduction Efforts. *Research in Nursing & Health* . 1999;22:369-379.	Predictors of restraint initiation for older adults were examined using secondary analysis of an existing data set of nursing home residents who were subjected to a federal mandate and significant restraint reduction efforts. Lower cognitive status and a higher ratio of licensed nursing personnel were predictive of restraint initiation. Key findings suggest that restraint initiation occurs, despite significant restraint reduction efforts, when a nursing home resident is cognitively impaired or when more licensed nursing personnel are available for resident care.
Sullivan-Marx EM, Strumpf NE, Evans LE, Baumgarten M, Maislin G. Predictors of Continued Physical Restraint Use in Nursing Home Residents Following Restraint Reduction Efforts. *Journal of the American Geriatrics Society*. 1999; 47(3):342-48.	These researchers performed a secondary analysis of data from a clinical trial involving 3 nursing homes and 201 physically restrained residents. 135 residents remained in physical restraints after study restraint reduction efforts. "Severe cognitive impairment" and/or "fall risk as staff rationale for restraint use" were significantly associated with continued physical restraint use following restraint reduction efforts.

The role of nursing administrators	
Dunbar JM, Neufeld RR, Libow LS, Cohen CE, Foley WJ. Taking Charge. The Role of Nursing Administrators in Removing Restraints. *The Journal of Nursing Administration* . 1997;27(3):42-8.	"This article describes the role of nursing administrators in reducing the use of physical restraints as part of a 2-year, national nursing home restraint-reduction project." Concerns and benefits relating to restraint-free care are addressed. Among the topics covered are legal liabilities, compliance with OBRA, costs of staff time, and family attitudes and concerns.
Patterson JE, Strumpf NE, Evans LK. Nursing Consultation to Reduce Restraints in a Nursing Home. *Clinical Nurse Specialist* .1995;9(4):231-5.	These researchers describe the 6 phase consulting process utilized by a clinical nurse specialist as part of a clinical trial to decrease restraint use. Activities and roles of the clinical nurse specialist during each phase are reported.
Review articles	
Evans LK, Strumpf NE. Myths about Elder Restraint. *IMAGE: Journal of Nursing Scholarship* . 1990;22(2):124-128.	The following beliefs are examined as myths: "The old should be restrained because they are more likely to fall and seriously injure themselves", "It is a moral duty to protect patients from harm", "Failure to restraint puts individuals and facilities at risk for legal liablity", "It doesn't really bother old people to be restrained", "We have to restrain because of inadequate staffing", and lastly "Alternatives to physical restraint are unavailable". The author also recommends topics for future investigation.
Guttman R, Altman RD, Karlan MS. *Report of the Council on Scientific Affairs. Use of Restraints for Patients in Nursing Homes* . Council on Scientific Affairs, American Medical Association. *Archives of Family Medicine* . 1999;8(2):101-5.	A review of restraint use in nursing homes including information about regulations and the Interpretative Guidelines. This article updates information regarding restraint use in nursing homes since the publication of the 1989 AMA report "Guidelines for the Use of Restraints in Long-Term Care Facilities".
Siderails	
Capezuti E. Preventing Falls and Injuries While Reducing Siderail Use. *Annals of Long-Term Care* . 2000;8:57-63.	"This article describes a program of research that aims to prevent bed-related falls and injuries while minimizing use of both restraints and siderails." The authors conduct individualized interventions addressing problems often resulting in siderail use: impaired mobility, sleep disturbance, nocturia/incontinence, and injury risk. The author concludes that "there is no single solution to prevent bed-related falls. Use of siderails often replaces the assessment process of unraveling the complex etiology of a resident's fall risk. Effective fall reduction programs emphasize the importance of a comprehensive assessment process and often employ an individualized, multifactoral intervention".

Capezuti E, Maislin G, Strumpf N, Evans LE. Side Rail Use and Bed-Related Fall Outcomes Among Nursing Home Residents. *Journal of the American Geriatrics Society* . 2002;50(1):90-96.	This article analyzes the effects of "physical restraint reduction on nighttime side rail use" and examines "the relationship between bilateral side rail use and bed-related falls/injuries among nursing home residents". Three nursing homes were examined in the study with 463 residents. "Despite high usage of bilateral side rails, they do not appear to significantly reduce the likelihood of falls, recurrent falls, or serious injuries."
Capezuti E, Talerico KA, Cochran E, Becker H, Strumpf N, Evans L. Individualized Interventions to Prevent Bed-Related Falls and Reduce Siderail Use. *Journal of Gerontological Nursing* . 1999;25(11):26-34.	"Five categories of problems that often result in siderail use: memory disorder, impaired mobility, injury risk, nocturia/incontinence, and sleep disturbance. As nursing homes work toward meeting the Health Care Financing Administration's mandate to examine siderail use, administrators and staff need to implement interventions that support safety and individualize care for residents. While no one intervention represents a singular solution to siderail use, a range of interventions, tailored to individual needs, exist. This article describes the process of selecting individualized interventions to reduce bed-related falls."
Capezuti E, Talerico KA, Strumpf N, Evans L. Individualized Assessment and Intervention in Bilateral Siderail Use. *Geriatric Nursing* . 1998;19(6):322-330.	"The use of bilateral siderails, similar to physical restraints, can be safely reduced by a comprehensive assessment process. This article presents an individualized assessment for evaluating siderail use to guide nurses in managing resident characteristics for falling out of bed and intervening for high-risk residents. The individualized assessment is consistent with federal resident assessment instrument requirements and includes risk factors specific to falls from bed."
Miles SH. Deaths Between Bedrails and Air Pressure Mattresses. *Journal of the American Geriatrics Society* . 2002;50(6):1124-1125.	A retrospective review of all voluntary report of deaths in beds with air mattresses that can be found in the Food and Drug Administration's on-line databases from 1994 to 2001. There were 35 deaths involving many product lines. "Two patterns were seen. In one, the mattress bunched up behind a person who was lying on the side of the bed, pushing the neck against a bedrail. In the second type, a patient died after sliding off the bed and having the neck or chest compressed between the rail and bed. Manufacturers attributed the deaths to poor clinical decision-making or inadequate monitoring."

How Quality Care Practices Preclude Restraint Use for Nursing Home Residents

How restraints affect a residents' emotional and physical well-being

The literature clearly illustrates the adversaries associated with the use of physical restraints. They have been seen to increase the frequency of incontinency, the presence of pressure ulcers, and the incidence of infections. Other consequences of restraint use include decline in a person's physical functioning (e.g. the ability to walk or other activities of daily living) and muscle tone, as well as an increase in contractures, often leading to an increase in falls with related serious injuries and other accidents (e.g. entrapment and strangulation).

While these affects are recognized by health care providers and residents' families, the emotional effects of restraint use is often overlooked. Many people become more agitated and confused when tied to their beds and chairs. Initially, they become fearful and anxious, trying for hours to personally remove the device or to get someone else to do it for them. When their fears turn into anger, they can exhibit verbal or physical aggression toward others. In response, staff may follow up by getting a physician order for medication to calm the person. Ultimately, this cycle of events leads to a resident who becomes depressed and withdrawn. Restrained residents face the loss of autonomy, personal dignity and self-respect. Not only do they personally feel the affects of being restrained, but their families and friends avoid visiting them out of an inability to improve their loved one's situations, leading to isolation. There is more to being physically safe at the end of life. One needs to feel emotionally attached and secure.

What type of restraints are being used in long-term care facilities

According to The Nursing Home Reform Act of 1987, the resident has "the right to be free from … any physical or chemical restraint imposed for purpose of discipline or convenience and not required to treat the resident's medial symptoms." The Centers for Medicare and Medicaid Services (CMS) defines a physical restraint in a nursing facility 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 that restricts freedom of movement or normal access to one's body."

There are many types of restraints being used in long-term care facilities, some that are sold as restraints and others that really are restraints but are described by manufacturers as enablers, positioners, self-release belts, safety devices, quick release belts, and pommel cushions. Some of the easily recognizable restraints include lap or waist belts, vests, wrist or ankle restraints. However, purchased devices are not the only restraints. It is possible that the manner in which staff speak to residents may be considered a restraint. Or, using items (e.g. bed sheets) to keep residents from rising from beds or chairs, restricting their movement can be a restraint.

Bed rails have been included in the definition of a physical restraint. Currently, the use of proper bed systems, including bed rails, is being examined by hospitals, nursing homes

and home care agencies since there have been a number of incidents and deaths that have occurred as people try to get out of beds. They have attempted to go over the rails, around the rails, and even through them.

What may be a restraint for one person may not be a restraint for another. If a resident expresses a desire for a lap belt so he can self-propel the wheelchair throughout the building and outdoors, and is able both cognitively and physically to remove it, the lap belt would not be seen as a restraint. However, if a cognitively and/or physically impaired resident attempts to get out of the chair and is restricted by a lap belt and feels restrained by the device, other quality approaches should be explored.

Quality Care approaches that ensure resident safety, and physical and emotional health

Ideally, all residents receive individual assessments by interdisciplinary teams of qualified, professional staff. As we know, each person has a history, a life story, unique to that individual. Staff needs to explore with each resident and his/her family (with permission from the resident or responsible person) personal routines, interests and preferences so meaningful care plans are developed to ensure resident safety and health. For example, a resident who routinely went to the bathroom once or twice during the night when she lived at home does not remember that she needs assistance in the nursing home. She has been seen attempting to get out of bed through the bed rail. In her situation, staff need to assess her routine, remove her bed rail, assess and monitor her pattern for going to the bathroom, and develop a system that assists her to the bathroom before she actually tries to do alone. A quality care approach is to assess the resident's routine and develop an individualized care plan with appropriate interventions.

Quality care approaches are those targeted to keeping individuals as active and autonomous as possible. It may involve engaging the person in more meaningful, regularly scheduled activities, providing him/her with muscle strengthening interventions, or performing a medication review to determine if they are creating unsafe conditions. While some may express concern that failure to use a restraint will result in more frequent falls and more serious injuries, studies show that the non-use of restraints does not increase the rate of falls and, in fact, the non-use of restraints results in less incidences of serious injuries when a fall does occur.

A best practice to improve the lives of people served is to have consistent caregivers. Providing the same nursing assistant everyday is comforting for the resident and his/her family, reduces anxiety, creates a safer environment, and fulfills the overall needs of each person.

Quality care and quality of life are the key goals for all people living in our nation's nursing homes. It takes a creative partnership between the resident, the family, and the caregivers to achieve these results.

Developed by Kendal Outreach

Alternatives to Restraints

Alternatives offer the opportunity to increase the quality of life for restraints.

