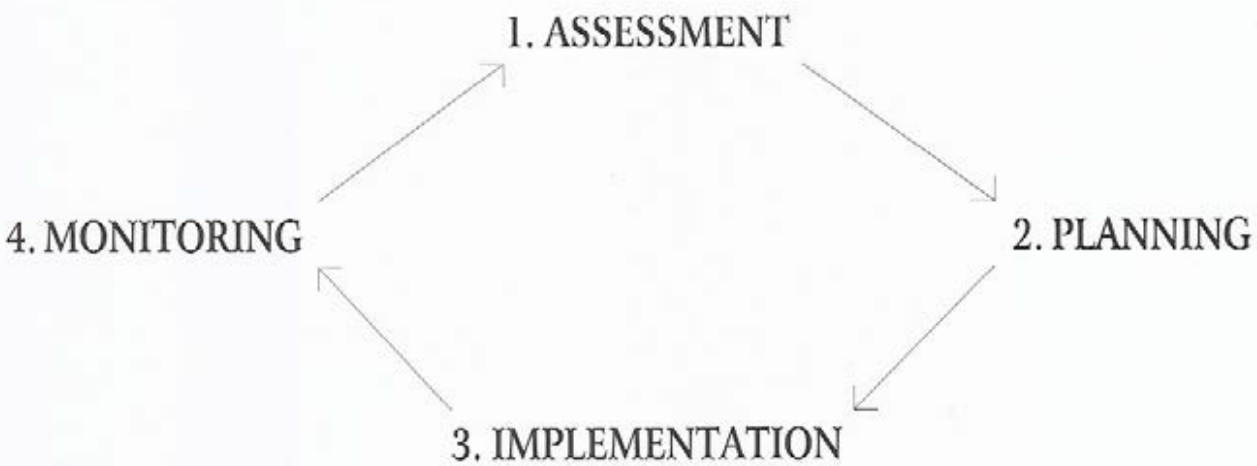
Four Steps to Restraint-free Care



Sample Behavior Mapping Chart

Resident's Name: _____ **Behavior** _____

Day of the Month

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Time																															
8:00-10:00 a.m.																															
10:00-noon																															
noon-2:00 p.m.																															
2:00-4:00 p.m.																															
Nurse's initials																															
4:00-6:00 p.m.																															
6:00-8:00 p.m.																															
8:00-10:00 p.m.																															
10:00-midnight																															
Nurse's initials																															
midnight-2:00 a.m.																															
2:00-4:00 a.m.																															
4:00-6:00 a.m.																															
6:00-8:00 a.m.																															
Nurse's initials																															

Instructions

A Behavior Mapping Chart can help you identify patterns of behavior and their possible causes. To customize a chart for a specific behavior, follow these guidelines:

1. Identify the type of behavior that you wish to monitor.
2. Develop a coding scheme to indicate the presence, absence, and severity of the behavior. Be careful to choose words for your coding scheme that accurately describe the range of the behavior without being judgmental. For instance, a coding scheme on the frequency of calling out might look like the following:

0 = none, quiet
1 = occasional calling out (1x per hour)
2 = frequent calling out (4-6x per hour)
3 = continuous calling out

3. Discuss the coding scheme with other staff members to ensure that descriptions are clear and complete.
4. Put the coding scheme on the chart so that all staff use the same notation.
5. Determine how often observations of the behavior are to be recorded. Be sure nurses initial their documentation at the end of their shifts.

Adapted from the Benedictine Institute for Long Term Care, Mt. Angel, Oregon

Family Interview Check List

- By what name does your relative prefer to be addressed?
- How typical is your relative's current behavior?
- What language does your relative speak?
- How did your relative earn a living?
- What are the names of family members that are important to your relative?
- What objects brought from home have particular meaning for your relative? What could you bring in that would give comfort to your family member?
- Did your relative have a pet?
- What is your relative's regular bedtime? Did he or she typically take a nap during the day? At what hours?
- Does your relative have any special hobbies?
- What was your relative's typical daily routine? Did it include time spent out-of-doors?
- How does your relative handle stress? How does he or she behave when asked to do something that he or she does not want to do? What is known to have a calming or reassuring effect on the individual? What might agitate your relative or make him or her anxious?
- How will we know when your relative has to use the bathroom?

