



# CAREGIVING

## Breaking Free Of Restraints

One facility's staff learn how even common 'positioners' can lead to injury

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The overuse of physical restraints is a common and troubling source of survey deficiencies in long term care facilities, as well as a hindrance to the health and well-being of the patients they serve. But significantly reducing restraints can be a difficult task that requires a new way of thinking on the part of caregivers and managers, who are sometimes not even aware of what constitutes a restraint.

This was the problem faced by The Presbyterian Home of Moshannon Valley, a 120-bed, nonprofit skilled nursing facility located in rural Philipsburg, Pa. In April 1999, the facility was judged to have a restraint rate of 38 percent, seriously out of compliance with state regulations. It was clear that a facilitywide change in attitude toward restraints was necessary.

### Team Gains Perspective

The process of moving toward a restraint-free environment began with the formation of a restraint reduction team, comprised of nursing supervisors, licensed practical nurses, nurse assistants, therapists, activities staffers, and others, including the administrator and director of nursing, when necessary.

The team was fortunate to have the support of the Pennsylvania Restraint Reduction Initiative (PARRI), a state-sponsored program dedicated to reducing the use of restraints in long term care facilities. Over time, the restraint reduction team would come to realize that the key factors in a successful program would have to include education, staff acceptance, and adminis-

trative and financial support. The education process began with several staff members attending an eye-opening training seminar offered by PARRI, in which drawings of actual patients were used to demonstrate how physical restraints can inadvertently lead to severe injuries or loss of life. Actually seeing these events—even in drawings—made such a strong impression on those who attended the seminar that the group became passionate about educating the remainder of the team. They realized that many devices in use at the facility that were being classified as enablers or positioners—lap positioners, Velcro or clasp seat belts, full lap trays, and cushions designed to prevent patients from sliding forward—were actually restraints.

Through countless hours of meetings, the restraint reduction team established patient-by-patient policies and mapped out a three-year plan to solve the facility's problem. Initially, a mandatory, one-hour training session was held for all staff at Presbyterian Home. The team quickly realized that staff would be more likely to support policy changes that were presented as a means of improving patients' quality of life and well-being, rather than an initiative dictated by regulations.

Recalling the impact of the visual presentation at the PARRI seminar, the initial training was designed to be interactive. The team devised the idea of placing some staff members in restraints during the hour-long training session to demonstrate the physical and psychological discomfort these devices cause for patients.

Not surprisingly, the restrained staff members caused many interruptions as they tried and failed to reposition themselves. The team also employed a mannequin with a hard helmet (to replicate a human skull) to illustrate how serious injuries can occur if a patient rolls over the top of a raised bedrail and hits the hard floor head-first. The team then demonstrated that the same fall with the bedrail lowered would be unlikely to cause injury if the floor were covered with soft, protective mats. Feedback from staff who attended the training session confirmed the impact of the visual demonstrations. Not only did these demonstrations capture staff attention, but they helped bring people around to a new way of thinking about restraints.

As was expected, staff at first resisted the new initiative, but through continuing education and support from the team, their fears of removing patient restraints began to subside. One of the most difficult barriers to overcome was changing the staff definition of restraints. Staff became aware that positioners or enablers were, in actuality, restraints.

It was also necessary to educate patients' families, many of whom believed that restraints contributed to the safety of their loved ones. Family education included information on both physical and mental side effects associated with restraint usage, including pressure ulcers, constipation, urinary incontinence, and depression. The staff also implemented interventions such as more frequent checks to reassure families that patient safety was the top priority.

### Slow, Methodical Process

Presbyterian Home began the process of reducing restraints in a slow, methodical fashion—working with one patient per nursing unit at a time. The goal to reduce

five restraints per month was initiated on a unit where most staff had come to accept the program. As successes were shared and staff witnessed the improvement in the quality of patients' lives, the transition in the other units went more smoothly.

Management attributed the facility's success to the systematic approach of slowly removing restraints and replacing them with less restrictive devices such as easy-opening seat belts for short periods of time, while monitoring the patients closely.

