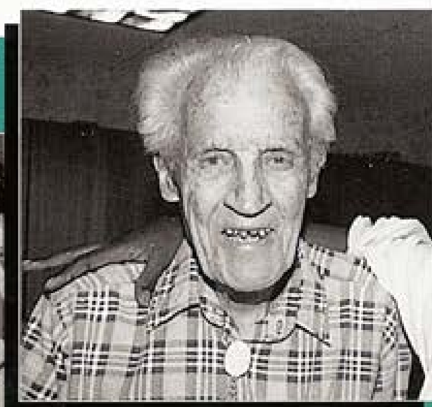
THE MANAGEMENT PERSPECTIVE



VIEWING AND RESOURCE GUIDE

Everyone Wins! Quality Care Without Restraints was produced by the Independent Production Fund, New York, New York, in association with Toby Levine Communications, Inc., Bethesda, Maryland, with funding from Beverly Enterprises, The Commonwealth Fund, Kendal Charitable Funds, and The Retirement Research Foundation. The producers and sponsors cannot be held responsible for decisions made by health care professionals when applying OBRA's principles to any individual resident who is under their care.

© 1995 Independent Production Fund

Other Materials in the Everyone Wins! Library

- **THE RESIDENT CARE LIBRARY:** six 15-minute videos and an inservice training manual: The New Resident; Up and About: Minimizing the Risk of Fall Injuries; Working with Residents Who Wander; Getting Hit, Grabbed, and Threatened: What It Means, What To Do; Staying Restraint Free Evenings, Nights, and Weekends; Now That the Restraints Are Off, What Do We Do?

- **EVERYONE WINS! A FAMILY GUIDE TO RESTRAINT-FREE CARE:** 14-minute video and pamphlet (available in quantity for separate distribution)

- **SURVEYING THE RESTRAINT-FREE FACILITY:** 14-minute video and discussion guide

- **PHYSICIANS AND RESTRAINT-FREE CARE OF THE ELDERLY:** 30-minute audiocassette on chemical and physical restraints

For further information, contact the Independent Production Fund, 45 West 45th Street, New York, New York 10036, 1-800-727-2470.

Everyone Wins! Quality Care Without Restraints

The Management Perspective

2 **Introduction**

3 **Viewing Guide**
3 Video Places and Faces
3 Key Concepts
4 Ideas to Think About

6 **Resource Guide**

6 Why Opt for Restraint-free Care?

6 What is the long-term goal of restraint-free care?
6 What are restraints?
6 How do current practical and legal attitudes toward restraint use differ from earlier attitudes?
7 What does OBRA require?
7 What are some of the unexpected benefits of restraint-free care for caregivers, residents, and family members?

7 Setting the Stage

7 What role do administrators play in supporting restraint-free care?
8 What is essential in planning for restraint-free care?
8 Where should you start?
8 Who are the key players?
9 What about resistant staff?
9 How can you get families involved?
10 Whose restraints should be removed first?
10 How should you go about removing restraints?

11 Keeping It Going

11 How long will the process take?
11 What can hinder the full development of a restraint-free program?
11 Why is continuous assessment important?
11 Why bother celebrating success?
12 What conceptual model will help you keep going?
12 Why have ongoing staff training programs?

13 **Related Resources**

Everyone Wins! is a video library about creative ways to provide quality care to nursing home residents without using restraints. It was developed to help staff in all long-term care facilities improve the care they are providing by getting to know their residents better and meeting their unique individual needs. It also seeks to provide individuals who visit nursing homes — for personal or professional reasons — with information on why restraint-free care is important and how they can help it be achieved.

The project began with visits to nursing homes throughout the country to learn what policies and procedures enabled some nursing homes to bring restraint use under five percent but led others to view a restraint-free goal as impossible. We sought to document successful practices and understand what kinds of barriers administrators perceived to be in the path of managing a restraint-free facility. The result is this package. Whether you are asking the key question, Why Opt for Restraint-free Care? Setting the Stage, or working on Keeping It Going, you will find information in both the video and guide to support your endeavor.

The video is approximately 16 minutes long and is a useful discussion-generating tool for a senior staff meeting. In it you will hear from administrators and staff at five different nursing homes, from New York City to Las Cruces, New Mexico, and from Naples, Florida, to Colorado Springs. Among these facilities are those that are for profit and not for profit, those that are large and some that are small, and those that are in various stages of achieving a restraint-free environment. The Viewing Guide that follows identifies the individuals you will see and hear in the video, lists some key concepts involved in providing restraint-free care, and provides a list of ideas to think about as you help move your facility to the next stage of providing restraint-free care.

The Viewing Guide is followed by a Resource Guide. Divided into three sections in the same way as the video (Why Opt for Restraint-free Care? Setting the Stage, and Keeping It Going), the Resource Guide is organized into a quick-to-read question-and-answer layout. Refer to those sections that respond to your own particular concerns and situation.

As you use these materials, bear in mind that achieving a restraint-free environment is a long-term goal. Reaching the goal requires a significant personal commitment from administrators and senior staff, and, for some, a new way of thinking about the residents you serve. A key focus of ***Everyone Wins!*** is individualized care — getting to know each resident in your facility in such a way that you can anticipate their needs and attend to them quickly.

Read on to learn why we have entitled this project, ***Everyone Wins!***

All individuals who work in or visit the facility must become involved in restraint-free care, including administrators, managers, physicians, nurses, aides, social workers, therapists, family members, and support staff.

Viewing Guide

Video Places and Faces

Everyone Wins! The Management Perspective was taped at the following locations:

Amsterdam House
New York, New York
James Davis, *Executive Director*

Harborside Healthcare Naples Rehabilitation and Nursing
Naples, Florida
Pamela M. Cox, *Administrator*
Lisa Rose, R.N., *Unit Manager*
Leslie Nowe, R.N.C., *Director of Nursing*
Margaret Rogan, *Resident*
Audrey Pogue, *Resident*

Living Center West
Cedar Rapids, Iowa
Donald J. Chensvold, *President, Health Care of Iowa*
Patrick J. Carmody, *Former Administrator*
Marlene N. Lacey, R.N.C., *Education Director*
Lois Doyle, L.P.N., *Director of Extended Therapy*

Namaste Alzheimer Center
Colorado Springs, Colorado
Debbie Scandura, R.N., *Administrator*
Paul Stickney, C.N.A.