Restraint-free Interventions for New Residents

- Position new residents in a location where they can be easily observed and supervised. Assign a consistent caregiver to assist the new resident through the initial period of adjustment.

- Anticipate resident's needs so restraint use is unnecessary and independence is enhanced; check vital signs; determine if the resident needs help repositioning or would be more comfortable in a different chair; see if the need for a walk or a nap is indicated.

- Keep in mind residents' needs for social contact. Try to pair a new resident with someone who speaks the same language.

- Use mealtimes, activities, and music to try to make the new resident a part of the community.

- Determine whether the use of psychotropic medications is affecting behavior.

- Be reassuring and speak slowly and face-to-face with the resident. Gently touching the resident can be calming and reassuring. Give the resident plenty of time to talk. Do not draw attention to possible memory problems.

- Consider monitoring unobtrusively all new residents' sleep patterns for the first 72 hours. Observe whether residents are restless and at what points in the night such restlessness occurs; which side they favor for sleeping; whether they go to the bathroom and if so, at what time; the degree of nighttime confusion; and where in the bed they sleep.

- Whenever possible, maintain residents' established routines. Enable them to be out of bed if awake and restless.

- Provide physical therapy to strengthen muscles, and occupational therapy to enhance independence in activities of everyday living.

- Orient the new resident to your facility several times during the first few weeks. Evaluate what additional orientation the resident requires.

- Ask if you can give any assistance before an unmet need puts a resident at risk.

Checklist for Minimizing the Risk of Fall Injuries

- Collect and analyze data on falls.
- Identify factors related to falls.
- Correct or minimize risk factors where possible.
- Conduct fall assessments.
- Identify residents at risk.
- Alert all staff to residents at high risk of falling.
- Develop and carry out a plan to prevent falls.
- Involve the family in care planning.
- Revise the care plan as needed.

Fall Assessment

Resident's Name:_____ Age:_____ Room:_____ Date:_____

Reason for Assessment Request:
( ) Recent Falls
( ) Change in Functional Ability
( ) New Admission
( ) Physical Restraint Removal
( ) Other

Brief Description of the Situation:_____

_____

Diagnosis:_____

1. Date of Admission
( ) Over 3 months (0 points)
( ) Less than 3 months (2 points) _____pts

2. History of Falling Within the Past Six Months
( ) No History (0 points)
( ) 1-2 times (2 points)
( ) Multiple Falls (5 points) _____pts

3. Medicine Use
(1 point for each medication taken more than three times per week — include prn medications)

( ) Antihistamines
( ) Antiseizure/Antiepileptics
( ) Diuretics
( ) NSAIDs
( ) Antihypertensives
( ) Benzodiazepines
( ) Hypoglycemic Agents
( ) Psychotropics
( ) Anti-Parkinson's
( ) Cathartics
( ) Narcotics
( ) Sedatives/Hypnotics
( ) Other (specify) _____
( ) If medication and/or dosage has changed in the past five days, add 1 point to the medication score. _____pts

4. Memory/Recall Ability: In the last seven days, recalls three out of four of the following (Always = 0 points, Sometimes = 4 points, Never = 2 points):

Current season, that he/she is in a nursing home, location of room, staff names/faces _____pts

5. Vision Pattern
( ) Adequate — able to see in adequate light with glasses on, if used (0 points)
( ) Inadequate — impaired vision in adequate light with glasses on, if used (1 point)
( ) Severely Impaired — no vision or sees only light, color, or shape (2 points) _____pts

Fall Assessment *Continued*

6. Continence in Last 14 Days
( ) Continent: complete control (0 points)
( ) Occasionally Incontinent: bladder 2x/week, but not daily; bowel once a week (2 points)
( ) Frequently Incontinent: bladder incontinent daily, but some control present; bowel 2-3x/week (3 points)
( ) Incontinent: multiple, daily episodes of bladder incontinence; bowel always incontinent (4 points) _____pts

