Least Restraint
Handout Package
Least Restraint

• What is a restraint?
• What comes to mind when you think of a restraint?
• Why were restraints used in the past?
• Are restraints used today? …For what purposes?

Least Restraint

• Restraint definitions varied
• Search for a standardized definition
• Beneficial for benchmarking: How does our use of restraints compare to other facilities?

Restraint Definition

• Definition from Minimum Data Set (MDS)
• Updated in 2010
• “Any manual method, or any physical or mechanical device, material or equipment that is attached or adjacent to the resident’s body, that the resident cannot remove easily and that restricts the resident’s freedom of movement or normal access to his/her body. It is the effect the device has on the resident that classifies it into the category of restraint, not the name or label given to the device, nor the purpose or intent of the device.”
Excluded from Definition:

- “If the resident has no voluntary movement, specifically is comatose or he/she is quadriplegic; trunk, limb, and chair restraints are coded as not used”
- Immobilization of a part of the body as required for medical treatment (e.g., splint)
- Temporary immobilization of a part of the body while performing a care procedure (e.g., taking BP)
- Temporary immobilization during transportation (e.g., vehicle seat belts)

Restraint Examples

- Full Bed Rails: “Full rails may be one or more rails along both sides of the resident’s bed that block 3/4’s to the whole length of the mattress from top to bottom. This definition also includes beds with one side placed against the wall (prohibiting the resident from entering and exiting on that side) and the other side blocked by a full rail (one or more rails).”

Restraint Examples cont’d

- Other types of Bed Rails: “(e.g., 1-side half rail, 1-side full rail, 2-sided half rail)”
- Trunk Restraint: “Includes any device or equipment or material that the resident cannot easily remove (e.g., vest or waist restraint).”
Restraint Examples cont’d

• Limb restraint:
  "Includes any device or equipment or material that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm) or lower extremity (i.e., foot, leg)."

Restraint Examples cont’d

• Chair Prevents Raising:
  "Any type of chair with locked lap board or chair that places the resident in a recumbent position that restricts rising or a chair that is soft and low to the floor (e.g., bean bag chair)."

Restraint Examples Cont’d

• Mechanical: Safety belts, W/C safety bars or lapboard, geriatric chairs, side rails
• Chemical: Psychotropic drugs
• Physical: Physical force
• Environmental: Locked doors (confinement to room/unit)
Rationale for Restraints

**Myths**
- Restraints ensure resident's safety and protection
- Restraints help residents feel more comfortable
- Restraints enable staff to get more work accomplished

Research indicates:
“Protecting older adults with physical restraints places them at risk for numerous short and long term physical, psychological and behavioral consequences” (Evans & Strumph, 1998)

Negative Physical Effects of Restraints
- Respiratory problems
- Cardiac stress
- Muscle atrophy
- Incontinence
- Contractures
- Skin trauma
- Death
Negative Psychological Effects of Restraints

- Depression
- Panic/Fear
- Humiliation
- Apathy
- Anger
- Social withdrawal

Restraint Removal Effects

- NO increased incidence of serious injuries
- NO increase in serious falls
- Reduced care time (i.e., restrained residents require frequent inspection, release, and exercise) (Phillips et al, 1993)
- No increased staffing in facilities (Evans & Strumph, 1998)

Restraint Free?

- Are there times when a restraint is required? Examples?
- Who decides a restraint is to be applied?
- How is the decision to apply a restraint made (process)?
How do we get to Least Restraint?

• Leadership commitment is critical
• Resident-centered philosophy/vision
• Develop policy & procedures
• Education
• Baseline measurement… Where are we at now?
• Ongoing restraint-use monitoring

How do we get to Least Restraint? (Cont’d)

• Review results and prioritize restraint reduction areas
• Incorporate restraint discussion into team conferences/staff meetings
• Brainstorm restraint reduction strategies for each resident individually… start with ‘easy’ cases
• Celebrate successes and reinforce efforts to address restraint use

Vision

• Organizational Vision Example

Health Services staff will embrace the philosophy of creating a restraint free environment in commitment to our mission.
Putting Vision into Action