PSYCHOSOCIAL

Play to the resident's strengths
Provide for sense of security
Wandering paths
Offer choices
Plants
Staff dress – encourage independence
Same caregiver
Apply the 5 Magic Tools (knowing what resident likes to *See, Smell, Taste, Touch, Hear*)
Know resident's agenda
Be calm and self-assured
Pets and children
Classes for Frequent Fallers
Volunteers

ACTIVITIES

Buddy system
Restorative care
TV, video, music, picture books
Punching bags
Art of Living programming
Distraction based on their "work/career"
Repeated activity

ENVIRONMENTAL

Non-wheeled chairs
Wing back chairs
Gliders
Use of tables
Couch for sleeping
Hand belts
Music
Floor patterns
Visual barriers, murals
Fence with bushes
Non-skid surface in bathrooms
Pad dangerous furniture corners
Dining room chairs
Easy chairs
Proper fit chairs
Bed placement
Recliner for sleeping
Tap belts
Lighting
Motion detectors
Notes with directions
Grab bars
Rest areas in halls
Room identifiers

PHYSICAL

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

SOURCE: Diana Waugh, BSN, RN
Waugh Consulting, 419.351.7654

Handouts

Topic: STRATEGIES to DECREASE RESTRAINT USE in CALIFORNIA

Expect and Promote Excellence in California Nursing Homes:
PHYSICAL RESTRAINT FREE CARE

EVERYONE DESERVES DIGNITY AND FREEDOM

Restraint- free individuals can eat, dress and move independently; maintain their muscle and strength; interact with others; and maintain their freedom and dignity.

PHYSICAL RESTRAINTS

WHAT ARE PHYSICAL RESTRAINTS?

A physical restraint is any object or device that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Examples include vest restraints, waist belts, geri-chairs, hand mitts, lap trays, and siderails.

POOR OUTCOMES OF RESTRAINTS

- *Accidents involving restraints which may cause serious injury:* bruises, cuts, entrapment, siderail deaths by strangulation and suffocation.
- *Changes in body systems which may include:* poor circulation, constipation, incontinence, weak muscles and bone structure, pressure sores, agitation, depressed appetite, infections, or death.
- *Changes in quality of life which may include:* reduced social contact, withdrawal, loss of autonomy, depression, disrupted sleep, agitation, or loss of mobility.

PHYSICAL RESTRAINTS ARE USED IN PLACE OF GOOD CARE BECAUSE

- Facilities or family members mistakenly believe that they ensure safety;
- Facilities fear liability;
- Facilities may use them in place of adequate staff.

RESTRAINTS ARE MOST OFTEN USED ON

- Frail elderly residents who have fallen or may fall.
- Residents with a dementing illness who wander unsafely or have severe behavioral symptoms.

PHYSICAL RESTRAINT USE IN CALIFORNIA:

California nursing home residents are more likely to be restrained (over 13%) than residents in nursing homes nationally (over 6%). The Advancing Excellence in America's Nursing Homes Campaign has set a goal of 5% or less for all nursing homes in the country. In many nursing homes across the country, residents are restraint-free without any increase in serious injuries. It is unrealistic to expect that all falls and injuries can be prevented.

LAWS and REGULATIONS

FEDERAL

The Nursing Home Reform Act of 1987 (OBRA '87) states the resident has the right to be free from physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

This law also includes provisions requiring:

- quality of care—to prevent poor outcomes;
- assessment and care planning—for each resident to attain and maintain her/his highest level of functioning;
- residents be treated in such a manner and environment to enhance quality of life.

CALIFORNIA

The California Code of Regulations states that the resident has the right to accept or refuse proposed treatments (including restraints) and to know:

- the reason for the restraint;
- the nature and seriousness of their illness;
- the type of restraint recommended and how often and for how long it will be used;
- the likely extent of improvement or remission expected from the use of restraints, and how long it will last;
- the type, likelihood, and duration of side effects and significant risks of restraint use;
- alternative treatments and their risks;
- why restraints are recommended; and
- the resident's right to accept or refuse the proposed treatment (i.e.: restraints), and to revoke consent for the treatment for any reason at any time.

RESTRAINT REDUCTION STRATEGIES

Twenty years of experience provide many strategies for safe restraint reduction and elimination.

Restraint reduction involves the whole facility, including administrators, nursing directors, physical and recreational therapists, nursing assistants, and housekeeping personnel. Family members and advocates can encourage the facility's efforts, and expect and insist that the facility:

- Complete a **comprehensive resident assessment** that identifies strengths and weaknesses, self care abilities and help needed, plus lifelong habits and daily routines.
- Develop an **individualized care plan** for how staff will meet a resident's assessed needs. It describes the care goals (e.g. safe walking), and when and what each staff person will do to reach the goal. The care team includes staff, residents and families (if the resident wants), and devises the plan at the quality care plan conference. The resident may also invite an ombudsman to attend. Care plans change as the resident's needs change.
- Train staff to assess and meet an individual resident's needs—hunger, toileting, sleep, thirst, exercise, etc.—according to the **resident's routine rather than the facility's routine.**
- Make permanent and consistent staff assignments and promote staff flexibility to meet residents' individualized needs.
- Treat medical conditions, such as **pain**, that may cause residents to be restless or agitated.
- Support and encourage caregiving staff to **think creatively** of new ways to identify and meet residents' needs. For example, a "night owl" resident could visit the day room and watch TV if unable to sleep at night.
- Provide a **program of activities** such as exercise, outdoor time, or small jobs agreed to and enjoyed by the resident.
- Provide **companionship**, including volunteers, family, and friends by making the facility welcoming.
- Create a **safe environment** with good lighting, pads on the floor to cushion falls out of bed; a variety of individualized comfortable seats, beds and mattresses; door alarms; and clear and safe walking paths inside and outside the building.

Nursing homes can implement specific programs for reducing physical restraints, including:

- Restorative care, including walking, and independent eating, dressing, bathing programs;
- Wheelchair management program—including correct size, and seat cushion good condition;
- Individualized seating program—chairs, wheelchairs, tailored to individual needs;
- Specialized programs for residents with dementia, designed to increase their quality of life;
- Videotaped family visits for distant families;
- Wandering program—to promote safe wandering while preserving the rights of others;
- Preventive program based on knowing the resident—to prevent triggering of behavioral symptoms of distress;
- Toileting of residents based on their schedules rather than on staff schedules.

FIND AN ADVOCATE:

Contact your local or state ombudsman if you have concerns about the care a resident is receiving. An ombudsman is a state-certified advocate for residents of nursing and residential care facilities who is familiar with the local facilities and often with the staff and residents. *All conversations with an ombudsman are confidential unless permission is given to use a person's name.*

CONTACT the California Ombudsman Program to find your local Ombudsman Program:

Office of the State Long-Term Care Ombudsman
California Department of Aging
1300 National Drive, Suite 200
Sacramento, California 95834
Voice: (916) 419-7510 Fax: (916) 928-2503
Statewide CRISISline (800) 231-4024
Website: http://www.aging.ca.gov/html/programs/ombudsman.html

Supported by a grant from the California HealthCare Foundation, based in Oakland, California. The grant, Voices for Quality: Strategies in the National Campaign for Excellence in America's Nursing Homes*, enables NCCNHR to provide training, consultation and support to the California Ombudsman Program.*

Voices for Quality:
Strategies in the National Campaign for Excellence in America's Nursing Homes

Project Overview and Action List

This project, supported by a grant from the California HealthCare Foundation, based in Oakland, California, aims to provide information and tools that can be used to train ombudsmen to engage consumers in quality improvement, by educating and engaging consumers to advance better quality care in nursing homes. The educational component will highlight strategies to promote facility involvement and hold nursing homes accountable to quality standards.

Project materials can be found online: http://www.nccnhr.org/public/245_1266_13817.cfm.

Here are nine things that you can do on a day-to-day basis in your work to keep the Voices for Quality project moving forward, and to promote the materials that have been developed around restraint free care!

- ✓ Post the Expect and Promote Excellence in California Nursing Homes: Physical Restraint Free Care consumer fact sheet on your organization's website. *Remember that there is room at the bottom of the second page to include contact information for regional ombudsman programs.*

- ✓ During your regular facility visits, explain to facility staff that this initiative is taking place because California continues to have one of the highest restraint rates in the country. Review the restraint indicator of the facility before you visit and discuss with the facility what they are doing to reduce restraints or to keep their restraint rate low. Encourage facility staff to work with the QIO and LANE to reduce restraints.

- ✓ When you visit nursing homes, provide copies of the Physical Restraint Free Care consumer fact sheet to residents, family members, resident councils, family councils, administrators, and nursing home staff.

- ✓ Use the Physical Restraint Free Care consumer fact sheet to train colleagues, family and resident councils, and other organizations. Explain that the California restraint rate is very high and that there are national and state initiatives to reduce restraints.

- ✓ Post a short information article in your organization's newsletter about the Voices for Quality: *Strategies in the National Campaign for Excellence in America's Nursing Homes* project.

- ✓ Enroll in the *Advancing Excellence in America's Nursing Homes* Campaign to show that consumers care about quality: www.nhqualitycampaign.org.

- ✓ Tell others about the *Advancing Excellence* Campaign and encourage them to enroll.

- ✓ Encourage facilities to be a part of the *Advancing Excellence* Campaign. Encourage them to choose restraints and staff turnover as two of their measures.

- ✓ Read about consumer involvement and NCCNHR's involvement in the *Advancing Excellence* Campaign: http://www.nccnhr.org/public/245_1266_13315.cfm.

A Brief Summary of the Campaign

As America's population ages and the first of the "baby boomers" turn 60 years old, a new coalition concerned about how we care for elderly and disabled citizens is reinvigorating efforts to improve the quality of care and quality of life for those living or recuperating in America's nursing homes. Health care providers, caregivers, medical and quality improvement experts, government agencies, consumers and others are joining the two-year *Advancing Excellence in America's Nursing Homes* campaign that will build on the success of other quality initiatives like Quality First, the Nursing Home Quality Initiative (NHQI), and the culture change movement.

The voluntary campaign, which will monitor key indicators of nursing home care quality, promotes excellence in caregiving for nursing home residents and acknowledges the critical role of nursing home staff in providing that care.

Advancing Excellence in America's Nursing Homes will assess progress toward achieving the following measurable goals:

1. Reducing high risk pressure ulcers;
2. Reducing the use of daily physical restraints;
3. Improving pain management for longer term nursing home residents;
4. Improving pain management for short stay, post-acute nursing home residents;
5. Establishing individual targets for improving quality;
6. Assessing resident and family satisfaction with the quality of care;
7. Increasing staff retention; and
8. Improving consistent assignment of nursing home staff, so that residents regularly receive care from the same caregivers.