7. Agitated Behavior in Last Seven Days
(Wandering; verbally abusive; physically abusive; socially inappropriate, e.g., is noisy, screams, disrobes, performs self-abusive acts, rummages, hoards, etc.)
( ) Behavior not exhibited in last 7 days (0 points)
( ) Behavior occurred less than daily (1 point)
( ) Behavior occurred daily or more (2 points) _____pts

8. Confined to a Chair (cannot walk even when assisted by staff)
( ) Confined to a chair and oriented (1 point)
( ) Confined to a chair and disoriented (3 points) _____pts

9. Blood Pressure
( ) Drop in systolic blood pressure of 20 mmHg or more between lying and standing (2 points) _____pts

10. Functional Gait Analysis
Assess a resident's gait while:
1) standing in one spot with both feet on the ground for 30 seconds (may hold on to assistive device if needed)
2) walking straightforward at least 5 feet
3) walking through a doorway
4) walking while making a turn

Check for any YES answer:

( ) Unable to independently come to a standing position (2 points) _____pts
( ) Exhibits loss of balance while standing (1 point) _____pts
( ) Requires hands-on assistance to move from place to place (2 points) _____pts
( ) Strays off the straight path of walking (1 point) _____pts
( ) Uses short discontinuous steps and/or shuffling steps (1 point) _____pts
( ) Has lurching, swaying, or slapping gait (1 point) _____pts
( ) Gait pattern changes when walking through doorway (1 point) _____pts
( ) Exhibits jerking or instability when making turns (1 point) _____pts
( ) Uses an assistive device, e.g., cane, walker, etc. (1 point) _____pts
( ) Wears poorly fitting shoes (1 point) _____pts

A score of 16 or more indicates a risk of falling.

TOTAL SCORE
_____pts

Source: Vivian Koroknay, Asbury Methodist Wilson Health Center, Gaithersburg, Maryland

How and Why People Wander

HOW DO PEOPLE WANDER?

- Directly from place to place
- Randomly
- Out exits or doors
- In a large repetitive circle
- Into other people's rooms

WHY DO PEOPLE WANDER?

Physical Needs

- Does the person need to use the bathroom?
- Is the person hungry, thirsty, or generally uncomfortable?
- Is the person seeking a place that is warmer or cooler, darker or lighter?
- Is the person seeking a place that is more familiar (do they have their own belongings and furniture in their rooms)?
- Is the person responding to physical illness, e.g., dehydration, infection, congestive heart failure?
- Is the person reacting to medication?

Psychological and Social Needs

- Is the person restless or agitated and trying to relieve anxiety?
- Is the person bored, lonely, or seeking company?
- Is the person following some once-routine activity, such as moving about at a time when he or she typically went home from work?
- Has the resident always worked through stress by increasing physical activity?

