THE UNIVERSITY OF IOWA

IOWA GERIATRIC EDUCATION CENTER

INFO-CONNECT

Restraint-Free Resident Care

The Facts . . .

- The resident has the right to be free of restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.
  (Code of Federal Regulations)
- No known benefits of restraint use exist.
- Risks of restraints involve the actual use of the restraints as well as the potential for negative post-restraint outcomes.
- Seclusion or restraint can only be used in emergency situations if needed to ensure a resident's physical safety and less restrictive interventions have been determined to be ineffective.
  (Code of Federal Regulations)

Definitions

Physical Restraint:

Any device that restricts a resident's movement and cannot be removed easily by the resident. Examples include:

Locked geri chairs/recliner chairs, restrictive side rails, vest/chest/jacket restraints, wrist or ankle ties, belts, hand mitts, sheet ties, and tightly wrapped sheets or blankets. (Park et al., 2005)

Medication Restraint:

Use of medications in addition to the resident's regular drug regimen to control behavior.

Seclusion:

Involuntary confinement of a resident in a room or an area where the resident is physically prevented from leaving.
(ShawPittman, 2000)

Myth of Protection

It is a misperception that restraints effectively protect residents and reduce the liability of medical staff and the institution. The tendency is to use restraints to prevent harm, but the reality is that there is a significant possibility that the use of them will do harm.

Risks of Restraint Use

While restraints have been used to protect residents from harm, there are many potential outcomes that are in fact harmful. Besides the risk of violating residents' rights there are other known risks:

- Increased risks of falls with injuries due to loss of muscle and balance
- Death from strangulation or entrapment
- Increased levels of confusion
- Pressure ulcers due to immobilization
- Pneumonia
- Urinary incontinence and constipation
- Emotional distress and lingering stress with long-term negative health consequences
- Contractures due to immobilization

Training Instead of Restraining

Nursing staff should be trained to identify the underlying reasons for a behavior. By carefully assessing the resident and the environment, the reasons for behaviors may be identified and eliminated or modified to resolve the situation for the resident and safely provide restraint-free care.

Systematic problem solving should be employed by the nursing staff who know the resident. An example of a process includes:

- Ask the resident what s/he needs.
- Ask the family or other informed individuals who might understand what the resident wants.
- Review the current health record, reports and notes to identify contributing factors such as possible sources of pain or discomfort.
- Evaluate medication usage which can lead to observed behaviors.
- Assess the resident's functional, mental and psychological status for indicators.
- Assess the environment for possible triggers.

Documentation

Use a behavior log to document behavior.

- When did it start? (Date and exact time)
- How long did it last?
- Where did it happen?
- Who was present?
- What was s/he doing?
- What precipitated the behavior?
- What made the behavior better?
- How many times did it happen?

Tips for Restraint-Free Care

By using assessment and knowledge about residents, there are many interventions which help eliminate the need for restraints:

- Identify and use the least invasive and bothersome treatments.
- Cover IV or catheter sites with long sleeves.
- Keep IV bags and tubes out of field of vision.
- Use distractions such as TV, music, activities, etc.
- Use relaxation techniques such as massages, warm baths, etc.
- Provide personal attention with active listening.
- Engage in conversations to help diminish anxiety.
- Invite the family to assist in comforting the resident.
- Reduce noises that trigger behaviors.
- Provide the most effective lighting—could be lower or higher.
- Assign consistent caregivers.
- Be creative for the residents.

(Park et al., 2005)

Common Care Challenges and Behavioral Interventions

Residents with mental status changes, cognitive deficits, or sensory deficits may exhibit challenging behaviors during activities of daily living. It is important to:

Make a Plan . . .

⇒ Identify the target behaviors to be changed and set an achievable, realistic **BEHAVIORAL** goal.

⇒ Investigate possible **ANTECEDENT** conditions to the target behavior and change the conditions to reduce likelihood of behavioral reoccurrence.

- **INTERNAL** antecedents: sensations, feelings, and experiences such as pain, hunger, fear, or perceived invasion of personal space
- **EXTERNAL** antecedents: factors in the physical or social environment such as noise, too many people, confusing surroundings or demands to function beyond his or her ability

⇒ Change the **CONSEQUENCES** for the targeted behavior.

⇒ Evaluate if any or all of the plan worked.