Nursing homes participating in the campaign will work on at least three of the eight goals and can access technical assistance and guidance from quality experts in reaching their targeted goals. Consumers participating in the campaign will help to create greater awareness of quality care and the resources available now, and encourage providers to improve the care they deliver. The campaign will report on providers' continuing quality improvement progress overall, and those reports will inform consumer choices for future long term care needs. For more information about the campaign, or to register for the campaign, visit the campaign Web site, www.nhqualitycampaign.org.

The *Advancing Excellence in America's Nursing Homes* campaign was founded by key stakeholders: Alliance for Quality Nursing Home Care; American Association of Homes and Services for the Aging (AAHSA); American Association of Nurse Assessment Coordinators (AANAC); American College of Health Care Administrators (ACHCA); American Health Care Association (AHCA); American Medical Directors Association (AMDA); Centers for Medicare & Medicaid Services (CMS) and its contractors, the Quality Improvement Organizations (QIOs); The Commonwealth Fund; The Evangelical Lutheran Good Samaritan Society; National Association of Health Care Assistants (NAHCA); National Citizen's Coalition for Nursing Home Reform (NCCNHR), and the National Commission for Quality Long-Term Care. Organizations that share a commitment to continuously improving quality care in nursing homes are encouraged to join the campaign.

How the campaign goals will improve quality

High quality nursing home care – where residents get the care that is right for them every time - is important for everyone. Nursing home residents, their families, and people who may someday choose a nursing home for themselves or a loved one should be able to expect the best possible care every time. The *Advancing Excellence in America's Nursing Homes* campaign is the first national effort to measure quality by setting measurable "clinical" and "process" goals.

In the *Advancing Excellence in America's Nursing Homes* campaign, nursing homes will voluntarily work on at least three of eight measurable quality goals. A provider must select at least one of four clinical goals and at least one of four process-related goals.

What is a "clinical goal?" It measures how well a nursing home cares for residents or patients with certain common conditions. Information for clinical goals for all nursing homes is collected by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare. You can read about these quality measures on Medicare's Nursing Home Compare Web site, www.medicare.gov/nhcompare/home.asp, and use them as one tool to help you evaluate the quality of a nursing homes' care.

Goal #1: Reducing pressure ulcers.

The campaign's first clinical goal (Goal 1) measures how nursing homes prevent or reduce pressure ulcers, also known as bed sores, for residents. Nursing home residents who cannot easily reposition themselves are often susceptible to this condition and need special care. Proven techniques can reduce and almost eliminate this uncomfortable and potentially dangerous condition. The campaign goal is for 50,000 fewer residents to suffer from bed sores by September, 2008[1].

Goal #2: Reducing the daily use of physical restraints.

The second clinical goal (Goal 2) will help residents to remain independent as well as safe. While physical restraints were once regarded as necessary for the safety of some residents, today the practice is to greatly reduce and even eliminate restraint use in nursing homes. Research has proven that restraints increase the likelihood of injury and may cause serious problems that jeopardize health and quality of life. The campaign will help nursing homes to learn the best ways to minimize restraints, and the goal is for at least 30,000 fewer residents to use restraints by September 2008[1].

Goals #3 & #4: Improving the management of pain in long stay residents and short-stay residents.

The next two goals will help residents with painful medical conditions to lead more comfortable, pain-free lives by treating them for pain. By September 2008, 40,000 fewer long-stay (Goal 3) and 130,000 fewer short-stay (Goal 4) residents will experience moderate-to-severe pain on a daily basis, due to efforts of the campaign[1].

[1] Based on an the 1999National Health Statistics estimate of 1.6 million residents residing in an American nursing homes at any one point in time.

"Process" goals help measure the overall satisfaction and experience of nursing home residents and staff as well as the nursing home's commitment to quality improvement. People in the nursing home field know a resident's experience can be improved by assessing resident and family satisfaction, improving retention of nursing staff who work with residents, and assigning the same nursing staff to residents on a consistent basis.

Goal 5: Setting individualized targets for clinical quality improvement.

In order to stay on track of their efforts to improve quality, nursing homes can set improvement targets in the Advancing Excellence campaign. Nursing homes that regularly set quality improvement targets are more likely to be committed to improving the quality of care they provide to their residents. The first of four process goals (Goal 5) is for 90 percent of all nursing homes to set annual clinical quality targets, using a system designed and assisted by Quality Improvement Organizations.

Goal #6: Measuring resident and/or family satisfaction and incorporating this information to quality improvement activities.

The campaign has a process goal for more than 80 percent of nursing homes to assess resident and family experience of care (Goal 6) and incorporate this information into their quality improvement plans.

Goals #7 & #8: Measuring nursing staff turnover and developing action plans to improve staff retention, and adopting "consistent assignment."

The last two campaign goals involve staffing issues. By September 2008, approximately 35,000 fewer staff will leave their jobs each year[2], and to improve quality of life, 80 percent of nursing homes will measure staff turnover and satisfaction (Goal 7). One-third of homes will adopt "consistent assignment" of CNAs to residents (Goal 8).

Regular campaign updates showing progress will be posted on the campaign Web site at www.nhqualitycampaign.org. In addition, the campaign will provide a listing of the homes participating to allow consumers, providers and organizations (such as state and national associations) to track which homes have enrolled.

[2] Based on a 2002 report by the American Health Care Association, current estimated total terminations for CNAs, RNs, & LPNs is over 574,000

Advancing Excellence in America's Nursing Homes
Campaign Goals & Objectives

Goal 1: Nursing home residents receive appropriate care to prevent and minimize pressure ulcers.

Objectives: By September, 2008:

a) The national average for high risk pressure ulcers is below 10%.
b) 30% of nursing homes will regularly report rates of high risk pressure ulcers below 6%
c) No nursing home will a report rate of high risk pressure ulcers that exceeds 24%
d) Compared to June 2006, approximately 50,000 fewer residents will have pressure ulcers

Goal 2: Nursing home residents are independent to the best of their ability and rarely experience daily physical restraints.

Objectives: By September, 2008:

a) The national average of the daily use of physical restraints will be at or below 5%
b) 50% of nursing homes will regularly report rates of daily use of physical restraints below 3%
c) No nursing home will a report rate of daily use of physical restraints that exceeds19%
d) Compared to June 2006, approximately 30,000 fewer residents be physically restrained daily

Goal 3: Nursing home residents who live in a nursing home longer than 90 days infrequently experience moderate or severe pain.

Objectives: By September, 2008

a) The national average of moderate or severe pain experienced by long-stay residents will be at or below 4%.
b) 30% of nursing homes will regularly report rates of moderate to severe pain for long stay residents under 2%
c) No nursing home will a report rate of moderate or severe pain that exceeds 20%
d) Compared to June 2006, approximately 40,000 fewer long stay residents will suffer from moderate or severe pain

Goal 4: People who come to Nursing Homes after staying in the hospital only sometimes experience moderate to severe pain.

Objectives: By September, 2008

a) The national average of moderate or severe pain experienced by post-acute residents will be at or below 15%.
b) 30% of nursing homes will regularly report rates of moderate or severe pain for post acute residents below 10%
c) No nursing home will a report rate of moderate or severe pain that exceeds 46%

d) Compared to June 2006, approximately 130,000 fewer post acute care residents will suffer from moderate or severe pain

Goal 5: Most Nursing Homes will set individualized targets for clinical quality improvement.

Objectives: By September, 2008

a) 90% of nursing homes will set annual clinical quality targets using the target-setting system at www.nhqi-star.org
b) 50% of nursing homes will set annual targets for clinical quality improvement that are at least 25% lower than their rate at that time.

Goal 6: Nearly all Nursing Homes assess resident and family experience of care and incorporate this information into their quality improvement activities.

Objectives: By September, 2008

a) The national average of Nursing Homes that regularly assess resident experience of care and incorporate into their quality improvement activities exceeds 80%.
b) 1.28[1] million residents will now be asked about their experience and satisfaction with the care provided to them in the nursing home
c) Regularly assessing family member experience of care, and incorporating this information into nursing home quality improvement activities will be measured, and become the usual experience in nursing homes nationally.

Goal 7: Most Nursing Homes measure staff turnover and develop action plans as appropriate to improve staff retention.

Objectives: By September, 2008

a) The national average of nursing homes that regularly measure staff turnover & develop action plans to reduce the rate of turnover (including setting targets for staff turnover) exceeds 80%
b) The national average for [measured] staff turnover (RN, LPN, CNA) will be reduced by 15%.
c) approximately 35,000 fewer nursing home nursing staff will leave their jobs each year

Goal 8: Being regularly cared for by the same caregiver is critical to quality of care and quality of life. To maximize quality as well as resident and staff relationships, the majority of Nursing Homes will employ “consistent assignment”.

Objectives: By September, 2008

a) One-third of Nursing Homes will have adopted “consistent assignment” among CNAs
b) 5300 nursing homes will have adopted “consistent assignment” among CNAs

[1] According to 1999 National Health Statistics, there is an estimate of 1.6 million residents residing in nursing homes at a single point in time

NCCNHR National Citizens' Coalition for Nursing Home Reform

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August 2006

Dear Residents, Family Members, and Others Who Support Quality Long-Term Care:

The National Citizens' Coalition for Nursing Home Reform (NCCNHR) encourages everyone who is concerned about quality nursing home care to participate with us in the *Advancing Excellence in America's Nursing Homes* Campaign. In June 2006, the NCCNHR Board made the decision to participate in this national effort after much thoughtful deliberation. **We believe that the campaign has the potential to bring national attention to serious problems in nursing home care that must be addressed. We also believe that the campaign provides opportunities to promote individualized care and to address specific clinical and workforce issues that can bring about real quality of care and quality of life for 1.5 million people who live in nursing homes.**

This campaign calls upon each nursing home in the country to choose targets and make progress on specific goals they elect, including reducing pain, pressure ulcers and restraint use; addressing staff turnover, implementing consistent assignment of nursing staff, setting clinical quality targets, and measuring resident and family satisfaction. While facility participation is voluntary, it is our hope that with this united effort, each nursing home will step up and focus on improvements that we know can benefit residents. Participating facilities will choose at least three measures but can choose to address all eight.

The organizations included in planning the campaign include provider associations, a foundation, nurses and physicians, a union, the Centers for Medicare and Medicaid Services, and other groups involved in long-term care. The campaign also provides opportunities for individual consumers and organizations to participate on the local, state and national level. NCCNHR views the campaign as an opportunity to provide concrete information to consumers on each of the areas that are going to be measured. We also believe that having advocates and consumers encourage facility involvement in the campaign will encourage facility participation and attention to these serious issues.