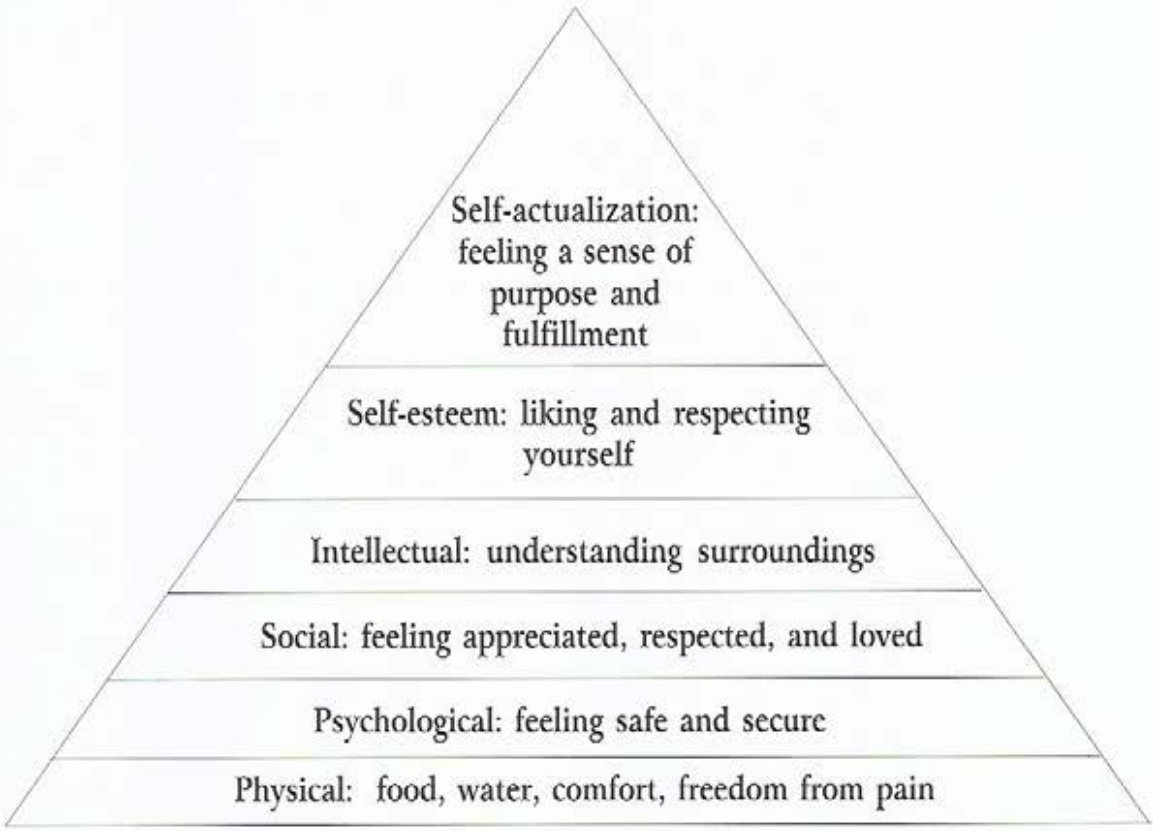
Cognitive Needs

- Is the person disoriented or lost?
- If the person is disoriented, is it due to medication or dementia?
- Is the person overstimulated or understimulated?

Making It Safe for People Who Wander

- Lock utility and storage rooms, and put away all cleaning materials and poisonous substances. Install alarms on exit doors and stairwells. Use key entries for elevators.
- Create indirect paths to exits and place chairs facing away from the exits.
- Post clear signs on doors (e.g., STOP, NO EXIT). Disguise doors by painting or wallpapering them to blend in with the walls. Make doorknobs the same color as the door or place fabric across doorways at doorknob height (so doorknob is covered).
- Attach an alarm to the resident's bed, door, or chair so you know when the resident is starting to move around.
- Develop a sufficient variety of activities to accommodate different interests and attention spans. Provide opportunities for exercise, particularly before meals.
- Pair two residents who like to walk.
- Have staff members accompany residents on walks. Some facilities have found that they can create a safe walking pattern for a resident by walking with them for a period of time. Imprinting a circular pattern, for example, can prevent wanderers from the frustration of winding up at dead ends.
- Watch for residents who may wear themselves out and require special rest periods or additional nourishment.
- Have residents who wander wear an identification bracelet with their name and the phone number of the facility. Keep a few handy in case the resident removes or loses the bracelet.
- Maintain a photo file of residents who wander and mount it at the entry doors, at the switch board, or at the security desk, so staff can intervene if they see a resident seeking to exit.
- Get to know neighbors, local businesses, and local police. Devise a specific procedure for situations in which a resident has wandered off the grounds.
- Have staff or volunteers take residents for outdoor walks once a day as weather permits.

A Hierarchy of Needs



Psychologist Abraham Maslow grouped human needs into a hierarchy. The first needs to be satisfied — physical needs — are at the bottom. Once these needs are met, psychological needs develop. This process continues up the hierarchy until all needs are met and a person reaches self-actualization.

Source: Adapted from A.H. Maslow, *Motivation and Personality* (New York: Harper & Row, 1954) and A.H. Maslow, *The Farther Reaches of Human Nature* (New York: Viking, 1971).

Ten Steps to Describe Behavior Accurately

1. What happened?
2. When did it happen?
3. Where did it happen?
4. How long did it last?
5. How severe was it?
6. Who was involved other than the resident and what did he or she do?
7. What preceded the episode?
8. What do you think caused the behavior to begin?
9. What do you think caused it to stop?
10. What were the consequences of the incident?