University Terrace Good Samaritan Village
Las Cruces, New Mexico
Kayln Johnson, *Administrator*
Judy Johnson, *Medicare Coordinator*
Gary R. James, R.N., *Charge Nurse*
Alicia Padilla, *Resident*

Cadwalader, Wickersham & Taft
New York, New York
Denice R. Krez, B.S.N., *Attorney*

Key Concepts

■ Restraint-free care enhances your reputation and image as a provider of quality care.

■ Individualized restraint-free care does not cost more money or require more staff. Residents who are free to move around have fewer skin problems, less incontinence, less agitation, and can do more for themselves.

■ Properly managed restraint-free care does not put residents at greater risk than keeping residents restrained, nor does it create a more significant liability for the facility as long as restraint-free policies and procedures are clearly documented and consistently applied.

■ Creating a restraint-free environment is an ongoing process — a continuous journey and a way of working, not a destination reached for once and for all. A restraint-free solution can be found over a period of time for virtually all residents, but no one solution will be successful for all residents or even for any single resident at all times. Creative problem solving is the key to providing individualized, restraint-free care for everyone.

■ Individualizing care starts with an interdisciplinary assessment of each resident's physical and medical condition, psychological state and needs, and social/environmental situation and background. It proceeds with the development of a care plan that moves each resident toward the goal of restraint-free care, the consistent implementation of the plan, and ongoing monitoring to assess whether continued implementation of the plan is useful. The process is cyclical and continuous.

■ All individuals who work in or visit the facility must become involved in restraint-free care, including administrators, senior managers, physicians, nurses, nurses aides, social workers, pharmacists, staff or consulting therapists, dietary workers, cleaning crew, family members, and volunteers.

Nursing assistants are often the most aware of residents' capabilities and needs.

Ideas to Think About

Think about the following points after you have seen the video. If you are using this video with a group, these are good topics for discussion.

■ A commitment to the goal of restraint-free care must come from the very top of the organization to be believable. Who in your organization can make this commitment and communicate it frequently and consistently?

■ In developing this video, numerous administrators talked quite honestly about how skeptical they were when first confronted with the idea of restraint-free care. Where would you place yourself along the continuum of believing that restraint-free care can be achieved? If you are currently skeptical, what factors would make you less so? If you are already committed to restraint-free care, what arguments will you present to your staff to win them over to your philosophy?

■ One nurse openly challenges Kayln Johnson about instituting restraint-free care, noting her past training in the use of restraints as a safety measure. Many administrators also express concern about the reaction of family members who may once have been told that restraints were the best solution for a particular situation. Think about how you will help nurses and family members understand new approaches to quality care that no longer include the use of restraints.

■ List ten people in your organization whom you absolutely need to have behind you for your restraint-elimination program to be a success.

■ When you bring these people together, ask: "How many of you have fallen during the last five years?" "How many have been in restraints?" and "How can you help everyone in the facility to understand that all people fall occasionally?"

■ List the tradeoffs in creating a restraint-free environment. What are the costs? What are the savings? What are the benefits? What are the risks? Will residents be less agitated? Will they be more independent? Will staff members feel better about themselves? Will they enjoy interacting with the residents more?

■ Time and time again, when an administrator of a long-term care facility that has successfully reduced the number of restraints in use is asked to name those factors that contributed to success, the answer is: Education, Education, Education. How does your current inservice program treat the use of restraints? Is its emphasis on restraint elimination or on conditions under which restraints can be used? Consider the subtle difference between these two messages: *Restraints can be used when* . . . and *Restraint-free care is the norm in this facility* . . . .

■ Take a fresh look at the forms you use. Do they perpetuate old attitudes? Do your admission forms have a box where the physician can routinely order restraints in perpetuity or on an as-needed basis?

Extremely supportive administrators and senior staff members are key to successful restraint-removal programs.

■ Many administrators express concern that restraint-free care will be very time-consuming. Consider asking your director of nursing to keep track of exactly how much time, how many people, and how many forms of documentation are required to keep residents restrained.

■ Marlene Lacey identifies a number of low-cost environmental changes that help prepare a facility for removing restraints. How many of these are appropriate for your facility? Brainstorm ways you can prepare your facility for a restraint-removal program. (When you brainstorm with a group, be sure that you list all possible ideas generated by group members before you start evaluating any of them.)

■ Conduct an audit to determine exactly how much the use of restraints cost your facility last year. Did you purchase restraints? Did you clean them? Did your laundry workers spend time untangling them? Commit to moving that amount of money into a fund to assist the restraint-free effort. Consider purchasing positioning devices or chair alarms rather than new vests.

■ Success breeds success. Involve as many staff members in the process of selecting candidates for restraint removal as possible. You may find some cases where no one even remembers why a resident has a restraint. Be sure to include nurses aides in this assessment process. They spend the most time with residents and often are the most aware of residents' capabilities and needs. Start small but think big.

■ If you see a resident in restraints, stop and ask why the restraint is being used. Ask what else has been tried. Ask when the next care plan meeting is. Ask how you can help reassess the resident's need for restraint.

Active programs are needed to help restraint-free residents live as normal a life as their capabilities allow.

■ Many administrators and senior managers have found that their own visibility on the floor is important to the success of the program. Can you help out in the dining room or activities area for an hour a day? Can you sit with a frail resident for an hour during her first day of restraint-free care? Can you take a walk with a resident who needs to move around? Don't forget about your night and weekend staff. They need to see you as well. Consider having a senior manager on duty during at least one weekday night and one weekend shift.

■ Think about the physicians who serve your facility. Are they behind your restraint-free goal? How can you effectively communicate this goal to them?

Resource Guide

Why Opt for Restraint-free Care?

What is the long-term goal of restraint-free care?