Please know that our organization will make every effort to be a strong voice for residents throughout the campaign and will continue our traditional advocacy work in other arenas. NCCNHR's involvement has already resulted in campaign plans that will better address resident care, specifically the inclusion of two workforce measures. We believe that NCCNHR's participation will complement and not in any way restrict our other organizational efforts.

In recent conversations with some residents and family members, I have been asked whether I really think that this campaign warrants consumer involvement. My answer is "yes."

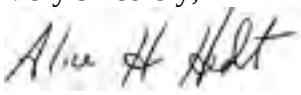
- **"Yes"** because it provides the opportunity to bring national attention and dialogue to issues that need to be addressed.
- **"Yes"** because it includes a component that provides opportunities for consumers to give input during the campaign.
- **"Yes"** because for the first time two areas related to staffing will be tracked and analyzed at the national level – turnover and consistent assignment.
- **"Yes"** because it provides opportunities for regular, on-going dialogue between consumers, providers, CMS and other key stakeholders. Consumer involvement is essential as we seek to improve quality.

I encourage each one of you to go to the campaign website and sign up as a consumer participant. You will not receive any mail or e-mails unless you indicate that you would like feedback. By enrolling, you will be saying that you believe nursing home care can improve. You are saying, "Yes to Excellence." NCCNHR also encourages you to:

- Visit the website at www.nhqualitycampaign.org and join the campaign as a *participating consumer* to learn more and to join others who EXPECT EXCELLENCE!
- Ask the nursing home(s) in your community if they are participating in *Advancing Excellence*. If not, encourage them to become involved.
- Talk to facility staff about what measures the nursing home will be addressing and how you as a consumer can support their efforts. Express your opinion about what measures the facility should address.
- **Encourage each facility to choose the two goals that are most closely linked to quality –** reducing staff turnover and increasing consistent assignment so that staff know the individual needs and preferences of each resident and so that important relationships can be developed.
- Hold discussions about *Advancing Excellence* in resident and family councils.
- Consider participating in community or statewide activities (Local Area Networks for Excellence, or LANES) to promote excellence in nursing homes.

NCCNHR believes that residents themselves, along with family members and advocates, can best define quality and provide essential information to facility staff about how their quality of life and quality of care can be improved. Please let us know about your involvement and ideas. Working together, we can improve the day-to-day lives of residents. Together, we can make a difference!

Very sincerely,



Alice H. Hedt

Tips for Local Ombudsmen on Involvement in Advancing Excellence campaign

The following tips were developed to assist local ombudsmen in identifying their role in the Advancing Excellence Campaign.

Ideas for Ombudsmen concerning involvement in the campaign:

- Utilize the campaign as a learning opportunity to educate yourself about quality care and resident directed care
- Utilize the campaign to promote quality practices in individual facilities and throughout the region served
- Utilize the campaign as an opportunity to do consumer education on each of the 8 goals
- Utilize the campaign to promote consumer & facility dialogue

The Local Ombudsman's Role in the Campaign:

- Talk with your State Ombudsman about their involvement with the Local Area Network for Excellence (LANE) & the campaign. Ask your State Ombudsman about his/her vision for how this campaign will be implemented in your state.
- Gather materials related to each of the 8 goals to educate yourself and others about quality practices related to each of the goals
- Utilize these materials to provide training for ombudsman volunteers & equip volunteers with information to share with residents & families.
- Request to provide training to resident and family councils – encouraging them to have discussions with the facility staff about the campaign measures
- Be sure to mention the campaign in all public education & training events – use the campaign as an opportunity to promote quality care.
- During visits talk to facility administration about their involvement in the campaign – if they are signed up, which goals they have chosen, progress on the goals – encourage facilities to choose the turnover & consistent assignment goals as NCCNHR believes these staffing related goals have the greatest impact on quality of care & life for residents.
- Ensure that facilities that have chosen the process goals are undertaking activities that realistically have potential to impact quality of care (ie. Consumer satisfaction surveys that accurately reflect resident and family concerns).
- Check quality measure data on the Nursing Home Compare website at www.medicare.gov for each facility and compare their measures to the state & national data. Use this information in your ombudsman advocacy with the facility.

Consumer Involvement in Advancing Excellence in America's Nursing Homes Campaign

Strategies for Consumers & Advocates

The National Campaign to promote excellence in America's nursing homes has the following objectives for the involvement of residents, their families and friends, and their advocates.

The Campaign will:
Provide consumers the opportunity to participate in a national two-year campaign designed to improve nursing home quality.

Provide consumers with concrete educational materials on the seven areas of quality being addressed in the campaign – pressure sores, restraints, pain, consistent assignment, staff turnover and retention, facility target setting, and resident and family satisfaction with the care residents receive.

Promote opportunities for residents, their families, ombudsmen, citizen groups, and other advocates to work with nursing facility staff on ways to achieve the campaign's goals and to support facilities' efforts to institute meaningful, lasting changes.

Create opportunities for national, state and local dialogues on nursing home quality that promote resident-directed care, culture change, improved quality of care and life for residents, and better working conditions for staff.

Strategies for the Individual Consumer

(Residents, Family Members, Ombudsmen, Advocates, and Others who are concerned about quality nursing home care)

- Visit the NH Quality Campaign site and sign up as a supporter. You can select whether to receive e-mails about the campaign in your state. http://www.nhqualitycampaign.org/
- Encourage facilities in your community (city, state, etc.) to enroll in the Campaign. All facilities – for profit, not for profit, individually owned – will benefit from setting specific goals and working to address them.
- Ask facility administration what goals they will be addressing and the steps they will take to make improvements. Share what goals you think are important to be addressed. (Each facility must chose at least 3 of the 8 – pressure sores; restraints; pain – short term residents; pain – long-term residents; setting targets; consumer satisfaction; staff turnover/retention; and consistent assignment.)

- Learn about the 8 topic areas (goals) and share information with other residents, family members and staff.

- Encourage discussion of the topic areas in family and resident councils.

- Examine the state specific data on the website and track your facily's progress.

- Contact the LANE Convener in your state and volunteer to work on the Campaign. (Most states have a LANE – Local Area Networks for Excellence - of providers, consumers, and others who are working to make improvements in nursing homes.)

Strategies for Consumer Advocates
(Citizen Advocacy Groups, Ombudsmen, Other Organizations)

In addition to the ideas above:

- Encourage participation in the campaign (i.e., meetings with Trade Associations, etc.)
- Host dialogue sessions on topic areas for consumers in your region.
- Participate in statewide coordinated efforts for the Campaign including the LANES (Local Area Networks for Excellence). Find out who your state's LANE Convener is by visiting the NH Quality Campaign website.
- Put articles about the Campaign and about the eight topic areas in your newsletter and on your website.
- Encourage local press to do stories about nursing home quality. Present educational programs on the goals of the campaign and how these relate to quality care.
- Provide consumers with information on the goals and their meaning. Disseminate information to residents and family members on quality as related to pain, pressure sores, restraints, turnover, etc.
- Track the number of facilities in your area that are participating in the campaign and continue to encourage participation of those that have not yet enrolled.
- Provide information to the public on how to select a facility that includes details about nursing home participation in the Campaign as a factor to consider. Note: Quality goals should be considered but should not be the primary reason to choose a facility. Consumers need to visit facilities in selecting a facility and look at facility performance, location, ability to meet resident needs, and staffing.

Expect and Work for Excellence.
Enroll in the Campaign Today.

www.nhqualitycampaign.org

A CONSUMER GUIDE TO CHOOSING A NURSING HOME

Consumer Fact Sheet May 2007

NCCNHR: The National Consumer Voice for Quality Long-Term Care knows that placing a loved one in a nursing home is one of the most difficult tasks a family member ever faces. But when it becomes necessary, prospective residents and their families should have the best information possible to make this decision. There are many resources that can help. The purpose of this guide is to help you navigate those resources, understand the information, and make an informed choice. Once your loved one is in a nursing home, NCCNHR can help you get good care there. Visit our website, www.nccnhr.org, or call us at 202.332.2275 for more information.

First, Explore Alternatives

If at all possible, plan ahead for future long-term care needs. If an individual and those close to them can discuss preferences related to long-term care and plan ahead of time, decisions and arrangements are much easier when the need for long-term care arises.

Before you look for a nursing home, be sure your loved one's condition and support system has been thoroughly evaluated. When properly diagnosed and treated, some conditions may improve significantly. Also, some people with serious medical conditions can remain at home with the proper support system. Talk with your loved one to find out about her/his wishes. Even if s/he has dementia and/or difficulty communicating, the prospective resident should be at the forefront of the decision-making process as much as possible. Since most people prefer to stay in their own home, it is important to investigate alternatives to nursing home care (e.g. home care, day care, assisted living). Sources of information about available services are the Eldercare Locator, telephone number: 1.800.677.1116 or website: www.eldercare.gov and the National Aging Information Center website: www.aoa.gov/NAIC/Notes/caregiverresource.html. If nursing home care is needed, decide whether long-term care or short-stay rehabilitation is needed.

Do Your Homework

As you begin to evaluate facilities, it's a good idea to do some preliminary research before you visit any nursing homes. Once you have gathered information, visits to the facilities you are considering will provide you with very important insights. (See "Visits to Nursing Homes" section, page 6.) Some issues to consider when evaluating facilities include quality of care and life, bed availability, provision of services that the resident will need, cost, and location in an area where friends and family of the resident can visit often. Ask nursing home residents, residents' families, citizen advocacy groups, your physician, the hospital discharge planner and clergy members for their opinions about various facilities. This guide will highlight some important sources of information to use in your evaluation, including:

- Long-Term Care Ombudsmen
- State or Local-Level Citizen Advocacy Groups
- Cost Information
- 'Nursing Home Compare' website
- State Nursing Home Inspection Reports
- Complaint Information
- Visits to Nursing Homes

Experts to Consult: The Prospective Resident, Long-Term Care Ombudsmen and Citizen Advocates

First, consult with experts. The best expert on what will be a good place to live is the prospective resident. Ask him or her about whether s/he wants to live near a particular family member or friend, in his or her hometown, if s/he prefers a large or small facility, etc. Then, a state or local ombudsman program and/or citizen advocacy group can assist you in piecing together the different sources of information to make an informed decision about nursing home care. An ombudsman is a state or

county government-funded advocate for residents of nursing homes, board and care homes, and assisted living facilities who will be familiar with the facilities in your area and often with the staff and residents who reside in them. Ombudsmen assist residents and others by:

- Educating consumers and long-term care providers about residents' rights and good care practices
- Investigating complaints and advocating for residents' rights and quality care in long-term care facilities; and
- Providing information to the public on long-term care facilities and policy issues.

S/he can help you find and interpret information from state inspection reports and the resident characteristics or quality measures that can be found on the Nursing Home Compare website: www.medicare.gov/NHCompare/home.asp. To find your Long-Term Care Ombudsman, go to the NCCNHR website: www.nccnhr.org and click on the button labeled "State Ombudsmen" or call NCCNHR at 202.332.2275 for ombudsman contact information.