One of the greatest milestones during the restraint-reduction process was the day that every lap positioner, Velcro or clasp seat belt, full lap tray, and cushions designed to prevent patients from sliding forward were removed from the facility. As staff witnessed small successes, their confidence began to build, and goals were expanded to becoming a totally restraint-free facility.

### **Establishing A Restraint-Free Policy**

All new admissions to The Presbyterian Home were required to sign a restraint-free policy statement, demonstrating that they understood that no physical restraints would be used—unless required to treat a medical symptom. PARRI's Karen Russell worked closely with the restraint reduction team, encouraging staff members to arrive at their own solutions for doing away with restraints. In one case, for example, a nurse assistant noticed that a blind patient was littering the floor with tissues in his failed attempts to toss them into a trash can. He was then subject to slipping on the tissues whenever he got up. The solution: a much larger trash can.

As the number of restrained patients at the facility began to dwindle, staff began to face the more challenging cases, including overcoming the objections of family members who feared their loved

ones would not be safe. This required greater support from Presbyterian Home's administration to both assist with family education and to purchase more costly equipment.

Each case was looked at individually to customize care for specific patients. This included the purchase of low beds, specialized chairs, dense floor mats, padded trochanter pants (hip savers), defined-perimeter mattresses (with slightly raised edges), body pillows, nonskid slippers, and even helmets.

Many wheelchairs were customized with both front and rear antitippers, drop seats, reclining backs, and pressure-reducing cushions to add comfort. The facility also added nonskid floor surfaces and removed wheelchair pedals for ease of movement. The facility acquired devices that prevent wheelchairs from moving when patients rise.

Environmental changes included pur-



chasing longer call bell cords for easier reach, padding sharp corners, and keeping bedside commodes in use on the 11 p.m. to 7 a.m. shift. In some cases, beds were moved against the wall to create a more open space and eliminate obstacles that could increase fall risk.

Part of the process included checking

patients more frequently to identify potentially risky behaviors. Pressure-sensitive and pull-type alarms were utilized during the restraint-reduction period to alert staff to potential safety concerns. Alarms were discontinued as measures were put in place to ensure the patients' safety. Not only were pressure-reducing devices used

on chairs, but patients were moved more frequently from one surface to another—from a wheelchair to a lounge chair, or from a lounge chair to a bed.

It also became apparent that many of the reasons that initially led to the restraint usage were related to pain control or behavioral changes caused by the progression of dementia or reactions to medication.

The need for education in these areas was evident, and the facility developed teams to address these concerns. Patients who displayed behavioral symptoms were referred to the vision team, which included the staff psychologist, to think up alternatives to restraints. Examples of behavior management were more one-to-one interaction, providing a calmer environment, and offering snacks or fluids.

The activities department redesigned its work schedule to make sure a staff member was on duty at all times to accommodate the growing and ever-changing needs of the patients. The team also reviewed patients' charts more thoroughly to identify and rule out behaviors caused by medication changes; environmental changes; or medical concerns such as pain, dehydration, or infections.

In March 2001, the facility had only 2 percent restraint usage. At this time, staff were making proactive decisions on the floor even before discussing the patients at the restraint-reduction-team meetings. Nurse assistants were offering suggestions to supervisors about fall prevention and measures to reduce risk for injuries. It was apparent that all staff felt empowered to take ownership of the patients' safety and well-being.

### **Sharing The Experience**

Taking note of the teamwork and spirit that occurred in the facility, PARRI's Russell approached the team and asked if

#### **For More Information**

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members would be interested in sharing experiences with other facilities that were finding the process overwhelming.

Preparation began in March for the Presbyterian Home to become a training site for other facilities. Through the efforts of PARRI, the staff at Presbyterian Home have developed stronger assessment skills

in evaluating patients who display behavioral symptoms or are at increased risk of falling.

Staff occupational and physical therapists and restorative nursing have been crucial during the process to increase patient endurance, provide strengthening programs, evaluate seating and reclining

positions, and obtaining adaptive equipment for use by staff and patients.

The number of falls has not increased with the removal of restraints, staff found. In fact, the severity of injuries related to falls has decreased. ■

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