• Staff will promote restraint free care whenever possible

• All other alternatives must be exhausted prior to deciding to use a restraint

• A restraint shall be considered as a temporary and unusual measure

Putting Vision into Action cont’d

• Document according to facility policy at all stages of restraint process

• Resident’s/guardian’s consent and physician’s orders are required for all restraints

Putting Vision into Action cont’d

• All restrained residents need to be checked q 15m and repositioned a minimum of q 2h or per care plan

• An ongoing regular review will be conducted
Least Restraint

- Restraining residents in any manner should be used as a last resort, when there is an identified risk of injury to self and others, and other alternatives have proven ineffective.

Alternatives to Restraints

- Electric beds – closer to floor
- Bed alarms
- Arco rails/Smart rails/assist rails
- Mobility aids e.g., trapeze, saska pole
- Pool noodles on bed or chair
- Bedside mats

Alternatives to Restraints (cont’d)

- Slip-resistant socks/appropriate foot wear
- Hip-protectors
- Chair alarms
- Front closure seatbelts (rather than rear)
- Walking program/exercise
Alternatives to Restraints (cont’d)

- Medication reviews
- Pain management
- Continence program
- Activity options (e.g., latches on board, geriatric dolls)
- Companionship

Rosehaven Program Experience

- MDS 2.0 measure used quarterly beginning in December, 1999
- Compared results to international benchmarks
- Included chemical restraints (MDS-MH)

Percentage of Residents with Full Rails
Chemical Restraints

• Captured in MDS-MH
• “Psychotropic medication administered as an immediate response to control agitation, threatening, destructive or assaultive behaviors in order to prevent harm to self or others. Chemical restraint is typically used in situations where the patient is displaying behaviors that have the potential to escalate to loss of control and/or harm to self/others…”

Chemical Restraints cont’d

… This definition excludes the use of psychotropic medication for treatment purposes, where a diagnosis has been identified and an ongoing course of treatment has been prescribed. It also excludes the use of PRN medication as part of an ongoing treatment plan…”

Chemical Restraints cont’d

… e.g., a patient with schizophrenia may receive antipsychotic medication on a regular basis to treat core psychotic symptoms, and may also receive a minor tranquilizer on a PRN basis to treat anxiety. If the patient’s behavior escalates to a point where there is risk of harm to self or others, either or both of these medications may be used as a chemical restraint.”
Dear Ethel:

A resident on my unit is at risk of falling, especially if she gets up quickly or without assistance. Her family is very concerned that she will fall and fracture her hip. Her family is insisting that we restrain the resident with a back-fastening seat belt. This increases her anxiety and makes her very restless. She continually tries to unfasten the seat belt and is constantly trying to get up. Before she was restrained, she ate well and slept through the night.

Continued…

Since we have restrained her, she refuses to eat and now she is out of bed at night. She used to walk freely around the unit and now she spends her time fastened to her chair, fretting and trying to get up. We no longer see her smiling and her behavior is becoming quite frantic. What can we do? Please help.

Sincerely,

Tied up
Dear Tied-up:

In trying to practice beneficence (prevent resident from breaking her hip), we have actually caused harm (maleficence), in that we have created agitation, loss of appetite and sleepless nights in this resident. Your manager needs to discuss with the family what the restraint has done for the resident. They need to work out a plan to get rid of the restraints. Perhaps a bed alarm could be used at night.

Continued…

The risks and the rights of individuals to take risks needs to be explained and the family needs to know how the resident’s behaviors have changed due to the restraints. From your letter, it appears that this resident had a much better quality of life before she was restrained. The manager could include the doctor in her family meeting. As well, the manager could also request a consultation with the Ethics Committee.

The CAPITAL CARE Group practices a Least Restraint Policy in all of their facilities.

Respectfully,
Ethel Ethics

In Summary: Has Least Restraint Philosophy Made a Difference?

• While we are not restraint free, have significantly reduced use of restraints
• Improved quality of life for residents (e.g., more active, greater control over life, etc)
• Staff more aware of alternatives to restraints
• No increase in the number of falls resulting in fractures