The long-term goal of restraint-free care is improved quality of life and care for nursing home residents. The use of restraints is incompatible with that goal. Restraints can lead to sensory deprivation, loss of positive self-image, and growing dependency, as well as to loss of muscle tone, balance, ability to walk, skin breakdowns, and frequently, incontinence and depression.

What are restraints?

Simply, a restraint is any device that restricts a resident's freedom of movement. Physical restraints include belts, vests, soft ties, gerichairs with locking trays, and full or split siderails. If a device cannot be removed by the resident, it is a restraint. Chemical restraints are medications that affect the mind and may modify mental and physical activity. They include psychotropic medications that restrict a person's control over his or her own behavior, and medications that are prescribed for purposes of discipline or convenience and not to treat a medical condition.

How do current practical and legal attitudes toward restraint use differ from earlier attitudes?

For many years, administrators, nurses, and nursing aides were trained to restrain elderly residents. It was believed that the use of restraints protected the elderly from accidents, and protected the nursing homes from liability for accidents. Recent research, however, has shown that restraints have detrimental physical and psychosocial side effects. With the use of restraints, elderly residents may be at a higher risk for increased incontinence, impaired circulation and swelling, decreased functional ability, decreased nutritional intake, imbalance, suffocation, and death. Emotionally and psychologically, restraints may increase feelings of desolation, depression, agitation, family stress, anger, and low self-esteem. These findings support moving to a restraint-free environment.

Nursing homes, contrary to a previously held common belief, are legally at greater risk for improper application and use of restraints than for failure to use restraints. Judgments pronounced on cases involving inappropriate ordering of restraints, failure to monitor and correct adverse effects on the resident, or errors in the mechanical application of the restraints have been far more significant than judgments on cases charging failure to apply a restraint. In fact, not a single case has been reported in which the absence of restraints was the sole basis for successful litigation. In light of recent research and findings, the presence of restraints, rather than the absence of restraints, is viewed as a liability.

A restraint-free solution can be found over a period of time for virtually all residents.

What does OBRA require?

In 1987, the Omnibus Budget Reconciliation Act (OBRA) established significant restrictions on restraint use on residents in nursing homes. OBRA states that residents have "the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for the purpose of discipline or convenience and not required to treat the resident's medical symptoms." OBRA supports efforts to eliminate restraint use in nursing homes. But, as the video points out, OBRA defines the minimum level of care required for compliance, not the maximum.

Current regulatory sanctions for facilities found out of compliance can range from civil monetary penalties to decertification. Support for implementing and following the OBRA guidelines is found in federal and state statutes and regulations that clearly and intentionally tilt the regulatory odds against the provider that indiscriminately applies physical restraints to its residents.

What are some of the unexpected benefits of restraint-free care for caregivers, residents, and family members?

Many have thought that the use of restraints makes caregiving more efficient and less worrisome for staff. To meet the guidelines of the Department of Health and Human Services for the care of restrained residents, however, requires an estimated 4.5 hours per resident per day. With restraint-free care, caregivers no longer have to spend so much time documenting, and are freed from doing things for residents that they are able to do for themselves once restraint free, such as eat and drink, use the bathroom, and move about. Instead, caregivers have time to get to know residents better as people, and to provide for their individual needs.

At one time, many health professionals believed that restraints decreased falls and prevented injuries. This also has been demonstrated to be false. A study by Tinetti (1986) found no greater number of serious injuries from falls among unrestrained residents than among those who were restrained. Other studies support this finding, indicating that residents are less likely to be hurt from falls when restraint free than when restrained. In general, restraint-free residents experience improved health as they are able to get more exercise, and improved temperament as they do not have to fight externally imposed limitations.

Families benefit when they witness positive, personalized care and an improved atmosphere in the nursing home. They inevitably experience increased satisfaction when they see improvements in their relatives.

Individualized care requires a thorough assessment of each resident.

Setting the Stage

What role do administrators play in supporting restraint-free care?

The restraint-reduction process ties in with the goals of total quality management and continuous quality improvement. As a starting point, these goals state that management is responsible for quality and for removing barriers that block efforts to achieve high quality care. If quality care is defined as restraint-free care, this requires management to remove or change ineffective or inefficient policies, procedures, and systems that stand in the way of restraint reduction.

Management will be more effective in implementing a new program if it focuses both on changing the work process and on educating the staff. A successful management team knows that quality improvement, including restraint reduction, is a never-ending process. Management and key staff must project a positive attitude and strong commitment to restraint reduction that extends over time.

A primary component of total quality management includes taking care of, being responsive to, and meeting the needs of customers. In a nursing home, the obvious primary customer is the resident, and so it is the resident's needs that are a foremost priority for all staff. Management must stress the importance of implementing a plan of individualized care that meets the best interests of each resident.

Finally, management must inform and involve the entire staff when implementing restraint-free care. An organization-wide commitment is necessary to improve the quality of any program. Restraint-free care training should involve multidisciplinary teams at all levels, from janitorial staff to primary caregivers to the top administrator. The experience of participating in

such an activity can increase the feeling of teamwork and contribute to the personal pride each employee takes in his or her work. The result is increased morale and improved productivity.

What is essential in planning for restraint-free care?

Each facility tackles restraint removal differently. It is clear, however, that facilities that have been successful share the following principles:

- a desire to offer individualized quality care that emphasizes normalcy and the preservation of residents' dignity
- a commitment to achieve a restraint-free environment
- extremely supportive administrators and senior staff
- strong quality care coordinators
- the involvement of staff at all levels and in all disciplines
- the participation of residents themselves to the extent possible
- the consistent use of an organized process of assessment, planning, implementation, and monitoring
- extensive ongoing education of staff and families.

Where should you start?

To begin, it may be helpful to organize a quality care improvement task force. It is crucial to include on the task force someone who has the commitment and power to influence change. Often, this will be the administrator. In any case, the administrator must find ways to show the staff that he or she is willing to share responsibility for risk taking. You also will want to include representatives of all levels of staff and all disciplines. You might include a family representative and a resident. A group of eight to ten individuals is a good size.