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Common Care Challenges:	Bathing	Toileting	Mealtime	Disruptive Vocalization
Common Antecedents/ Sources of Stress:	• Room temperature (e.g., cold, drafty) • Water temperature (e.g., too hot, too cold) • Unfamiliar facilities or routine (e.g., sterile, not-homelike) • Embarrassment or emotional discomfort • Physical discomfort or pain with movement • Misperception or fear	• Lack of privacy or comfort • Misperception (e.g., thinks trash can is the toilet) • Way-finding problems (e.g., unable to see or find toilet) • Language loss (e.g., unable to communicate needs) • Functional deficits (e.g., unable to disrobe or get to the toilet in time) • Unaware of "social rules" • Urinary tract infections • Medications (e.g., diuretics and medication side effects)	• Incontinence/need to void • Pain (e.g., mouth, gums, ill-fitting dentures, mobility) • Overstimulation (e.g., noise, confusion, crowding) • Competing demands for attention (e.g., medications, food, or conversation) • Eating utensils are not understandable • Food or eating style is unfamiliar • Overwhelmed by choices or demands	• Sensory overstimulation or understimulation • Immobility • Pain or discomfort • Fatigue • Vocal tics • Psychotic symptoms (e.g., hallucinations or delusions) • Psychological distress (e.g., boredom, loneliness, anxiety, or fear) • Caregiver behaviors (e.g., indifferent or impersonal) • Depression
Behavioral Interventions:	• Collect a "bathing history" • Base bathing method and time of day on history • Use past memories to encourage cooperation • Provide a reason to bathe • Use one person to assist rather than several • Cover all body parts not being washed • Provide a washcloth to cover face and eyes • Wash hair last or wash in a beauty salon or barber shop • Distract person with familiar conversation • Use familiar terms or words • Offer choices, encouragement and feedback • Bathe in room using bed, towel, or sponge bath as an alternative	• Clear pathways to toilet • Provide cues to find toilet (e.g. pictures or signs) • Use color contrast (e.g., a white toilet with a bright-colored wall) • Develop a personalized routine using person's long-standing habits • Monitor behavior • Use easy-to-remove clothing • Cue or assist as needed • Monitor intake after 6 pm to avoid accidents • Eliminate caffeine • Monitor medication type, interactions, and side effects • Monitor intake/output to assure adequate intake and hydration • Minimize "fuss" if accidents occur	• Develop calm, quiet, home-like routines • Dine with small groups or in own room • Use tablecloths, flowers, candles, and lowered lighting (all are associated with less mealtime aggression) • Provide space so each has his or her own territory • Tolerate "messy" behavior • Cue or assist as needed • Simplify food presentation • Provide appropriate utensils (e.g., use color contrast and one plate/utensil rather than several) • Redesign routines to avoid overstimulation and confusion • Adopt flexible, adaptable mealtime policies (e.g., open kitchen, cafeteria style, or restaurant style)	• Offer adequate pain medication • Avoid large group activities, noise, and commotion • Create home-like setting • Offer environmental sounds (e.g., tapes of rain, wind, etc.) • Use aroma or pet therapy to soothe or distract • Maximize sensory function • Treat physical problems • Ambulate or escort outdoors • Use one-to-one activities, reassurance, and reminiscence to distract • Reassure through touch, conversation, music, or a taped voice of loved one • Schedule naps and monitor routines (Smith, 2000)

N. E. S. T. Approach

(Buettner & Fitzsimmons, 2005)

This training utilizes a nonpharmacological approach with evidence-based interventions of disturbing behaviors in the older adult with dementia.

N.E.S.T. approach to program planning and implementation looks at the:

- **N.** "needs" of individual residents
- **E.** "environment" of resident
- **S.** appropriate levels of "stimulation" and rest
- **T.** "techniques" and approaches used by care providers

A nest is a carefully created environment providing structure, safety, caring and warmth with specially trained health care providers serving as behavior specialists for frail elderly adults with dementia.

Overview of N.E.S.T. Process

- Define and name specific behavior observed
- Review behavior flow sheets, brainstorm possible causes and interventions with interdisciplinary team
- Full behavioral evaluation
- Behavioral, functional, and leisure assessment
- Select intervention/protocol "Simple Pleasures Book" based
- Re-evaluate in two weeks, reassess and modify intervention

If you are interested in forming a best practices N.E.S.T. Team at your facility, contact Sherry McKay, (N.E.S.T. trainer), University of Iowa College of Nursing, 319-335-7120.

References

Beck, C.K. (1998). Psychosocial and behavioral interventions for Alzheimer's disease patients and their families. *American Journal of Geriatric Psychiatry, 6*, 41-48.

Burke, M.M., & Laramie, J.A. (2004). *Primary Care of the Older Adult*. Mosby: St. Louis.

Code of Federal Regulations, Title 42, Volume 3 (CITE: 42CFR482.13), 482-484.

Iowa Geriatric Education Center Info-Connect. (2000). *Understanding and Managing Aggression (Brochure).* Iowa City, Iowa: Smith, M.

Nasr, S.Z., & Osterweil, D. (1999). The Nonpharmacologic management of agitation in the nursing home. *Annals of Long Term Care, 7*(5).

Park, M., Hsiao-Chen Tang, J., Ledford, L., (2005). *Evidenced-Based Practice Guideline*: *Changing the practice of physical restraint use in acute care.* The University of Iowa Gerontological Interventions Research Center, Research Translation and Dissemination Core.

Shaw Pittman (2000, June). HCFA issues guidelines on patient restraints and seclusion. (1) online www.shawpittman.com.

Strumpf, N.E. Robinson, J.P., Wagner, J.S., & Evans, L.K.(1998). *Restraint-free Care: Individualized Approaches for Frail Elders*.: Springer Publishing Company: New York.

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