Also, many states and/or communities have active Citizen Advocacy Groups that are knowledgeable about nursing homes and can be very helpful in evaluating advice and information you receive. To find a local or state citizen advocacy group go to the NCCNHR website: www.nccnhr.org and click on the button labeled "Citizen Groups" or call NCCNHR at 202.332.2275.

Cost Information

Most nursing homes participate in the Medicare and/or Medicaid programs, which reimburse them for part or all of the care that some residents receive. Medicare pays for post-hospital rehabilitation care and hospice care services for short periods of time. Medicaid pays for nursing home care for longer periods for those who are financially eligible.

Most nursing home residents, even if they pay privately when they enter a home, eventually run out of money because of the high costs. They then apply to have the cost of their care paid for by Medicaid. Unless you are certain the resident can pay indefinitely with private funds, choose a facility that accepts Medicaid payment. Find out what your state's Medicaid eligibility rules are. Note that spouses may keep some assets and have a regular income even if their partner is on Medicaid. For additional information about the rights of residents paying for care through Medicaid, contact the long-term care ombudsman program and/or a local consumer advocacy group.

'Nursing Home Compare' Website

(If you don't have internet access, ask the Ombudsman for this information.)

Nursing home data is provided by the federal government through 'Nursing Home Compare': www.medicare.gov/NHCompare/home.asp. On this site, you can search for nursing homes by state, county, city, or zip code. Once you have selected a nursing facility or facilities, you are given the option of viewing several different types of information including facility characteristic, inspection, staffing level, and quality measure information. Below are consumer tips on how – and how not – to use each of these sources of information.

Facility Overview

On 'Nursing Home Compare' the "About Homes" section gives an overview of basic characteristics of each facility. Data in this section includes the type of ownership (for-profit, non-profit, church-related, etc.), type of payment accepted (Medicare, Medicaid, or both), the size of the facility, and whether or not the facility is part of a chain. All of this information can be helpful in getting a preliminary picture of what the facility is like.

State Nursing Home Inspection Reports

'Nursing Home Compare' provides inspection reports for each facility. State inspection or "survey" reports contain information about any deficiencies found when inspectors complete their annual inspection of the facility. Inspections take place at least every 9 to 15 months. You can also

obtain state inspection reports from the state survey agency, the facility itself, or the long-term care ombudsman. Each facility is required by law to make the latest state inspection report available for examination in a place readily accessible to residents. To look at a summary of state inspection information on 'Nursing Home Compare', click on the tab labeled "Inspections."

Tips:

- ✓ Check the date of the inspection results posted on the website to be sure that they are dated within the last 9-15 months. If the date is earlier than that, there has likely been a more recent inspection. (The date of the inspection is listed right above the deficiency summary.)
- ✓ View previous inspection results (by clicking on the button labeled "View Previous Inspection Results" located above the list of deficiencies) to see what the pattern of quality has been over a three year period.
- ✓ Compare the number of deficiencies cited to the state average.
- ✓ If a facility has received a deficiency citation in a particular area, be sure to ask questions about this area when you visit the facility.
- ✓ Obtain actual inspection reports at the facility itself or from the long-term care ombudsman program if you don't have access to the web.

Cautions:

- ➢ Beware of choosing a facility with a very high number of deficiencies compared to other facilities in the area and the state average.
- ➢ Don't assume that a "deficiency free" rating necessarily means that there are no problems with care at a particular facility.

Complaint Information

You should also delve deeper by gathering information about the number and kind of complaints that have been filed against a facility. Verified or "substantiated" complaint information is included along with the nursing home inspection results on the 'Nursing Home Compare' website. Consumers can also obtain information about complaints filed against a particular facility (substantiated or unsubstantiated) by contacting the state survey and inspection agency, the long-term care ombudsman program, or through a website called Member of the Family at: www.memberofthefamily.net.

Staffing Information

'Nursing Home Compare' also provides information about the hours of nursing care provided at each facility. Staffing levels are a critically important factor to consider in evaluating the quality of care given at a facility. The information provided on nurse staffing levels includes national and state staffing averages, and the daily average for individual nursing homes.

Tips:

- ✓ Pay attention to the number of Certified Nursing Assistant (CNA) staffing hours. CNAs provide 90% of the hands-on resident care.
- ✓ Look for facilities with high levels of RN staffing. Studies show that RN involvement in care is important for quality.
- ✓ Visit the facility and ask staff and families about the actual numbers of staff available to directly care for residents on each shift.

Cautions:

- ➢ The staffing hours reported on 'Nursing Home Compare' include not only direct care from nurses and nursing assistants but also administrative nursing time. This makes it difficult for consumers to know how much direct care residents are receiving.
- ➢ The staff hour data used for 'Nursing Home Compare' is self-reported by the facility and is not audited for accuracy.

Quality Measures

'Nursing Home Compare' also provides information on "Quality Measures." To see this, select the nursing home using the search criteria

from the homepage and then click on the tab labeled "Quality."

Nursing homes have many opportunities to improve care and their scores on the measures. Ask the facility if they are participating in the training provided by their state's Quality Improvement Organization and if the facility has signed up for the national *Advancing Excellence in America's Nursing Homes Campaign*.

"Quality Measures" provide important information; however, they are just one piece of the puzzle in choosing nursing home care. The measures are meant to provide indicators of quality care and comparative information. Measures include 14 indicators for chronic care (long-stay) residents, and 5 indicators for acute care (short-stay) residents. The measures use data taken from quarterly assessments of individual residents done by the facility. The information gathered from the individual's assessment is then combined with the assessments of the other residents in the facility to produce a facility-wide measure for each category. **Quality Measures are designed to provide comparison information among facilities and are not intended as a nursing home rating system.**

You should use quality measure information as <u>one</u> indicator of care; however, the importance of actually visiting facilities and talking with residents, family members and staff cannot be overemphasized. **Discuss questions about these measures with a variety of people, including the ombudsman, facility staff, and others you talk to about the facility.**

MEASURES FOR "LONG-STAY" RESIDENTS

"Long-Stay" residents are those in an extended or permanent stay in a nursing home. **A high percentage score on Quality Measures 1 through 4 may indicate there is not enough staff available to attend to residents' individualized plans of care.**

1. **Percentage of residents whose need for help with activities of daily living (ADLs) has increased**. A high percentage may indicate that residents are not encouraged to do things on their own, such as feeding themselves or moving from one chair to another. Ask how resident independence is promoted.
2. **Percentage of residents who spend most of their time in bed or in a chair**. A high percent here may indicate that there is not enough staff to assist residents with getting dressed and out of bed or that there are not organized activities for residents. Ask questions about who is responsible for getting residents up and dressed in the morning and when.
3. **Percentage of residents whose ability to move about in and around their room worsened**. Nursing home staff should encourage residents to do as much as possible on their own and to engage in activities. Again, ask questions about how staff provide assistance to promote resident independence.
4. **Percentage of residents who are physically restrained**. Studies show that restraints are detrimental to resident physical and mental well-being. Restraints are often used to compensate for a lack of adequate staff to attend to resident needs and safety. A high percentage in this category is a red flag. You should ask staff what methods, other than restraints, are used to provide a safe environment for mobility. Restraints may not be used without a doctor's order.

A high percentage in Quality Measures 5 to 7 may indicate that there is a lack of adequate staff to toilet residents on an individualized schedule.

5. **Percentage of low risk residents who lose control of their bowels or bladder.** Loss of bowel or bladder control is not a normal sign of aging. "Low risk" residents would be those people whose medical or physical condition does not indicate that they would have this problem. Ask questions about whether residents are toileted on an individual schedule, and how bladder and bowel movements, and food and fluid intake are monitored.
6. **Percentage of residents who have/had a catheter inserted and left in their bladder.** A catheter should only be used if it is medically necessary - not to compensate for inadequate staffing levels to toilet residents.

7. **Percentage of residents with a urinary tract infection (UTI)**. UTI's occur when bacteria builds-up around a catheter or when the area where waste leaves the body is not kept clean. Ask questions about attention to resident personal hygiene, infection control and treatment procedures if you see a high percentage of residents with UTI's.
8. **Percentage of high risk residents who have pressure sores**. A high percentage on this quality measure may indicate that residents are not being repositioned as frequently as necessary. Ask questions about how often residents are repositioned, toileted, or have diapers changed and how fluid intake is monitored.
9. **Percentage of low risk residents who have pressure sores.** A high percentage on this measure may indicate that staff are not encouraging able residents to get out of bed or be up and moving around. Ask questions about how residents who are mobile are encouraged to stay active and how frequently residents are toileted.
10. **Percentage of residents who have become more depressed or anxious**. A high percentage in this measure may indicate that residents lack meaningful activities and/or that anxiety and depression are not being monitored. Ask questions about ways staff monitor and treat residents' depression and specifics on available activities for residents. Activities should be offered based on what residents choose.
11. **Percentage of residents with moderate to severe pain.** A high percentage here may indicate that residents do not receive regular pain assessments. If residents are in pain, it should be addressed quickly. Ask staff how frequently residents receive a pain assessment and how quickly medications are prescribed for pain management.

MEASURES FOR "SHORT-STAY" RESIDENTS

"Short-Stay" residents are those needing short-term skilled nursing care or rehabilitation, but who are expecting to return home.

1. **Percentage of residents with delirium**. Delirium is severe confusion and rapid changes in brain function, usually caused by a treatable physical or mental illness. A high percentage on this measure could mean that nursing home staff does not adequately deal with symptoms of delirium. Each nursing home should have a plan for helping residents who suffer from delirium. You should ask staff about their plan for handling and preventing delirium.
2. **Percentage of residents who had moderate to severe pain.** Residents should always be checked regularly by nursing home staff to see if they are having pain. If residents have pain it should be addressed quickly. Ask staff how frequently residents receive a pain assessment and how quickly medications are prescribed for pain management.
3. **Percent of residents with pressure sores.** A high percentage on this quality measure may indicate the residents are not repositioned or encouraged to reposition themselves frequently. Ask questions about how often residents who are immobile are repositioned and toileted to prevent pressure sores from developing and how residents who are mobile are encouraged to move about.

Tips:

- ✓ Compare a facility's score with others in the area and/or the State to see how it measures up.
- ✓ All of these quality measures are negative measures. This means they measure a condition that is undesirable. Consumers should look for facilities that score below the state average – and the lower the better.
- ✓ If you have questions about the quality measure information that is provided, call 1-800-MEDICARE, or contact your State Quality Improvement Organization (QIO).
- ✓ Remember, quality measures are just one factor in making a decision. Visits, talking with the ombudsman program and citizen group, reviewing the surveys, and looking at staffing issues are necessary for informed decisions.

