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Eliminating Physical Restraints in Your Nursing Home

Establish Organizational Support

- Secure absolute support of administration, corporate office or governing body by comparing your restraint use rate to national data.
- Designate staff person ("Change Agent") to oversee process. No specific discipline or position is needed but must have deep personal commitment to concept.
- Gain support and active participation of medical director to discuss with all attending physicians individually or in a meeting.
- Gain insight into staff attitudes; calm fears. Collect “Staff Attitudinal Survey” from all departments and shifts. Interview small groups of staff to learn their concerns about restraint elimination.
- Distribute restraint materials supporting elimination.
- Facilitate small group discussions.
- Distribute letter or memo to staff about facility’s commitment to improve the life of residents by eliminating restraints.
- Calm staff fears, assure they will not be held responsible for residents' falling during the early stages of the process as long as they are doing their job and not being neglectful.

Engage and Prepare Families

- Inform families of upcoming policy change.
- Send letter from administrator, nursing administration or Restraint Reduction Committee to residents, families, and physicians. Provide reasoning behind shift toward a standard of care that emphasizes autonomy, quality of life, and the resident's right to be free from restraint. Explain negative effects and risks associated with physical restraints. Compare your facility data to national data. Include regulations regarding physical restraints.
- Offer to meet with family members. Arrange meetings with family of every resident, unit by unit, small groups, or individual.
- Discuss commitment to “no-restraint policy” and benefits with all potential residents and family prior to admission and again upon admission.

Establish and Facilitate Restraint Reduction Team

- Select members for interdisciplinary team or performance improvement (PIP) team. Choose all disciplines including nursing (CNAs, RNs, and LPNs from all shifts), physical therapy, occupational therapy, social services, activities, and admissions. Choose those supportive of approach or experienced in restraint reduction.
- PIP team to write policy that makes restraints an unacceptable option.
  Policy includes:
  - statement that physical restraints violate resident rights, autonomy, and dignity;
  - multiple negative physical, emotional, and social effects associated with use; and
  - process for exploring all possible measures in order to avoid use.

- Announce across the board “No-Restraint” policy

Implementation of No-Restraint Policy

- Provide customized training for each group of staff including nursing assistants, housekeeping staff, and other interdisciplinary team members on all shifts.
- Training includes types of restraints, adverse effects of restraints (physical, emotional, psychosocial), and alternatives to physical restraints.
- Education must be ongoing. Mini restraint reduction/elimination sessions (15-20 minutes) on the units are one opportunity. Include case studies and problem solving.
- Ensure that a no-use restraint policy is part of new employee orientation.
- Target the quick successes.
- Begin reduction work on one unit with the strongest staff support and teamwork. Work to remove restraints one resident at a time. Do not move to another unit until all restraints are successfully eliminated.
- Involve nursing assistants from all shifts who work with the selected resident. Frontline staff know the resident’s daily habits, routines, idiosyncrasies, and capabilities.
- Frontline staff and PIP team members should choose the easiest resident(s) to work with first and over time move to more complex resident situations.
- Examine present use of restraints on a resident by resident basis using information from the MDS and care plan documentation.
- Different team members should collect their unique information about resident and discuss and evaluate findings together to safely and successfully remove restraints.
- Conduct deep root cause analysis while looking for underlying causes of behaviors that place the resident at risk for restraint use. During discussion, include all key content.
    - Why was the restraint ordered?
    - What are underlying medical conditions, both acute and chronic?
    - What is the resident’s fall risk and why? What medications does the resident receive that increase risk of falls?
    - Do not substitute physical restraints with chemical restraint such as sedatives or hypnotics.
    - What are their toileting habits and how does this place them at risk? Are they continent or incontinent?
    - What are triggers for the resident’s behavior which place him or her at risk for restraint use? Is restlessness or agitation a factor? What are the details and underlying reasons for this?
    - What activities does the resident enjoy? How engaged is the resident and what individualized activities are possible?
    - What interventions are necessary to safely seat the resident and maximize their function? Is there a need for special seating considerations for comfort and posture? Are physical or occupational therapy evaluations needed?
- Once the resident is accepted by the team for restraint reduction, designate staff, such as the social worker to talk with resident and family. Provide written materials and provide facts about the adverse effects of physical restraints and elements of your fall prevention program. Assure that alternative strategies and interventions will be used for the resident's safety during the process.
- Determine who will be responsible for notifying the resident's physician of the decision to remove restraints.
- Avoid re-application of restraints once they have been eliminated.
- Develop an individualized care plan as a team in cooperation with unit staff. The resident’s quality of life should be primary concern. The care plan reflects all information gathered about the resident include

their past and present roles, interests, habits, routines, behaviors, physical capabilities, and potential risks.

- Focus on the needs of the resident, not the staff. For example, if the resident has always bathed before bed, then the staff should honor resident's preference for and evening bath.
- Innovative staffing and flexibility are ways that individual needs can be respected as staff alter their own routines to accommodate the needs of each resident.
- Use consistent assignment to assign each nursing assistant and nurse to the same group of residents on a "permanent" basis. This allows frontline staff to know the resident, their baseline, and how best to respond to challenging behaviors.
- Adapt the environment to the resident, not the resident to the environment. If a resident slips from one type of chair, the intervention is to find a more comfortable and appropriate chair.
- If staff is hesitant or fearful, start by removing restraints for a specific period of time. For example, have Mr. Jones sit without a restraint near the staff desk in comfortable chair (not a geriatric chair) when staff are charting or during an activity that Mr. Jones particularly enjoys. Gradually increase his time out of the restraint. Incorporate the movement toward restraint elimination in his care plan. Document what does and doesn’t work. What doesn't work for one resident might work well for another. Be persistent.
- Residents who have restraints removed should be reviewed at least monthly during Restraint Reduction meetings until members feel comfortable the resident is functioning safely without restraints. Should a problem arise, the committee should reassess needs and find alternatives or adaptations.

Monitoring and Evaluation

- Encourage communication about the resident among all staff during restraint elimination.
- Track incidents of falls and fall related injuries. Accurately assess the environment and specifics of each fall using a post fall huddle and deep root cause analysis.
- Keep a notebook at the staff desk for all staff to write concerns or insights into the resident's daily routines and needs. Encourage staff to participate in this valuable communication tool between staff in all departments. For example, housekeeping staff notes that the resident goes to bathroom in stocking feet after their nap (a safety consideration) or activity staff share what the resident enjoys from the activity cart (providing information helpful to staff when the resident is awake at 3:00 am). The notebook can be used to note what interventions or strategies are working best with the resident. Input from all shifts and all disciplines is helpful in developing individualized care plans.
- Re-examine staff perceptions and attitudes as needed. Re-interview or resurvey staff to elicit thoughts regarding restraint elimination.
- Re-examine family and physician perceptions. Check-in often during the elimination process until the resident is stable.
- Continue to elicit comments and ideas about the elimination of physical restraints through various means such as letters, during meetings, or in casual conversation.