Verbal Communication Strategies

- Use concrete, exact, positive phrases; repeat the same phrase.
- Break instructions down into single tasks like, "walk forward," "stop," "please turn around," and "sit down."
- Make a suggestion if the person is unable to make a choice.
- Use a calm, soft, slow voice pattern.
- Ask one question at a time and wait for a response.
- Do not argue or try to reason.
- Use distraction.
- Only promise what you will be able to do.
- Include the person in your conversation.
- Identify the person's vocabulary and use it — if a resident uses the word "potty" for bathroom, then staff should use that word. (Do **not** use childish words unless the resident does.)
- Treat the resident as an elder or peer, not as a child.
- Acknowledge the person's feelings and help him or her identify what is wrong if there is difficulty communicating it. For example, "You look sad. Do you miss your daughter after she leaves?"
- Intervene early if it appears the resident is about to get upset, especially if he or she is with another resident. Intervene before the behavior escalates.

Source: Joanne Rader, Benedictine Institute for Long Term Care, Mt. Angel, Oregon.

Non-verbal Communication Strategies

- Practice looking friendly — your attitude is contagious.
- Make your verbal and non-verbal messages the same.
- Move slowly and approach the resident from the front, rather than from the side or from behind. Make eye contact with the person.
- Assume an equal or lower position to help the resident feel less powerless.
- Take care not to overwhelm a resident either physically or verbally. (Approaching an anxious resident with three or more people may lead to a catastrophic reaction.)
- Use lots of touch if a resident enjoys it. Allow time for the resident to touch you.
- Identify symbolic behaviors and their meaning — the cup the resident hangs onto after meals may be symbolic of having coffee with friends and may provide security and comfort.

Source: Joanne Rader, Benedictine Institute for Long Term Care, Mt. Angel, Oregon.

Comprehensive Siderail Assessment

Circle the appropriate number.

Independent <-----> Totally Dependent

Bed mobility 1 2 3 4 5

1. Resident does not need any help to roll from side to side, to shift weight up and down bed, or to come to a sitting position from a supine position.
2. Resident occasionally needs some help to move around in bed, such as brief verbal cues to grab siderail.
3. Resident requires one person to assist in rolling from side to side.
4. Resident requires two people to turn in bed.
5. Resident is unable to initiate any movement.

Transfers 1 2 3 4 5

Process of moving between positions, to/from bed, chair, standing (exclude transfers to/from bath and toilet)

1. Requires no supervision or physical assistance to complete necessary transfers. May use equipment, such as railings, trapeze.
2. Requires intermittent supervision (e.g., verbal cuing) and/or physical assistance for difficult maneuvers only.
3. Requires one person to provide constant guidance, steadiness, and/or physical assistance. Resident may participate in transfer.
4. Requires two people to provide constant supervision and/or physically lift. May need lifting equipment.
5. Cannot and has not gotten out of bed.

Mobility 1 2 3 4 5

1. Walks with no supervision or human assistance. May require mechanical device (e.g., a walker), but not a wheelchair.
2. Walks with intermittent supervision (e.g., verbal cuing and observation). May require human assistance for difficult parts of walking (e.g., stair, ramps)
3. Walks with constant one-to-one supervision and/or constant physical assistance.
4. Wheels with no supervision or assistance, except for difficult maneuvers (e.g., elevators, ramps). May actually be able to walk, but generally does not move.
5. Is wheeled, chairfast, or bedfast. Relies on someone else to move about, if at all.

Comprehensive Siderail Assessment *Continued*

Toileting 1 2 3 4 5

Process of getting to and from a toilet (or use of other toileting equipment, such as bedpan), transferring on and off toilet, cleansing self after elimination, and adjusting clothes.

1. Requires no supervision or physical assistance. May require special equipment, such as a raised toilet seat or grab bars.
2. Requires intermittent supervision for safety or encouragement, or minor physical assistance (e.g., clothes adjustment or washing hands).
3. Continent of bowel and bladder. Requires constant supervision and/or physical assistance with major/all parts of the task, including appliances (e.g., colostomy, ileostomy, urinary catheter).
4. Incontinent of bowel and/or bladder, and is not taken to a bathroom.
5. Incontinent of bowel and/or bladder, and is taken to a bathroom every two to four hours during the day and as needed at night.

