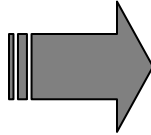


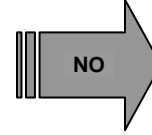
# GUIDELINES FOR RESTRAINT USE

## INITIAL ANALYSIS

- Determine the reason for device use in context of resident's condition, circumstances and environment
- Determine the medical symptoms creating the need for device use
- Determine the impact on the resident's function
- Begin risk/benefit analysis



Does the device restrict freedom of movement?

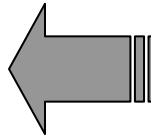


Document reason for use, add to POC, and revise periodically

YES

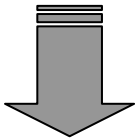


This meets the definition of a RESTRAINT – proceed with restraint protocol



## RESTRAINT PROTOCOL

- #1 - May not be used for convenience or discipline
- #2 - Must be used to treat medical symptoms
- #3 - An alert resident who requests a restraint must be assessed following the protocol

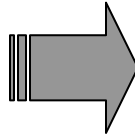


## INDIVIDUALIZED COMPREHENSIVE ASSESSMENT

- Incorporates restraint and other relevant RAPs
- Identifies a specific medical symptom that warrants the use of the device
- Identifies the underlying cause of the medical symptom
- Rules out other possible interventions
- Involves resident and family in determining the risks and benefits
- Analyzes all information

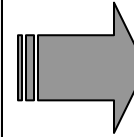
Information should include at minimum:

- ✓ What has happened /or is happening to the resident (medical symptom)
- ✓ When is the need occurring?
- ✓ What is the cause?
- ✓ What interventions have been tried?
- ✓ Why didn't alternative work?
- ✓ What is the least restrictive device?
- ✓ What is the time frame?
- ✓ Will it elevate the resident's quality of life?



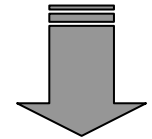
## INTERDISCIPLINARY TEAM MEETING

- Evaluates relevant factors leading to the consideration of a device
- Determines that the residents' needs are being met and the need to use restraints is not the result of an unmet need
- Investigates alternatives to restraints and determines that alternative measures have been exhausted and found to be unsuccessful
- Weighs the risks and benefits of restraint use
- Develops measures to minimize risks and resident decline
- Makes decision that device is most appropriate



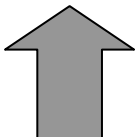
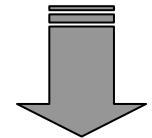
## PHYSICIAN'S ORDER

- Specifies: type/reason/duration
- Physician makes a personal exam prior to use and every 30 days to document authorization for the restraint

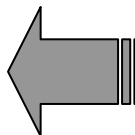


## INFORMED CONSENT

Obtains written consent of resident or authorized representative prior to use (may honor orders in place on transfer from another healthcare facility x 24 hrs)

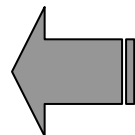


Reassessment and reevaluation for reduction/elimination



## IMPLEMENTATION

- Correct application is supervised by a nurse
- Applied per manufacturers' instructions
- Resident is monitored at a minimum of every 30 minutes while restrained



## COMPREHENSIVE INDIVIDUALIZED PLAN OF CARE

- Developed with input from the resident and/or family
- Based on informed choice. Risks and benefits are identified and explained to family/resident
- Addresses medical symptoms
- Addresses safety issues as a result of restraint usage
- Identifies measures to minimize the risk of resident decline and maintain strength and mobility (including rehabilitative and restorative care)
- Specifies, at minimum, type of restraint to be used, when restraint is to be used, when it should be released
- Addresses meaningful activities and other psychosocial needs
- Ensures the restrained resident receives a nutritionally adequate diet
- Plan must be evaluated and revised as necessary

**EMERGENCY RESTRAINT USE:** Physical restraints may be used in an emergency situation without authorization of, or personal examination by, the attending physician only to protect the resident from injury to self or others. Emergency use shall not be continued for more than 12 hours without personal examination and authorization by the attending physician.

**F221 – §483.13 (a) The resident has the right to be free from physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptom.**