Such a group can be charged with the following responsibilities:

- Review the provisions of current federal and state regulations regarding restraint use.
- Evaluate the facility's current practices and level of restraint use to establish baseline data from which to measure progress. Include in this assessment the number of falls, serious injuries, pressure ulcers, incontinent episodes, and other data that will demonstrate that problems related to restraint use will decline. This step also provides a good opportunity to define exactly what constitutes a restraint. Many facilities have adopted the standard that a restraint is anything that restricts a resident's freedom.
- Survey staff, family, and where possible, residents' attitudes about restraint elimination. Plan to collect data a second time one year after the program has begun to assess attitudinal change.
- Conduct an audit on the incidence, severity, and circumstances of falls during the last six months. Maintain records on these factors once you start eliminating restraints in order to analyze any changes that occur.
- Develop operational procedures that reflect a consistent and organized approach to determining the individual needs of residents.
- Research and brainstorm alternatives to restraints for each reason restraints have been used in the past, e.g., wandering, falling, aggression.
- Determine how you will communicate the new policy and procedures to the staff: What educational materials will be used? Will special equipment be needed, e.g., a VCR and monitor? Will you use role playing? (Some facilities restrain staff members during training to develop an understanding of the psychological effects of being restrained.) How will family members participate? How will residents participate? Will training be accomplished formally or informally? Will an outside consultant be retained or will training be conducted by existing inservice staff?
- Strategize means of overcoming resistance from staff and families. (In a fall 1991 survey, the American Association of Homes and Services for the Aging found that resistance from staff and families were the top two obstacles to reducing the use of restraints.) Some homes have found it very effective to plan family council meetings in which they give families the experience of what it is like to be in a restraint.
- Determine how you will orient and train new staff and temporary workers.
- Formulate a step-by-step time line. Start with small, attainable goals.
- Agree on ways to celebrate the completion of each major stage.

Who are the key players?

Everyone who works at the nursing home is a key player, but it may be valuable to appoint a quality care improvement coordinator to oversee the restraint-elimination process. The coordinator should be respected, creative, and compassionate about the needs of both the residents and the staff, have strong leadership skills, and be enthusiastic and committed to the elimination of restraints. The coordinator also must have the authority to ensure that everyone understands the program's goals, address fears and concerns of staff members, respond to problems that arise, and head up the task force.

Restraint removal is most effective when implemented by an interdisciplinary team. Nursing assistants, for example, spend the most time with residents and often have detailed knowledge of residents' needs and preferences, so it is crucial that they are involved in the restraint-removal process. Social workers and various other specialists also can help assess a resident's specific needs and his or her likely response to change. Nursing staff can help to maintain continuity by communicating frequently with therapists and including them in planning meetings.

Primary care nursing works well in many long-term care facilities to facilitate the restraint-removal process. When one nurse or nursing assistant takes care of the same group of residents every day, individualized care plans are much easier to implement consistently. Primary care also encourages the development of real relationships between residents and caregivers, which in turn often results in heightened job satisfaction and increased self-esteem. In some cases, either caretakers choose which residents they will attend or residents choose their own primary caregiver.

Consider also some minor adjustments in staffing patterns to accommodate your new policy. Staffing may need to be strengthened during those hours — typically morning and early afternoon/late evening — that are peak activity times for residents. If many residents wander at night, some day staff may need to switch to nights.

In addition, it will be necessary to increase communication across shifts. One shift may be enthusiastic about working with residents to eliminate restraints, while another may request or apply restraints, not understanding or not being aware of the goals of the other shift. Involving all staff in the same training programs and holding shift-change conferences can help eliminate such inconsistencies in care. The point is to have all employees working toward the same goals.

What about resistant staff?

It is not unusual to find that while most staff readily accept a restraint-free policy, a few adamantly oppose it, even after extensive participation in inservice programs. Nurses may feel that restraint elimination conflicts with what they were taught, or that they will not be supported by management if a problem arises. In the past, nurses were taught to apply restraints if they believed residents were at risk of injury without them.

Emphasize the following points to such individuals:

- Management is strongly committed to restraint elimination.
- Both theory and practice in regard to restraint use have changed substantially in the last few years.
- Residents' behavior and level of functioning often improve once restraints are removed.
- Risk is a big part of living.
- Each resident is entitled to a dignified existence, no matter how impaired he or she is.
- A restraint-free environment is both possible and worthwhile.
- Restraint removal can contribute to a more positive and pleasant work environment.
- Eliminating the use of restraints may actually reduce staff workload because residents may be able to function more independently and take care of a greater percentage of their own needs.

Another strategy is to give the resistant staff member some responsibility for creating a successful restraint-removal program on his or her own unit. It also will be helpful to clearly communicate the successful elimination of restraints elsewhere in the facility. Administrators report that when none of these messages or methods results in the desired level of cooperation, it is sometimes necessary to make cooperation a condition of continuing employment.

How can you get families involved?

Family involvement in planning and implementing a restraint-free program is critical. (Note: ***Everyone Wins!*** includes a separate video/print package that introduces families to quality care without restraints).

Families who are new to the long-term care process will be particularly pleased to know the dignity and freedom with which their family members are treated. The restraint-free goal may be a powerful marketing message.

Families with members who are already residents will need education and support as they experience the change from the use of restraints to the elimination of restraints. Bear in mind that family members may have been told their relative was being restrained for his or her own safety and may perceive an increased risk of going restraint free. Explain that knowledge of quality care has increased dramatically in recent years and that ongoing research indicates that quality, safe care is possible without restraints. Point out that in many cases, residents have improved their level of functioning and become happier and more independent following the removal of restraints. Provide ample time for adequate communication to occur, and involve family members in assessment procedures. Encourage family members to voice their concerns and provide concrete information to address their fears.

Many will need reassurance similar to that provided to staff members. If a family continues to express significant resistance to restraint removal, ask them if they could support removing the restraint on a very gradual basis, e.g., an hour or two each day, and build from there.