Cautions:

- Don't assume that the information provided is 100% accurate. These measures are based on facility-reported information that is not independently audited for accuracy.
- These measures only *suggest* good or bad care. Also, even when these measures show percentages lower than the state average in one area (e.g., prevention of pressure sores), they don't necessarily mean there will be lower percentages in other areas (e.g., prevention of incontinence).

Visits to Nursing Homes

Before making a decision about nursing home placement, visit any facilities you are considering. You can learn a great deal about a nursing home by taking time to sit and observe how staff interacts with residents. Also, speak with residents and their family members to get a full understanding of life in the home. Gather information on both quality and payment issues.

It is very important to visit homes a second and third time during the weekend or evenings -- times when many nursing homes reduce their staff and services. If at all possible, take the resident to visit potential nursing homes before a decision is made. This visit can give you insight into the resident's wishes and may ease his or her fears.

Here's what to look for on your visits:

Using your senses -- sight, hearing, smell, touch:

- Do you notice a quick response to call lights?
- Are there residents calling out? If so, do staff respond quickly and kindly?
- Do the meals look appetizing? Are residents eating most of their food? Are staff patiently assisting residents who need it?
- Are there residents in physical restraints (formal or informal devices that hold residents in beds, chairs, and wheelchairs)? Why?
- Do resident rooms appear to reflect the individuality of their occupants?
- Are rooms, hallways, and meal tables clean?
- Is the environment noisy?
- Is there cheerful, respectful, pleasant, and warm interaction among staff and residents?
- Does the administrator seem to know the residents and enjoy being with them?
- Do staff and administration seem comfortable and peaceful with each other?
- Do residents look clean, well-groomed, well-fed, and free from bruises?
- Do many residents seem alert? happy? peaceful?
- Are residents seated comfortably?
- Is the home free from any unpleasant smells?
- Are residents engaged in meaningful and pleasant activities by themselves or with others?

Things you can ask of staff:

- Does each shift have enough help to be able to care for residents as they'd like?
- Do they enjoy their work? Are their ideas and information solicited and valued by supervisors?
- What activities are residents involved in?
- Are staff permanently assigned to residents?
- Are temporary staffing agencies used?
- How are the nursing assistants involved in the care planning process?
- Is the facility currently implementing any "culture change" or "Pioneer Network" practices? (for more information, see www.pioneernetwork.net or call 585.924.3419)
- How much training is given to staff?
- How often do residents who need it receive assistance with toileting?
- If residents are using disposable briefs, how often are they changed? Why are briefs used instead of toileting?
- What approaches does the facility use to prevent use of physical or chemical restraints?
- How does the staff assure family and resident participation in care planning meetings?
- What does the facility do to encourage employee retention and continuity?
- How long has the current administrator been at the facility?
- Has the facility undergone any recent changes in ownership or management?
- Does the facility provide transportation to community activities?
- What kind of therapy is available to residents?

- Can you give me an example of how individualized care is given to the residents?
- Is there a resident and/or a family council? Will the facility give you contact information for the leaders of these councils?
- What happens if someone has a complaint or problem? Are family/staff conferences available to work out a solution?
- Are residents involved in roommate selection?
- Who decides where residents sit for meals?
- Under what circumstances might a resident be transferred to another room or unit or discharged?
- Does the facility employ a professionally qualified social worker? ("Professionally-qualified" means with a bachelors or masters degree in social work.)

Things you can learn from talking with other residents and their families:

- Are residents treated with respect and kindness?
- Are residents helped with meals?
- Does the facility respect the resident's wishes about their schedule (bedtime, baths, meals)?
- Is attention given to residents at night if awake? Is there anything for them to do?
- Does the resident have the same nursing assistant most days?
- Is there a family or resident council? If so, is the council led independently by families or residents or is it directed by staff members?
- Are staff responsive to resident requests? Do they assist the resident with toileting?
- Are snacks always available to residents? Fresh fruit?
- Do residents participate in care planning conferences? Are his or her opinions valued?
- Has the resident had missing possessions?
- Who handles resident or family member concerns? Is that person responsive?
- Does the resident get outside for fresh air or activities as much as s/he wants?
- What is best/worst thing about living in the home?

The importance of fire safety in nursing homes:

A nursing home, like any institution, should have plans in place regarding fire safety precautions to ensure the safety of residents, staff, and visitors. This is especially important for nursing home residents who are frail, ill, may be unable to walk without assistance, or are immobile. Unfortunately, despite the importance of automatic sprinkler systems, new federal regulations regarding fire safety standards in nursing homes issued in January 2003 do not require that all nursing homes have sprinklers. Only those facilities recently constructed or undergoing major renovations or modernization projects are required to install sprinklers. Below are some questions to ask and things to look for regarding fire safety during your nursing home visits.

- Is the building well maintained? Are hallways and doorways clear of clutter, paper products and debris?
- Are sprinklers, smoke detectors, and emergency lighting systems installed throughout the facility? Are these systems all in working order and frequently tested?
- Is there an evacuation plan in place, are staff aware of the plan, and do they drill on the plan?
- Is there a notification system in place that alerts the fire department should a fire break out?
- What is the facility's smoking policy?
- What is the staff to resident ratio during all shifts? Fires usually occur during the night when staffing is most limited.
- What is the plan for notifying family members should there be a fire?

The importance of knowing the facility's emergency evacuation plan:

A nursing home, by law, is required to have emergency evacuation plans in place in the event of a natural or man-made disaster. When visiting a nursing home you should inquire about the facility's emergency preparedness and evacuation plans. These plans should be very detailed. Below are some questions to ask staff about emergency preparedness plans.

- ***The plan*** What is the facility's emergency plan for evacuation and for "sheltering in place"? Plans will be different for hurricanes, tornados, and terrorist attacks.
- ***Staffing concerns*** Are there enough staff to carry out the evacuation plan during all shifts? What are the training procedures for staff

related to emergency evacuations? Are evacuation drills practiced during all shifts?

Coordination with other resources How is the plan coordinated with other facilities in the area? Are there contracts in place with transportation and other facilities to provide housing for displaced residents? Are all the facilities contracted with the same transportation company and if so does that company have enough vehicles to accommodate all the facilities? How is the plan coordinated with other community resources, the city, county, and state emergency management agencies?

- ***Supplies*** What type and how much emergency supplies does the facility have on hand? (food, generators, flashlights, water, oxygen, etc.) If the facility needs to be evacuated, are there plans for supplies to be transported? Can residents have their own emergency supplies in their rooms?

- ***Resident information*** How are the residents informed about the plan? How will residents be identified in an evacuation? How will information about the resident and supplies such as medications be transported? Will these go with the resident or separately?

- ***Role of the family*** How and when will family members be notified about evacuation plans? How can family members be helpful in an emergency situation? Can family members meet the residents at a designated location and/or can they come to the facility to assist? Family members have the right to evacuate their loved-one on their own and move them to a special needs shelter if they choose.

Information that all nursing homes must post and make available to residents:

When you visit a nursing home, check to make sure the following information is clearly posted and visible. If this information is not easily accessible, you should ask the staff where this information is normally posted.

- **Daily staffing of licensed and unlicensed nursing staff for each shift.** As of January 2003, all Medicaid and Medicare certified nursing homes must publicly post the number of nursing staff they have on duty to care for residents on each daily shift. Licensed and unlicensed staff include: registered nurses, licensed practical nurses, and nurse aides.
- **Name and contact information for all State client advocacy agencies** including the State Ombudsman program, the state survey agency, the protection and advocacy network, and the Medicaid Fraud Control Unit.
- **Results of the most recent state or federal survey.** All facilities must make recent survey information available and easily accessible, where individuals wishing to examine survey results do not need to ask for them. Easily accessible means in a place such as the lobby or other areas frequented by residents, family members, and the public.

Family Involvement: Getting Good Nursing Home Care

Once your loved one is living in a facility, your continued care, support, love, and involvement in his or her life are absolutely key to getting good care there. Make sure you:

- ***Visit frequently*** and encourage others to visit;
- ***Speak up*** to raise concerns and compliments;
- ***Attend*** quarterly care plan conferences and advocate for individualized care;
- ***Follow up*** on the agreed upon care plan. Make sure the resident's doctor knows what is in the plan. Notice if the plan is not being followed and request another meeting if necessary;
- ***Get to know*** the staff and help them get to know the resident. Share details in writing about the resident's likes, dislikes, and daily routines;
- ***Participate*** in family council meetings if a family council exists, or seek out other family members to organize one;
- ***Make contact*** with your community's long-term care ombudsman, any local citizen advocacy groups and become familiar with the state and federal laws and regulations that apply to nursing homes and;
- ***Document*** (date, time, persons involved) any problems you might observe so that managers, the ombudsman, or state survey agency can investigate.

State-Specific Resource Listings

For state-specific listings of resources related to nursing home advocacy, information, and oversight, visit www.nccnhr.org, and click on "Get Help."

NCCNHR Publications

Call NCCNHR at 202.332.2275 for a publication list or visit our website at www.nccnhr.org. The webpage includes Consumer Fact Sheets on:

- Assessment and Care Planning
- Restraints
- Family Involvement
- The Pioneer Movement that is promoting individualized resident directed care

You can find detailed information about how to get good care in nursing homes using NCCNHR publications, including:

Nursing Homes: Getting Good Care There --
a consumer action manual with action strategies and in-depth consumer information
Cost: $11.95

Nursing Home Staffing: A Guide for Residents, Families, Friends, and Caregivers
Cost: $7.50

NCCNHR (formerly the National Citizens' Coalition for Nursing Home Reform) is a nonprofit membership organization founded in 1975 by Elma L. Holder to protect the rights, safety and dignity of America's long-term care residents.

 NCCNHR, 1828 L Street, NW, Suite 801, Washington, DC 20036 ● Phone: 202.332.2275 ● Fax 202.332.2949 ● Email nccnhr@nccnhr.org ● Website: www.nccnhr.org.

We Need You! Please get involved in *Advancing Excellence in America's Nursing Homes*!

(A National Campaign to Improve Quality of Life for Residents and Staff)

High quality nursing home care – where each resident gets the care that is right for them – is important to all of us. Nursing home residents, their families, and people who may someday choose a nursing home should be able to expect the best possible care and quality of life. The *Advancing Excellence in America's Nursing Homes* campaign is the first national effort to measure quality by setting measurable "clinical quality goals" and "organizational improvement goals."

What is Advancing Excellence in America's Nursing Homes?