### **ASSESSING/REASSESSING THE RESIDENT**

- The determination of whether a device is or is not a restraint is based on an individualized comprehensive assessment of the particular resident. The assessment identifies the specific medical symptoms and evaluates the risks and benefits and the purpose being considered for the use of a device or practice. The determination must include whether the resident is capable of independently removing the device and whether the device restricts the resident's freedom of movement. The answer to this question will vary with the individual resident and situation.
- Facilities must assess the resident to determine their functional status. Determine what the level of function is, what is important to the resident to maintain, and what quality of life area will the use of the device improve, maintain or enhance. Improved functional status can be physical or emotional.
- **In the interpretive guidelines for F221, §483.13, medical symptom is defined as an indication or characteristic of a physical or psychological condition.**
  - The law and the statute prohibit the use of physical restraints except to treat medical symptoms. Evolving professional standards of practice continue to identify treatment options that tend to be more effective than restraints. When added to the strong association of restraint use with negative physical and psychological effects there are fewer reasons for justifying the use of restraints to treat medical symptoms than in the past.
  - Short term use of restraints may have some benefits, for example:
    - Restraints used to prevent a severely dehydrated and confused person from pulling out a lifesaving I.V. Restrain only to the extent necessary to protect the I.V.
    - Restraints used to allow a doctor or nurse to examine a delirious person to find the cause of their symptoms.
    - A confused, disoriented resident returns from the hospital after undergoing a surgical procedure. Restraints used for a limited time to prevent the resident from pulling out stitches, tubes or dislocating a hip or knee replacement would constitute medical justification.
  - **The medical symptom for the restraint will be the reason the device is required to improve the resident's functional status.**
  - **If a facility has residents who need to be restrained, the facility must have an ongoing systemic gradual restraint reduction program in place.**
  - **If a restraint is used, it must be the least restrictive for the least amount of time – consider short-term or time-limited orders.**

### **RESIDENT CHOICE AND RESTRAINT USE**

- An alert resident may request and have a restraint – but the restraint protocol must still be followed.
- In order for the resident to be fully informed, the facility must explain, in the context of the individual resident's condition and circumstances, the potential risks and benefits of all options under consideration including using a restraint, and alternatives to restraint use. Whenever restraint use is considered, the facility must explain to the resident how the use of the restraints would treat the resident's medical symptoms and assist the resident in attaining or maintaining his/her highest practicable level of physical and psychological well-being. In addition, the facility must also explain the potential negative outcomes of restraint use which include, but are not limited to, declines in the resident's physical functioning (e.g., ability to ambulate) and muscle condition, contractures, increased incidence of infections and development of pressure sores/ulcers, delirium, agitation, and incontinence. Moreover, restraint use may constitute an accident hazard. Restraints have been found in some cases to increase the incidence of falls or head trauma due to falls and other accidents (e.g. strangulation, entrapment). Finally, residents who are restrained may face a loss of autonomy, dignity and self-respect, and may show symptoms of withdrawal, depression, or reduced social contact. In effect, restraints can reduce independence, functional capacity, and quality of life. Alternatives to restraint use should be considered and discussed with the resident. Alternatives to restraint use might include modifying the resident's environment, and/or routine.
- In the case of a person who is incapable of making a decision, the surrogate or representative cannot require the use of a restraint in the absence of a medical symptom. Legally authorized persons have the authority to act on behalf of the resident to refuse treatment that has been offered under 42 CFR 483.10 (b)(4). There is no corresponding right to authorize treatment that is not necessary to treat a medical symptom. The legal representative with durable power of attorney for health care decisions is lawfully authorized to make decisions about restraint use to treat a resident's medical symptoms; however, the representative may not request the restraint for the sake of convenience or discipline.
- Restraints may not be used to countermand an expressed wish of the resident to not receive a particular treatment or to violate an advanced directive.

### **BED RAILS**

- The use of bed rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms. Residents who attempt to exit a bed through, between, over or around bed rails are at risk of injury or death. Bed rails used as restraints increase the risk of more significant injury from falling from a bed with raised bed rails than without bed rails. They also increase the likelihood that the resident will spend more time in bed and fall when attempting to transfer from bed. Therefore, rigorous assessment should tend to avoid using a bed rail as a restraint. Other interventions that may be incorporated in the care plan include:
  - **Providing frequent staff monitoring at night with periodic assisted toileting for residents attempting to rise to use the bathroom**
  - Providing restorative care to enhance abilities to stand safely and to walk
  - A trapeze to increase bed mobility
  - Placing the bed lower to the floor and surrounding the bed with a soft mat
  - Equipping the resident with a device that monitors attempts to rise
  - Furnishing visual and verbal reminders to use the call bell for residents who are able to comprehend this information
- Assessments should also include a review of the resident's:
  - Bed mobility (Ex. Would the use of the bed rail assist the resident to turn from side to side, or, is the resident totally immobile and cannot shift without assistance?)
  - Ability to transfer between positions, to and from bed or chair, to stand and toilet (Ex. Can the resident transfer safely with no risk of falling? Moderate risk? High risk? Would using a bed rail add to or detract from that risk?)
- It is expected that the restraint reduction process be done in a systematic, individualized and gradual manner. (Ex. Lessening the time the bed rail is used while increasing visual and verbal reminders to use the call bell)
- Bed rails can create a barrier and decrease socialization and interaction with others, **especially when padded**. The plan of care for a resident using bed rails must address these issues.
- The same device may have the affect of restraining one individual but not another, depending on the individual resident's condition and circumstances. For example, partial rails may assist one resident to enter and exit the bed independently while acting as a restraint for another.
- **As a general practice, facilities should consider only adding bed rails when a resident's assessment indicates that a rail or rails would assist with mobility and transfers; bed rails should not automatically be applied to all beds. When bed rails are used, an assessment of the mattress and bed frame for gaps should be completed.**