The start of a restraint-reduction program may also be a good opportunity to activate a family council, if one does not already exist, as a means of sharing and discussing changes in policy. Consider also pairing families who support restraint reduction with those who do not.

Families of newly admitted residents may need guidance to understand that hospitals and long-term care facilities may approach restraint use very differently. Since new residents may arrive with particularly poor functioning due to whatever illness, surgery, or situation caused them to need long-term care in the first place, families will want to learn what special procedures have been implemented for assessing the needs of the new residents. (Note: The ***Everyone Wins! Resident Care Library*** includes a separate module on assessing the needs of the new resident.)

Whose restraints should be removed first?

Individualized care requires a thorough assessment of each resident, taking into account the person's physical abilities, level of cognitive functioning, life experiences, ways of coping, strengths and vulnerabilities, preferences and dislikes, circadian rhythms (whether they are "day" or "night" people), and social and emotional needs.

Each resident also needs to be assessed to determine why he or she was restrained in the first place and whether or not the original problem is still pertinent. Common reasons include wandering, being at risk of falling, jeopardizing life support systems, agitation, and poor positioning. Just as commonly, however, the resident may have come to the long-term care facility from a hospital with orders for restraints that no one has ever questioned. Once the original reason for the restraint is known, staff members will need to brainstorm new means of achieving the same care objective. Changes in the environment, use of positioning devices, aggressive restorative therapy, and additional social activity are among the options staff should explore.

Every nursing home resident is entitled to a dignified existence, no matter how impaired he or she is.

If a resident has been restrained for particularly agitated behaviors, e.g., hitting or screaming, a more comprehensive assessment may be needed to discover what is causing such reactions and what approach might eliminate the agitated behavior. Some people act out in response to the restraints themselves and become much calmer without them. (Note: The ***Everyone Wins! Resident Care Library*** includes a separate module on this topic: Getting Hit, Grabbed, and Threatened: What It Means, What To Do.)

Finally, a complete review of medications is necessary to determine if any of the behaviors for which the individual is being restrained are actually caused by a particular medication.

How should you go about removing restraints?

Do not try to remove everyone's restraints at once. Begin with a pilot program on one unit only, or one part of one unit. Select a unit with relatively few highly challenging restraint situations as well as one whose staff is most likely to set a positive tone for the rest of the organization.

Start with the easiest cases. Based on individual assessments and care plans, start removing restraints from no more than one or two residents a week so that all staff can be particularly alert to a limited number of situations. Be sure you prepare the resident for this process, just as you have prepared staff and family members.

If a person is both physically and chemically restrained, work with physicians and pharmacists to remove the chemical restraints first. This will make the residents more alert when the physical restraints are removed, and reduce the risk of falls. Often a gradual approach is needed. It may take a year or so to get all people out of restraints, but the important thing is to keep reassessing, innovating, and moving toward the restraint-free goal.

Many homes report it is easiest to remove restraints at first during mealtimes, when many staff members are available to assist with and monitor residents. It also is a good idea to get newly unrestrained residents stabilized before removing others' restraints. Once the first resident is restraint free, it becomes easier and easier to remove restraints from other residents.

Don't forget to reward staff who have been particularly observant and/or who have developed highly creative solutions to meet resident needs. One facility videotapes clever solutions to share at staff meetings. In another facility, where the director of nursing conducts inservice courses for other local homes, she validates her staff's creativity by inviting them to join her in her presentations.

KEEPING IT GOING

How long will the process take?

Achieving restraint-free care is a gradual, ongoing process without a quick-fix solution. Once a facility gets going, however, progress usually occurs steadily.

The size of the facility and the number of people for which it cares will certainly influence the length of time needed to remove restraints, as will the problems individual residents present. The length of time needed also will relate to the extent to which restraints were used at the start of the process. It is reasonable to expect that if management is consistent, within two years the facility will be permanently transformed.

What can hinder the full development of a restraint-free program?

Implementing and maintaining a restraint-free program is not a simple, one-time project. It is an ongoing effort that requires continuous support and reinforcement. Under the less than ideal circumstances that staff must face daily, there are many reasons a program can fail.

An important issue in maintaining progress is the orientation and training of new staff. When staff members terminate or temporary staff is employed, the new or temporary staff may not have the training or background to provide restraint-free care. If provisions for their training are not made, previous training efforts are nullified in at least some areas of the facility. Similarly, when administrators or senior staff are replaced, orientation must include a discussion of the facility's policy regarding restraints.

Staff may become complacent over time, allowing their procedures to become sloppy, thinking that they know all there is to know about restraint-free care. They may fall into a routine and forget to consider the individuality of each resident. Or, after working with a resident who presents a particularly difficult challenge, staff members may become discouraged and lose sight of the long-term goals of restraint-free care, giving up on their efforts to implement change.

Management may be inclined to halt the program in the event of an injury or if family members apply pressure because they are unhappy with restraint removal. Sometimes administrators fail to provide strong support for the basic tenets of implementing a restraint-free program. Nursing home staff will be much less likely to adopt a new program that lacks adequate leadership or lacks a person responsible for nurturing and motivating staff in their efforts. Staff leaders have a significant responsibility to help their staff internalize the goals and message of restraint-free care in order to prevent a premature loss of program support.

The most basic reason that restraint-free programs fail is that the facility, including management and staff, never accepts the basic philosophy of restraint-free care. They may view OBRA as a restricting burden rather than as a facilitator that will bring increased independence and contentment to residents and greater job satisfaction to staff.

Why is continuous assessment important?

Assessment is important to maintain the momentum of a restraint-free program. Only through continuous assessment will staff be able to recognize any progress made. Assessment will provide a means to measure both effective and ineffective tactics in accomplishing the goals of the program. Specific tracking and assessment of the following information will indicate a natural direction for the staff to follow: the types of restraints used; the incidence, severity, and circumstances of falls; and the attitudes toward restraints among staff and family members.

One nursing home found it helpful to have a "Room of the Day" program. Each day, one resident's room was featured, and every staff member was to visit that room sometime during the day. Everything in the room was evaluated and judged to be either a help or a hindrance to restraint-free care. This program worked for this facility as it included all levels of staff and provided a means of constant evaluation. Through this program, the practices and techniques that proved to be successful could be implemented and shared with everyone.