This is a national two-year campaign to improve the quality of life and care in nursing homes across the country. Every nursing facility may participate by voluntarily pledging to focus on three or more campaign goals. Nursing homes that participate will have free access to assistance and information from quality experts to help them meet their targeted goals. The majority of resources are available through the campaign's Web site at www.nhqualitycampaign.org. Over 20 national organizations and 46 statewide coalitions are participating in this campaign.

What are the goals of the campaign?

There are eight goals nursing homes can select. These goals were chosen because improvements in these areas will be able to improve resident care and quality of life.

The campaign goals are:

1. Reduce pressure ulcers
2. Reduce use of physical restraints
3. Improve pain management for long stay residents
4. Improving pain for short term stay residents
5. Establish facility targets and strategies for improving quality
6. Assess resident and family satisfaction
7. Increase staff retention
8. Increase consistent assignment of staff so residents receive care from the same caregivers.

Why should nursing home consumers be involved?

Nursing home consumers are crucial to the success of the campaign. We need all family members, friends, residents and concerned citizens to contribute ideas and suggestions as a part of this quality improvement initiative. Your involvement will encourage nursing homes to participate, assist facilities in choosing goals, and support facilities as they work to improve resident care and quality of life.

What can you do?

√ Find out more about the campaign by visiting the official Web site at: www.nhqualitycampaign.org.

√ Click on the "For Consumers" button and register as a participating consumer to show that you want nursing homes to strive for excellence.

√ Ask your nursing home administration if they are participating in the campaign.

√ If the nursing home where you reside or visit is participating, find out how and what goals they have chosen. Discuss what steps they will be taking to improve quality and how consumers can participate.

√ If the nursing home where you reside or visit is not participating in the campaign, talk to the administration about it and encourage them to sign-up. Suggest which goals you think would be most useful to residents.

√ Talk to other families, residents, and consumers of nursing home care. Educate them about this campaign and encourage them to participate.

√ Discuss the campaign during resident and family councils meetings.

√ Volunteer to brainstorm with a team from the nursing home on how to improve in the areas chosen by the nursing home to work on.

√ Contact the LANE (Local Area Network for Excellence) if you want to be a part of statewide activities. Click on "For LANEs" on the Web site.

January 2007 CONSUMER TOOL, SAMPLE

Dear Resident Council President,

Today I am writing to tell you about an exciting opportunity for you and the residents and staff at the nursing home you call home. It ‘s the Campaign for Advancing Excellence in America’s Nursing Homes.

This is a voluntary two-year campaign for nursing homes. The campaign goals include creating a culture of person centered, individualized care and an empowered workforce in nursing homes. The campaign monitors key indicators of nursing home care quality, promotes excellence in caregiving for nursing home residents and acknowledges the critical role nursing home staff have in providing care.

When your nursing home signs up they will agree to work on at least three of the following eight measurable goals.

l. Reducing high risk pressure ulcers;
2. Reducing the use of daily physical restraints;
3. Improving pain management for longer term nursing home residents;
4. Improving pain management for short stay, post-acute nursing home residents;
5. Establishing individual targets for improving quality;
6. Assessing resident and family satisfaction with the quality of care;
7. Increasing staff retention; and
8. Improving consistent assignment of nursing home staff, so that residents regularly receive care from the same caregivers.

Please talk with your administrator today and ask them to visit the website www.nhqualitycampaign.org/ with you and to sign on to the campaign.

If you have additional questions about the campaign please talk with your local long-term care ombudsman or contact me at 1-800-288-1376.

Sincerely,

Patricia “Pat” Tunnell
Colorado State Long Term Care Ombudsman

CC: Administrator
Medical Director
DON
Long Term Care Ombudsmen

Expect and Promote Excellence in California Nursing Homes:
PHYSICAL RESTRAINT FREE CARE

EVERYONE DESERVES DIGNITY AND FREEDOM

Restraint- free individuals can eat, dress and move independently; maintain their muscle and strength; interact with others; and maintain their freedom and dignity.

PHYSICAL RESTRAINTS

WHAT ARE PHYSICAL RESTRAINTS?

A physical restraint is any object or device that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Examples include vest restraints, waist belts, geri-chairs, hand mitts, lap trays, and siderails.

POOR OUTCOMES OF RESTRAINTS

- *Accidents involving restraints which may cause serious injury:* bruises, cuts, entrapment, siderail deaths by strangulation and suffocation.
- *Changes in body systems which may include:* poor circulation, constipation, incontinence, weak muscles and bone structure, pressure sores, agitation, depressed appetite, infections, or death.
- *Changes in quality of life which may include:* reduced social contact, withdrawal, loss of autonomy, depression, disrupted sleep, agitation, or loss of mobility.

PHYSICAL RESTRAINTS ARE USED IN PLACE OF GOOD CARE BECAUSE

- Facilities or family members mistakenly believe that they ensure safety;
- Facilities fear liability;
- Facilities may use them in place of adequate staff.

RESTRAINTS ARE MOST OFTEN USED ON

- Frail elderly residents who have fallen or may fall.
- Residents with a dementing illness who wander unsafely or have severe behavioral symptoms.

PHYSICAL RESTRAINT USE IN CALIFORNIA:

California nursing home residents are more likely to be restrained (over 13%) than residents in nursing homes nationally (over 6%). The Advancing Excellence in America's Nursing Homes Campaign has set a goal of 5% or less for all nursing homes in the country. In many nursing homes across the country, residents are restraint-free without any increase in serious injuries. It is unrealistic to expect that all falls and injuries can be prevented.

LAWS and REGULATIONS

FEDERAL

The Nursing Home Reform Act of 1987 (OBRA '87) states the resident has the right to be free from physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

This law also includes provisions requiring:

- quality of care—to prevent poor outcomes;
- assessment and care planning—for each resident to attain and maintain her/his highest level of functioning;
- residents be treated in such a manner and environment to enhance quality of life.

CALIFORNIA

The California Code of Regulations states that the resident has the right to accept or refuse proposed treatments (including restraints) and to know:

- the reason for the restraint;
- the nature and seriousness of their illness;
- the type of restraint recommended and how often and for how long it will be used;
- the likely extent of improvement or remission expected from the use of restraints, and how long it will last;
- the type, likelihood, and duration of side effects and significant risks of restraint use;
- alternative treatments and their risks;
- why restraints are recommended; and
- the resident's right to accept or refuse the proposed treatment (i.e.: restraints), and to revoke consent for the treatment for any reason at any time.

RESTRAINT REDUCTION STRATEGIES

Twenty years of experience provide many strategies for safe restraint reduction and elimination.

Restraint reduction involves the whole facility, including administrators, nursing directors, physical and recreational therapists, nursing assistants, and housekeeping personnel. Family members and advocates can encourage the facility's efforts, and expect and insist that the facility:

- Complete a **comprehensive resident assessment** that identifies strengths and weaknesses, self care abilities and help needed, plus lifelong habits and daily routines.
- Develop an **individualized care plan** for how staff will meet a resident's assessed needs. It describes the care goals (e.g. safe walking), and when and what each staff person will do to reach the goal. The care team includes staff, residents and families (if the resident wants), and devises the plan at the quality care plan conference. The resident may also invite an ombudsman to attend. Care plans change as the resident's needs change.
- Train staff to assess and meet an individual resident's needs—hunger, toileting, sleep, thirst, exercise, etc.—according to the **resident's routine rather than the facility's routine.**
- Make permanent and consistent staff assignments and promote staff flexibility to meet residents' individualized needs.
- Treat medical conditions, such as **pain**, that may cause residents to be restless or agitated.
- Support and encourage caregiving staff to **think creatively** of new ways to identify and meet residents' needs. For example, a "night owl" resident could visit the day room and watch TV if unable to sleep at night.
- Provide a **program of activities** such as exercise, outdoor time, or small jobs agreed to and enjoyed by the resident.
- Provide **companionship**, including volunteers, family, and friends by making the facility welcoming.
- Create a **safe environment** with good lighting, pads on the floor to cushion falls out of bed; a variety of individualized comfortable seats, beds and mattresses; door alarms; and clear and safe walking paths inside and outside the building.

Nursing homes can implement specific programs for reducing physical restraints, including:

- Restorative care, including walking, and independent eating, dressing, bathing programs;
- Wheelchair management program—including correct size, and seat cushion good condition;
- Individualized seating program—chairs, wheelchairs, tailored to individual needs;
- Specialized programs for residents with dementia, designed to increase their quality of life;
- Videotaped family visits for distant families;
- Wandering program—to promote safe wandering while preserving the rights of others;
- Preventive program based on knowing the resident—to prevent triggering of behavioral symptoms of distress;
- Toileting of residents based on their schedules rather than on staff schedules.

FIND AN ADVOCATE:

Contact your local or state ombudsman if you have concerns about the care a resident is receiving. An ombudsman is a state-certified advocate for residents of nursing and residential care facilities who is familiar with the local facilities and often with the staff and residents. *All conversations with an ombudsman are confidential unless permission is given to use a person's name.*

CONTACT the California Ombudsman Program to find your local Ombudsman Program:

Office of the State Long-Term Care Ombudsman
California Department of Aging
1300 National Drive, Suite 200
Sacramento, California 95834
Voice: (916) 419-7510 Fax: (916) 928-2503
Statewide CRISISline (800) 231-4024
Website: http://www.aging.ca.gov/html/programs/ombudsman.html

Supported by a grant from the California HealthCare Foundation, based in Oakland, California. The grant, Voices for Quality: Strategies in the National Campaign for Excellence in America's Nursing Homes*, enables NCCNHR to provide training, consultation and support to the California Ombudsman Program.*

Alternatives to Restraints

Alternatives offer the opportunity to increase the quality of life for restraints.

PSYCHOSOCIAL

Play to the resident's strengths
Provide for sense of security
Wandering paths
Offer choices
Plants
Staff dress – encourage independence
Same caregiver
Apply the 5 Magic Tools (knowing what resident likes to *See, Smell, Taste, Touch, Hear*)
Know resident's agenda
Be calm and self-assured
Pets and children
Classes for Frequent Fallers
Volunteers

ACTIVITIES

Buddy system
Restorative care
TV, video, music, picture books
Punching bags
Art of Living programming
Distraction based on their "work/career"
Repeated activity

ENVIRONMENTAL

Non-wheeled chairs
Wing back chairs
Gliders
Use of tables
Couch for sleeping
Hand belts
Music
Floor patterns
Visual barriers, murals
Fence with bushes
Non-skid surface in bathrooms
Pad dangerous furniture corners
Dining room chairs
Easy chairs
Proper fit chairs
Bed placement
Recliner for sleeping
Tap belts
Lighting
Motion detectors
Notes with directions
Grab bars
Rest areas in halls
Room identifiers

PHYSICAL

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

SOURCE: Diana Waugh, BSN, RN
Waugh Consulting, 419.351.7654

GUIDE WITH VIDEO:
EVERYONE WINS! THE FAMILY GUIDE TO RESTRAINT FREE CARE

Before the Video

Hi! Welcome and thank you for joining us for this very important presentation about restraints.

