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MDS Alert

QUALITY ASSURANCE: Follow This Facility's Path Away From Physical Restraint Use

Find out why taking it slow and including this key discipline pays off.

Are you looking to drive your facility's physical restraint QI way down without creating safety problemsor a backlash from families?

Take some notes from a nursing facility in Arkansas that whittled its restraint use from 22 percent to 1.6 percent, a rate it's maintained for six months to a year, according to **Terri Hatfield, LPN,** in a webinar presentation by Advancing Excellence in America's Nursing Homes. Some of the inside secrets gleaned from the process improvement include:

• **Take it slow and easy.** Make a list of residents in restraints and start with the easier cases, advised Hatfield. And don't try to take more than one resident per hall or section out of restraints at a time.

Reasoning: Trying to remove too many residents at a time from restraints can overwhelm staff and lead to falls and other negative outcomes. Also, caregivers and residents' families are more likely to "jump on board" with restraint reduction if they see it's working.

• **Get rehab on the case.** Initially, the resident is only unrestrained when he's under the supervision of the rehab therapist, Hatfield reported. Once therapy develops a plan for the resident, the staff tries it out for a week. For example, the team always starts a resident on restraint reduction on a Monday. If it's working by the next Monday, great, she noted. If not, the team goes back to the drawing board to find a long-term solution.

• **Keep families in the care plan loop.** Encourage the family to come by during the hours OT and PT are working with the resident. Assure the family that you have the person's comfort and safety as priority. If the facility only works on one restraint-reduction case per section of the facility at a time, the staff has time to work with the families closely, Hatfield pointed out.

• **Follow the RAI rules for restraint use.** Before using a restraint, make sure the team has "exhausted every other avenue," advised Hatfield. Use the process in the RAI User's Manual that spells out what surveyors will be looking for if they find a resident has been physically restrained. "You must be treating a medical symptom or diagnosis -- not just a behavior or falls." For example, one of the residents in the Arkansas facility still using a restraint has a medical symptom of poor balance and trunk control caused by a brain tumor.

Reminder: You count a device as a restraint based on its effect on ther esident. The RAI User's Manual defines a physical restraint as "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body."

For example, a Merry Walker may be helping someone be mobile but still serve to restrain the person if she can't easily open the gate and exit the device. "You can use such a device [if you do the proper assessment and care plan it], but you can't be 'restraint-free' if you use any such device," cautions **Donna Balsley, RN, MBA, FACHE,** director of healthcare quality improvement at Quality Insights of Pennsylvania.

Tip: Code a Merry Walker or other devices used to help the resident ambulate as a cane/walker/crutch at Item G5a, whether or not you code them as a restraint, advises the RAI User's Manual.

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