Why bother celebrating success?

Nothing will foster further success more than the celebration of success. Staff will feel a sense of pride and be encouraged when successes they have experienced are shared with other staff members. Everyone will be more motivated to try new practices that have proven to be successful with others.

Successes can and should be emphasized when hiring new staff. This will attract employees who are interested in working in a restraint-free environment. Successes also should be shared with other nursing homes in the area. Promoting exchanges between staff of different facilities who have experienced success will foster excitement and enthusiasm for continued efforts. Those who share will be encouraged to continue their efforts, and those who hear about it will have an incentive to implement new techniques and practices in their own work.

When restraint-free, residents may be able to function more independently and take care of a greater percentage of their own needs.

What conceptual model will help you keep going?

The entire staff will benefit if a four-stage model of Assess, Plan, Intervene, and Evaluate is implemented from the onset of the restraint-free program. This plan will help staff to understand the long-term nature of the program.

Assess. Prior to making any changes or removing any restraints, a complete assessment should be made of each resident's needs and of any environmental hazards that may need attention. Individual assessment of each resident is important as it will enable staff to form a plan for restraint removal that anticipates potential hazards or difficulties that are specific for a particular resident.

By evaluating the facility's current practices, a baseline may be established that will be useful in gauging future progress. This baseline also will serve as a quality assurance check and feedback mechanism for staff. As the program proceeds, progress can be tracked on a monthly basis.

Plan. Once data from the assessment is gathered, it can be used to create a plan of action for each resident and for the facility as a whole. If the entire staff is educated on restraint removal before a program is implemented, then everyone can contribute ideas and help to create both individual care plans and a facility's master plan. Full support for the program will be much more likely when staff input is requested and used. Keep these five basic points in mind while creating the master plan:

1. Gain support from administrators and staff.
2. Form a committee or task force.
3. Appoint a coordinator.
4. Evaluate the forms that you are using to see if they perpetuate old attitudes.
5. Train staff to understand and implement restraint reduction.

The formation of a plan will help all staff to see where they are going and to identify the significance of changing their daily procedures.

Intervene. It next will be necessary to find alternatives to restraints. Alternatives to restraints include:

- individualized care
- changes in the physical environment to improve safety
- physical interventions, such as therapy and exercise
- psychosocial interventions, such as activity programs, individual attention, and validation therapy
- changes in the daily routine to provide a heightened feeling of normalcy to the day.

Many ideas for restraint alternatives can come from staff members who have had direct interaction with the residents. Such staff members often are able to come up with the most creative and most appropriate interventions.

Evaluate. The consequences of restraint reduction should be evaluated on an ongoing basis to stay abreast of the program's successes and setbacks. Written records should be maintained that document risks to each resident and identify techniques that have successfully enhanced mobility or eliminated hazards. Continuous evaluation is necessary to mark progress and to recognize the strengths and weaknesses of the program.

Why have ongoing staff training programs?

Orientation and training for new staff as well as continuing staff education are key to the success of the restraint-free program. To ensure that the staff is involved in actually implementing the program, staff education should include information that would answer the following questions:

- What are the positive effects of restraint-free care?
- How can residents be assessed?
- What are some alternative interventions?
- How can falls be prevented and how can residents be assessed with regard to falling?
- What are better ways to provide postural support than using restraints?
- What are some ways to distract residents' attention so that medical treatments, e.g., catheters or IVs, are not interrupted?
- What are some strategies for communicating with confused residents?

The best problem solving is likely to come from the staff directly. Teach them to brainstorm and to find the answers to problems on their own.

RELATED RESOURCES

FOR TRAINING

The ***Everyone Wins! Resident Care Library*** is a good place to start.

The following list contains additional training resources:

■ *Before the Going Gets Rough* and *After the Going Gets Rough.* Good Samaritan Family Support Services, 1015 NW 22nd Street, Portland, OR 97210 (503-229-7348).

■ *Care of the Alzheimer's Patient, A Manual for Nursing Home Staff* by L. Gwyther. Alzheimer's Disease and Related Disorders Association (ADRDA), 1985. Call your local chapter or the ADRDA chapter in Portland, OR (503-229-7115).

■ *Innovation in Restraint Reduction.* Video. The American Health Care Association, 1201 L Street, NW, Washington, DC 20005-4014 (1-800-321-0343).

■ *Magic, Mystery, Modification, & Mirth: The Joyful Road to Restraint-free Care*. Mt. Angel, OR: Benedictine Institute for Long Term Care.

■ *An Ombudsman Guide to Effective Advocacy Regarding the Inappropriate Use of Chemical and Physical Restraints.* National Citizens' Coalition for Nursing Home Reform, 1424 16th Street, NW, Suite L2, Washington, DC 20036-2211.

■ *Untie the Elderly.* The Kendal Corporation, Kennett Square, PA 19348 (610-388-7001).

■ *Retrain, Don't Restrain, National Nursing Home Restraint Minimization Program.* The Jewish Home and Hospital for Aged, 120 W. 106th Street, New York, NY 10025 (212-870-5000).

FOR BACKGROUND

American Association of Homes for the Aging. "Nursing Home Report: Decreased Restraint Use." *Survey on the Use of Restraints in Nursing Homes* (Fall 1991): 1-14.

Andreasen, M.E. "Make a Safe Environment by Design." *Journal of Gerontological Nursing* 11, no. 6 (1985): 18-22.

"Assessment and Care Planning: The Key to Good Care, A Guide for Nursing Home Residents and Their Families." Washington, DC: National Citizens' Coalition for Nursing Home Reform, 1992.

"Behavior Management in the Nursing Facility: Inservice Materials for Staff and Supervisors." Pasadena, CA: Beverly Foundation, 1993.

Blakeslee, Jill et al. "Debunking the Myths." *Geriatric Nursing* 11, no. 6 (1990): 290.

— "Making the Transition to Restraint-free Care." *Journal of Gerontological Nursing* 17, no. 2 (1991): 4-8.