I am _____ and I am your Ombudsman. I am an independent advocate for your family members while they are residents in (this nursing home).

Why am I here? As advocates, we are supporting a statewide effort to reduce or even eliminate restraints in nursing homes. Restraints are any object or device that restricts movement or the ability to get to a part of the body. Usually a specialty device is used. Examples include vest or jacket restraints, waist belts, geri-chairs, hand mitts, and lap pillows.

Did you fall when you were a child? When you were learning to walk, did you fall? Of course!

After you fell, did your parents carry you all the time or push you back down so you wouldn't fall again? No. Why?

It was important for you to learn to walk. Why? Because as people, we walk.

So, do we all need to be able to move freely? Yes, that's the ideal. Why?

Because:

- *that is the way we become independent*
- *taking risks helps us to increase our skills and capabilities*
- *that is the way we explore and learn about our world*
- *because movement allows our minds to wonder and experience new things*

I'm going to show you a short video about the importance of restraint reduction. Afterwards, we can talk about the video and what steps you can take to help keep your family member safe and restraint free.

After the Video

I know that some of you might feel the same way that Jack Chekhov originally felt about keeping his wife Emma in restraints. People have long believed restraints help protect family members from injury.

In reality, the video was completely truthful when it talked about how restraints often create more harm than good. Restraints aren't a guarantee against falls. They put people at risk for poor circulation, weak muscles, loss in appetite, bedsores, and

even death.
Out of restraints, residents can participate more in their community and have a better quality of life while they live here. This is their home now. (Distribute and discuss *Restraint Risks and Alternatives to Restraints* sheets).

Why am I here? As families and friends, every one of you wants the very best care for your loved one. The Ombudsman program is also committed to helping your loved ones have the best care possible and the highest quality of life. We believe that reducing restraints is an important part of achieving a better quality of life.

[Talk about the progress at this nursing home. Did the administration call you (the Ombudsman) in? Is the family council supporting this new initiative? Has staff been trained? Has the administration committed to reduce restraints? You will need to verify the answers to these questions with the facility.]

This is not a process that occurs over night. Like in Emma's case, each restraint reduction is done with careful progress and the participation of the family and friends is crucial in making it a success. You know your loved one the best and need to share with the staff what is working and what is not. Talk about habits, likes and dislikes, shifts in behaviors. Together, we can find alternatives. The video only briefly discussed alternatives such as the education of staff to behavior and personal needs, but other alternatives can involve equipment such as modified chairs, lower beds, bed and chair alarms, cushions and boosters. I have a handout you can use to help staff get to know your loved one. When staff know the individual resident, they can find answers for care (Distribute and discuss *Resident Information* sheet).

By working together we, the staff, the resident, family and friends, and the Ombudsman, we can all make sure the resident is safe.

We have many resources to help everyone in this process, or we can access what may be needed. So please ask. I would like to be of assistance. Do you have any questions?

Removal of restraints has been taking place for some time all over the country. Over and over we hear success stories and we are encouraged and excited to be a part of making life better for residents. Thank you so much for letting me share your time. Again, talk with me anytime. Here is my contact information. (Distribute *Restraint Reduction* sheet and business cards.)

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Based on materials developed by the Texas Office of the State Long-Term Care Ombudsman

THAT'S GREAT FOR OTHER FAMILIES BUT…

When a family considers the prospects of removing restraints, commonly held concerns and beliefs may arise. The following is clarifying information for each concern based on recent studies.

It is not safe to remove restraints.

Safety is important. Residents free of restraints are less likely to sustain a serious injury. Quality of life, choice, freedom from restraint and dignity are more important than perceived safety. The process of removing restraints includes looking at how residents can be kept safe and restraint free.

Serious injuries will increase.

Several studies have shown that restraint-free care does NOT increase the rate of serious injuries fractures, lacerations requiring stitches or visits to the emergency room. Indeed, many studies have shown that injuries decrease in both numbers and severity when restraints are removed.

My family member is too sick and too frail to remove restraints.

There are many options for residents of all ages and health conditions. When families and staff work together, they find ways to provide successful, safe restraint-free care for your loved ones.

Doctor/Facility recommends that we use restraints.

Although restraints are necessary in very few cases, there aren't many restrained residents who have a medically appropriate need for restraints. Don't be afraid to question the doctor's or facility's orders. It is important for family members to be active in the resident's care. If you make it clear that you are in full support of restraint-free care for your family member, you can discuss possible alternatives with the doctors and the facility staff.

There isn't enough staff to protect my family member without restraints.

Restraint-free care does not require extra staff. The ratio of care receivers to caregivers has no bearing on a facility's rate of restraint use.

My family member has never raised complaints about the restraints.

Often residents worry about raising concerns or complaints for fear of retaliation. Although it is crucial to talk with your loved ones about how they are feeling, silence about restraints doesn't mean consent or contentment with their current situation. Try to observe agitation, body posture, attitude toward life, and possible feelings of hopelessness or helplessness that often accompany residents in restraints.

I can't tell facility administration how to run their nursing home.

The most important thing is your loved one's care. Facilities are open to family members' suggestions to improve the quality of care for their residents. Care is always changing for residents because the resident is always changing. Flexibility and openness in care is crucial to good quality of care and life. The work of the nursing home staff, doctors, and administration relies on the input from family members and friends who know the resident the best.

Maybe the facility is too big (too small) to become restraint-free.

Large facilities may take longer to train staff, educate families and complete a restraint reduction project than smaller facilities.

The facility is in the city/country and that might make it harder for them to take off the restraints.

There are restraint-free facilities in rural, suburban and urban areas -- it makes no difference.

None of the other families with residents in the nursing home seem concerned about restraints.

Many families may not know about the current information on restraint reduction and in many cases, care is varied between residents. What is right for someone else doesn't translate to the best quality of life and care for your loved one. Don't let the status quo stop YOU from questioning practices or raising concerns.

How do we get started? Are the restraints just taken off in one day?

The most common alternative involves temporarily untying the older adult -- at mealtimes, when families and friends visit and when a staff person is close by. Other commonly used alternatives involve wheelchair cushions and adaptations, and individualized napping, toileting and exercise schedules. Be part of a team including staff and medical professionals to assess your loved one's status and alternatives. This isn't an overnight decision, but a gradual process to analyze and meet your needs and concerns on every level.

There is no one right alternative to restraint use, especially for those who are agitated, wander or fall repeatedly. There may be as many options as there are nursing home residents. The important thing is to be an active participant in your loved one's care.

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RESIDENT INFORMATION

Ideally, this form is completed by the resident. If the resident cannot complete this form, it should be completed by the resident's family or close friends.

Resident's Name _____

1) By what name do you prefer to be addressed?

2) What language do you prefer to speak?

3) What was your occupation/job?

4) What family members and friends are important to you? What are their names?

5) What objects brought from home could have particular meaning? What could be brought that would provide comfort?

6) Do/did you have a pet? Pet's name? What kind is/was it?

7) What was a typical (daily) routine?

- Sleeping pattern: awaken, nap, bedtime? What hours?
- Meal times?
- Bath or shower? When?
- Did you spend time out-of-doors?
- Special hobbies, membership organizations
- Religious activities or other interests?

8) Favorite foods?

9) Food allergies/dislikes?

10) How will staff know when you have to use the bathroom?

11) How did you/do you handle stress? How did you react when you were asked to do something that you did not want to do?

12) What might cause agitation or anxiety?

13) What has a calming or reassuring effect on you?

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RESTRAINT REDUCTION

Resident-Centered Care

Our goal is that every nursing home resident will realize optimal quality of life and receive the highest quality of care.

Resident-Centered Care:

- respects each individual's uniqueness
- assures dignity and privacy
- provides a predictable environment of care
- involves each resident in directing his/her own care
- offers a choice of schedules, care and services based on the individual's needs and preferences
- gives residents opportunities to suggest activities

Freedom from Restraints

When restraints are removed according to a plan of care, the resident experiences freedom of movement again and improved quality of life. He or she begins to talk more, to be animated, to enjoy life, to interact with others, to often regain continence, to lessen the risk of developing pressure ulcers, and to increase strength that allows more movement around the nursing home.

Advocacy

Your local Long-Term Care Ombudsman is a catalyst for optimal quality of life and quality of care for every nursing home resident. Responsibilities include identifying, investigating, and resolving complaints made by or on behalf of residents and providing services to assist in protecting the health, safety, welfare, and rights of residents.

Residents have the right to be free from restraints. Your local Long-Term Care Ombudsman can answer questions you may have about restraints.

CONTACT YOUR LOCAL OMBUDSMAN
for help in improving the quality of life and care for your loved one.

(Name and Address of Local Ombudsman Program)
(local program phone number)

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Restraint Risks

Individuals that are restrained are at risk of suffering a variety of results.

DEATH by

- Strangulation
- Suffocation
- Broken neck
- Pneumonia subsequent to chest compression and reduced air exchange due to any restraint that goes around chest
- Sepsis (severe illness caused by infection) infected lungs, skin abrasion, dehydration, urinary tract infection

PHYSIOLOGICAL

- Loss of muscle tone
- Pressure sores even in low risk individuals
- Decreased mobility – inability to stand, walk, turn, etc.
- Reduced bone mass from lack of pressure on long bones which leads to greater risk of breaks both pathogenic and subsequent to fall
- Stiffness
- Incontinence
- Dehydration
- Constipation / fecal impaction

PSYCHOLOGICAL

- Depression
- Agitation
- Frustration
- Loss of dignity
- Loss of self-esteem
- Loss of confidence
- Thoughts of suicide
- Increased boredom
- Increased feelings of loneliness
- Increased feelings of helplessness
- Feelings of confusion related to being punished
- Loss of willingness or drive to be involved in life

SOURCE: Diana Waugh, BSN, RN
Waugh Consulting, 419.351.7654

RESTRAINT REDUCTION
Presentation to Family Councils

SAMPLE AGENDA

- **Welcome and Introductions**

  The Ombudsman introduces self and has all family members introduce themselves.

- **Read and Follow the *Guide with Video* script.**

  Introduce the video:
  EVERYONE WINS! The Family Guide to Restraint Free Care

- **After video - Read and Follow the *Guide with Video* script.**

- **Distribute the following materials where indicated in the *Guide with Video* script:**

  - Restraint Risks and Alternatives to Restraints
  - Resident Information
  - Restraint Reduction

- **Use the "That's Great but..." guide** if needed

- **Tell them how to contact you.**