Check all that apply.

Body Control: _impaired standing balance _impaired sitting balance _unsteady gait

Mobility Device: _cane _walker _wheelchair _self-propelled _pushed by others

Mood/Behavior pattern: _wandering _verbally abusive _physically abusive _socially inappropriate

Psychotropic medications: _antipsychotics _antianxiety/hypnotics _antidepressants

History of falling: _no _yes
if yes, when: ___>30 days ___<30 days ___time of day ___injury

Sleep pattern: Bedtime_____ OOB in AM_____ Naps_____

RISK ASSESSMENT Each facility should determine the number and types of risk factors that must be present to justify use of a siderail.

_____low (totally independent or totally immobile)
_____moderate (lacks the ability to transfer safely; at risk for falling; requires supervision)
_____high (history of falling from bed or falling in bedroom)

Source: Adapted from The Jewish Home and Hospital for Aged, New York, New York

Questions to Ask Yourself When Residents Are Awake at Night

- Have they been awakened by the staff accidentally or on purpose? If on purpose, was it necessary to complete the interventions at that time?
- Were they once night workers?
- Are they lonely?
- Are they dehydrated or hungry?
- Are they in pain?
- Is a light shining in their eyes?
- Is it noisy outside their room?
- Were they poor sleepers before admission?
- Have they been sleeping too much during the day?
- Are they warm enough or too warm?
- Do they need to use the bathroom?

Alternative Activities and Ideas for Evenings, Nights, and Weekends

- Provide an activity cart on each unit filled with items that promote strength and mobility so residents can participate in these activities at any time.
- Use water beds, low beds, or alarmed beds instead of siderails.
- Provide music according to individual preference for residents to listen to via earphones.
- Make snacks available.
- Take a walk with the resident.
- Keep a resident company and provide personal attention.
- Be creative with the use of volunteers and swing-shift staff so that more staff members are available when shifts change.

Add your ideas here:

- _____
- _____
- _____

Why Increase Your Activity Program?

1. Activities promote a resident's sense of identity.

2. Activities give residents a sense of control and independence that is derived from caring for one's own body, possessions, and surroundings.

3. Activities contribute to a sense of self-esteem and the esteem of others that comes from performing a valued service or producing a valued object.

4. Activities promote meaningful relationships and inclusion in a supportive group.

Activity Starters

- Enable residents to serve tea and pass a tray of cookies to reinforce the individual's role as host or hostess and give an opportunity to practice well-preserved social skills that contribute to self-esteem.

- Encourage female residents to apply makeup, choose nail polish, comb hair, and perform other grooming activities to help them feel control over their bodies.

- Ask residents to sort through a sewing basket, jewelry case, or tool box to help them feel control over their immediate environment.

- If indicated by their care plan, invite residents to volunteer to set and clear the table, wash and dry dishes, or fold laundry to help them feel that they can contribute.

- Promote a sense of group participation with sing-alongs and dances.

- Look for opportunities to sit with a resident in a small group involved in a calm conversation, hold his or her hand, and provide positive attention to reinforce a sense of inclusion. This can be particularly reassuring for severely impaired people.

- Chop and saute vegetables where residents can smell them to provide sensory stimulation and important reminiscing opportunities for those who can no longer actively participate in kitchen activities.

Add your ideas here:

- _____

- _____

Discovering the Strengths of Volunteers

Research suggests that the best way to accomplish the goals of a volunteer program is to allow volunteers to lead from their strengths rather than asking them to fulfill the needs of the organization. The following tool can help you discover the strengths of volunteers and provide clues as to how you can best work together:

The Window of Work

Wise Whys Write down why you decided to become a volunteer for this organization.	**Glad Gifts** List any talents, skills, interests, or hobbies you do well and that you enjoy doing.
Quests List things you want to learn more about, or skills you would like to develop.	**Taboos** List what you do NOT like to do or what you never want to be asked to do.

Source: Adapted from Scheier, Ivan H. *Building Staff/Volunteer Relations.* Philadelphia, PA: Energize Inc., 1993.