Braun, Judith V., ed. *Toward a Restraint-free Environment — Reducing the Use of Physical and Chemical Restraints in Long-term and Acute Care Settings.* Baltimore: Health Professions Press, 1993.

Brower, H.T. "The Alternatives to Restraints." *Journal of Gerontological Nursing* 17, no. 2 (1991): 18-22.

Implementing and maintaining a restraint-free program requires continuous support and reinforcement.

"Can Physically Restrained Nursing Home Residents Be Untied Safely?" Progress Report #92-14. New York: The Jewish Home and Hospital for Aged, 1992.

"The Changing Role of Restraints in Long Term Care: An Assessment of Restraint Reform Measures and the Risks Associated with the Use of Restraints." Washington, DC: Law Offices of Casson, Harkins and Greenberg, 1990.

Coberg, Ann, Deborah Lynch, and Barbara Mayretish. "Harnessing Ideas to Release Restraints." *Geriatric Nursing* 12, no. 3 (1991): 133-134.

Coons, Dorothy H. "Training Staff to Work in Special Alzheimer's Units." *The American Journal of Alzheimer's Care and Related Disorders and Research* (September/October 1987): 6-12.

Cutchins, C.H. "Blueprint for Restraint-free Care." *American Journal of Nursing* 91 (1991): 36-42.

Downs, M. *Eliminating Restraints Resource Manual: A Guide for Nursing Home Staff*. Waterbury, VT: Planning Division, Agency of Human Services, 1990.

Eigsti, D.G. and N. Vrooman. "Releasing Restraints in the Nursing Home: It Can Be Done." *Journal of Gerontological Nursing* 18, no. 1 (1991): 21-23.

Evans, Lois K. and Neville E. Strumpf. "Myths About Elder Restraint." *Image: Journal of Scholarship* 22, no. 2 (1990): 124-128.

___. "Reducing Restraints: One Nursing Home's Story." In *Key Aspects of Elder Care: Managing Falls, Incontinence and Cognitive Impairment*, edited by S. Funk, E. Tornquist, M. Champagne, and R. Wiese. New York: Springer Publishing, 1992.

Evans, Lois K., Neville E. Strumpf, and Carter Williams. "Redefining a Standard of Care for Frail Older People: Alternatives to Routine Physical Restraint." In *Advances in Long Term Care,* edited by P. Katz, R. Kane, and M. Mezey. New York: Springer Publishing, 1991.

Gold, Marla. "Moving Away from Restraints." *Provider* 17, no. 1 (1991): 20-26.

Goldman, Beryl D. et al. "Staff Attitudes on the Use and Elimination of Physical Restraints." Kennett Square, PA: The Kendal Corporation, 1991.

Hall, G. "Examining the End-stage: What Can We Do When We Can't Do Anymore?" *Journal of Gerontological Nursing* 17, no. 5 (1991): 3-4.

Hunt, Alan Reeve. "Legal Issues Involved in the Use of Restraints: Analyzing the Risks." Presented before a National Symposium, co-sponsored by the U.S. Senate Special Committee on Aging and The Kendal Corporation, December 4, 1989.

Kallman, S.L., M. Denine-Flynne, and D.M. Blackburn. "Comfort, Safety, and Independence: Restraint Release and Its Challenges." *Geriatric Nursing* 13 (1992): 143-148.

The consistent use of an organized process of assessment, planning, implementation, and monitoring is a major part of providing dignified individualized care.

Restraint-free residents experience improved health as they are able to get more exercise, and improved temperament as they do not have to fight externally imposed limitations.

Kapp, Marshall B. "Nursing Home Restraints and Legal Liability." *The Journal of Legal Medicine* 13 (1992): 1-32.

Kayser-Jones, Jeanie. "Culture, Environment, and Restraints: A Conceptual Model for Research and Practice." *Journal of Gerontological Nursing* 18, no. 2 (1992): 13-20.

Kusserow, R.P. *Minimizing Restraints in Nursing Homes: A Guide to Action.* Washington, DC: Department of Health and Human Services, Office of Inspector General, 1992. OE1-01-91-00840.

Magee, Rose, Elizabeth C. Hyatt, and Sally B. Hardin. "Institutional Policy: Use of Restraints in Extended Care and Nursing Homes." *Journal of Gerontological Nursing* 19, no. 4 (1993): 31.

Masters, Renee and Sheila Favro Marks. "The Use of Restraints." *Rehabilitation Nursing* 15, no. 1 (1990): 22-25.

Miles, Steven H. and Patrick Irvine. "Deaths Caused by Physical Restraints." *The Gerontologist* 32, no. 6 (1992): 762-766.

Mion, Lorraine C. and Anne T. Mercurio. "Methods to Reduce Restraints: Process, Outcomes, and Future Directions." *Journal of Gerontological Nursing* 18, no. 11 (1992): 5-11.

National Citizens' Coalition for Nursing Home Reform, comp. *Restraint Packet A: Inappropriate Use of Physical and Chemical Restraints*. Washington, DC: National Citizens' Coalition for Nursing Home Reform, 1994.

National Citizens' Coalition for Nursing Home Reform, comp. *Restraint Packet B: Alternative Care Approaches to Reduce Inappropriate Use of Physical and Chemical Restraints.* Washington, DC: National Citizens' Coalition for Nursing Home Reform, 1995.

Phillips, C.D. "Reducing the Use of Physical Restraints in Nursing Homes: Will It Increase Costs?" *American Journal of Public Health* 83, no. 3 (1993).

Rader, Joanne. "Modifying the Environment to Decrease Use of Restraints." *Journal of Gerontological Nursing* 17, no. 2 (1991): 9-13.

Rice, L. *A Practical Guide to Reducing the Use of Restraints in Nursing Homes.* Boston: Massachusetts Executive Office of Elder Affairs, 1991.

Ryden, M.B. "Alternatives to Restraints and Psychotropics in the Care of Aggressive, Cognitively Impaired Elderly Persons." In *Geriatric Mental Health Nursing: Current and Future Challenges*, edited by K.C. Buckwater. Thorofare, NJ: Slack, Inc., 1992.

Schnelle, John F., Sandra F. Simmons, and Marcia G. Ory. "Risk Factors that Predict Staff Failure to Release Nursing Home Residents from Restraints." *The Gerontologist* 32, no. 6 (1992).

Schnelle, J., et al. "Reducing and Managing Restraints in Long-term Care Facilities." *Journal of the American Geriatrics Society* 40 (1992): 381-385.

Residents are less likely to be hurt from falls when restraint free than when restrained.

RELATED RESOURCES *continued*

Sloane, P.D., D. Papougenis, and J.A. Blakeslee. "Alternatives to Physical and Pharmacologic Restraints in Long-term Care." *American Family Physician* 45 (1992): 763-769.

Stilwell, E.M. "Nurses' Education Related to the Use of Restraints." *Journal of Gerontological Nursing* 17, no. 2 (1991): 23-26.

Strumpf, Neville E., Lois K. Evans, and Doris Schwartz. "Restraint-free Care: From Dream to Reality." *Geriatric Nursing* 11, no. 3 (1990): 122-124.

Suprock, L.A. "Restraints in the 90s: Changing the Rules." *Geriatric Nursing* 11, no. 6 (1990): 288-289.

U.S. Department of Health and Human Services. Office of Inspector General. "Minimizing Restraints in Nursing Homes: A Guide to Action." 1992. OEI-01-91-00840.

Werner, Perla et al. "Individualized Care Alternatives Used in the Process of Removing Physical Restraints in the Nursing Home." *Journal of the American Geriatrics Society* 42, no. 3 (1994): 321–325.

___. "Reducing Restraints: Impact on Staff Attitudes." *Journal of Gerontological Nursing* 20, no. 12 (1994): 19-24.

Williams, Carter Catlett. "Liberation: Alternative to Physical Restraints." *The Gerontologist* 29, no. 5 (1989): 585-586.

Young, Kathryn F. and Patricia A. Vucic. "Turning a Dream into Reality, Developing a Restraint-free Environment." *Nursing Homes* (September/October 1990): 29-32.

Families benefit when they witness positive, personalized care and an improved atmosphere in the nursing home.

Advisors

Eugene Clarke, Senior Vice President, Quality Management, Beverly Enterprises, Fort Smith, Arkansas
John Diffey, President, The Kendal Corporation, Kennett Square, Pennsylvania
Brian F. Hofland, Ph.D., Senior Vice President, The Retirement Research Foundation, Chicago, Illinois
Linda Keegan, Vice President, Public Relations and Professional Development, American Health Care Association, Washington, D.C.
Mary Jane Koren, M.D., Principal Clinical Coordinator, The Peer Review Organization of New Jersey
Mathy Mezey, Ed.D., F.A.A.N., Independence Foundation Professor of Nursing Education, New York University, School of Education, Division of Nursing, New York, New York
Richard Neufeld, M.D., Vice President of Medical Affairs, The Jewish Home and Hospital for Aged, New York, New York
Susan Pettey, J.D., Director of Health Policy, American Association of Homes and Services for the Aging, Washington, D.C.
Wayne Smith, Ph.D., Gerontology Consultant, Catonsville, Maryland
Carter Catlett Williams, M.S.W., A.C.S.W., Social Work Consultant on Aging, Rochester, New York
T. Franklin Williams, M.D., Distinguished Physician, Department of Veterans Affairs, Professor of Medicine Emeritus, University of Rochester, School of Medicine, Rochester, New York
Tony Yang-Lewis, C.Q.S.W., Director, Alzheimer's Program, Cobble Hill Nursing Home, Brooklyn, New York

Consultants

Camille Cohen, R.N., M.A., Research Associate, The Jewish Home and Hospital for Aged, New York, New York
James Davis, Administrator, Amsterdam House, New York, New York
David Fielding, L.N.H.A., Director of Long-term Care Program, New York City Area Office, New York State Department of Health, New York, New York
Beryl D. Goldman, Director of Health Services, The Kendal Corporation, Kennett Square, Pennsylvania
Vivian Koroknay, R.N., C.R.R.N., M.S., Director of Rehabilitation and Restorative Care Services, Asbury Methodist Village Wilson Health Care Center, Gaithersburg, Maryland
Lee Krueger, Senior Director of Professional Development, Beverly Enterprises, Fort Smith, Arkansas
Tim Lane, Administrator, Greensboro Health Care Center, Greensboro, North Carolina
Steven Lipson, M.D., Medical Director, Hebrew Home of Greater Washington, Rockville, Maryland
Jean Marks, Associate Executive Director, Alzheimer's Association, New York City Chapter
Evelyn Munley, Health Policy Analyst, Policy and Government Affairs Division, American Association of Homes and Services for the Aging, Washington, D.C.
Joanne Rader, R.N., M.N., F.A.A.N., Clinical Research Fellow, Benedictine Institute for Long Term Care, Mt. Angel, Oregon, and Assistant Professor, Oregon Health Sciences University, Department of Mental Health Nursing
Janet Wells, Senior Program Specialist, Health Advocacy Services, American Association of Retired Persons, Washington, D.C.

Project Team

Independent Production Fund
Lisa Zbar, Project Director
Christopher Lukas, Senior Producer
Chris Larson, Video Producer, Editor
Karen Michel, Audio Producer, Narrator
Valerie Shepherd, Video Producer, Editor
Laurie Sude, Video Editor
Christos Pathiakas, Video Editor
Michael Karzis, Associate Producer
Liz Soriano, Associate Producer
Jessica Ljubicich, Researcher

Alvin H. Perlmutter, Director, Independent Production Fund
Anthony Padron, Director, Finance

Toby Levine Communications, Inc.
Toby Kleban Levine, Project Director and Instructional Designer
Patrick J. Gallagher, Director of Publications
Deborah Anker, Researcher
Gwen Smith, Researcher
Carolyn Cocca, Editor
Cheryl Hecht, Proofreader
DRPollard & Associates, Inc., Graphic Design