RESTRAINTS:
*The Exception, Not the Rule.*

A Guide for Residents, Their Families and Friends to Promote Good Care in Place of Restraints in California Nursing Homes

by Sarah Greene Burger, RN-C, MPH, FAAN
Introduction
This Guide introduces residents, their families and friends to care practices that preclude the use of physical restraints. Health care practitioners (physicians, nurses, therapists, administrators, pharmacists, dieticians, social workers) in the United States and Europe have twenty-five years of experience providing restraint-free care. The cornerstone of these practices is knowledge of each resident’s lifelong habits and preferences. This knowledge is learned through strong consistent relationships between residents, families and their caregivers. The information applies to residential care homes, assisted living, and home care.
Participating Organizations

AARP California

AFSCME (American Federation of State, County and Municipal Employees) Council 57

American College of Health Care Administrators, California Chapter

California Association of Long Term Care Medicine (CALTCM), the California state chapter of the American Medical Directors Association (AMDA)

California Chapter of the American Society of Consultant Pharmacists

California Department of Aging, State Long-Term Care Ombudsman Program

California HealthCare Foundation

California Long-Term Care Ombudsman Association (CLTCOA)

California Physical Therapy Association

Conference of Gerontological Nurse Practitioners, Northern California Chapter

Gray Panthers California

Lumetra

National Senior Citizens Law Center

Northern California Council of Activity Coordinators

Southern California Association of Activity Professionals (SCAAP)
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ILLUSTRATION ACKNOWLEDGMENTS

Page 2  - Wrist restraint: Drawing by Web Bryant
Page 2  - Physical Restraints can cause great harm.
   Woman in Geri-Chair: Used with permission by Michael Jacques.
Page 3  - Sheet used as a restraint: Used with permission by Michael Jacques.
Page 5  - Geri-Chair: Used with permission by Michael Jacques.
Page 5  - Restraint Deaths - Three illustrations: Graphics by Eddie Thomas for the Star Tribune, Minneapolis, MN. Re-printed with permission.
Page 6  - Used with permission by Michael Jacques and Web Bryant.
Page 8  - Drawing by Web Bryant
Page 9  - Drawing by Web Bryant
Page 14 - Used with permission by Michael Jacques and Web Bryant.

Restraints: The Exception, Not the Rule.

While living at your house, your very frail mother, Mrs. Jansen, fell and broke her hip. She has been in the hospital for three days. Now she is going to a nursing home. The Doctor says she may have to stay there, which makes you very sad. Your only concern is your mother’s safety. You ask that your mother have bed side rails and a waist restraint when she is sitting. The nurse says physical restraints are not used in this nursing home. You are shocked.

Questions race through your mind.
- Have I chosen the wrong nursing home?
- Why didn't they tell me before I got here?
- What is so bad about restraints?
- Will this nursing home be able to care for my mother safely?
- Didn't the hospital use restraints?

You are right to ask all those questions, because your mother’s safety is very important. This Guide answers your concerns so you will know that you are lucky your mother is in a restraint free nursing home.

Here is why:
- Restraints are harmful;
- Restraints do not keep a resident safe or free from falling;
- Restraints do not reduce harm from a fall;
- Family members don't have the right to force Nursing Homes to restrain their loved one;
- Good care avoids restraints;
- Family members are essential to planning restraint free care.  

To know how to help your mother, Mrs. Jansen, you need the basics. Let's start with, what is a restraint?

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1. Adapted from an email from Mary Larson, Consultant to Lumetra, CA QIO, December 12, 2007.
What is a Physical Restraint?

A physical restraint is anything near or on your body which limits movement or your ability to get to a part of your body. You cannot remove the restraint easily. Usually a specially designed device is used. Here are some common restraints.
Sometimes equipment, materials, and devices meant for other purposes are used as restraints. A chair or wheelchair is put so close to a table that the person cannot move. A fur toy is filled with heavy sand and put in the person’s lap to prevent rising. In a residential care home, couches may be arranged in a square to prevent a resident from leaving. The use of covers for door knobs (made to keep children out of rooms) that lock a person in a room are restraints. Sometimes you have to look carefully to see these restraints.

**KEY POINTS:** Physical restraints come in many forms. It is important to know why they are being used. A quarter siderail may help a person with a stroke turn over by herself. That rail would not be a restraint. It is not the device itself, but the effect of the device on an individual. Does the device help or limit movement?
What can happen to people who are restrained?

As Mrs. Jansen’s daughter, you want your mother restrained for safety after breaking her hip. Let’s see why it is better to increase her safety without using restraints. The goal will be to have your mother Mrs. Jansen walk again. If she is restrained, she may not walk again.

<table>
<thead>
<tr>
<th>Unrestrained People Usually</th>
<th>Restrained People Usually</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feel good about themselves</td>
<td>Feel embarrassed – Here is what they say: “I feel like a prisoner” “I’ve never been so humiliated” “Why are they punishing me?” “What if there is a fire?”</td>
</tr>
<tr>
<td>Have normal appetites because they are moving around</td>
<td>Don’t eat well and lose weight, which can lead to malnutrition.</td>
</tr>
<tr>
<td>Drink normally because they are more likely to be able to reach the drink</td>
<td>Don’t drink enough and may become dehydrated, a dangerous condition in elders.</td>
</tr>
<tr>
<td>Breathe easily</td>
<td>Say, “I feel as if my chest is being crushed.” * Don’t breathe well, which can lead to pneumonia or death from strangulation on a vest or waist restraint or bedrail.</td>
</tr>
<tr>
<td>Have skin in better condition</td>
<td>Suffer cuts, bruises, lacerations from struggling to get out of restraints. Suffer pressure sores from sitting or staying in bed too long without being able to move.</td>
</tr>
<tr>
<td>Sleep according to their own habits</td>
<td>Don’t sleep as they have not been moving</td>
</tr>
<tr>
<td>Use toilet with or without help</td>
<td>Say, “I can’t get to the toilet at night. I wet my bed.” * The same thing happens in a chair. Urine or stool soaked clothes increase pressure sores. Incontinence can lead to urinary tract infections.</td>
</tr>
<tr>
<td>Have circulation normal for age</td>
<td>Have swollen legs when up in chair due to not moving</td>
</tr>
<tr>
<td>Have nervous system normal for age</td>
<td>Feel tension due to physical and psychological effects of being restrained. Tension may lead to acting out for which a psychoactive drug may be added.</td>
</tr>
<tr>
<td>Maintain muscles and bones normal for age</td>
<td>Have muscle and bone wasting due to disuse. Increase in contractures or a shortening of the muscles. Contractures prevent people from straightening their legs. Bones break from disuse.</td>
</tr>
</tbody>
</table>

Imagine what it would be like to be in this chair every day, all day.

You could not:
- Move the chair yourself;
- Get a drink of water;
- Lie down when you want;
- Sit in a soft, comfortable chair.

- Get to the bathroom;
- Talk to someone at the other end of the hall;
- Stand up when you want;

What would this chair say to you about yourself?

How would it make you feel?
- Dependent?
- Childlike in a high chair?
- Naughty?
- Bad?

Who is most often restrained?
- Elders who are very old, frail and unsteady on their feet.
- Elders living with dementia.
- People with very distressed behavior who appear to frighten others.

Restraint deaths occur in a number of ways:

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Federal law (L), regulations (R) and State Operations Manual (SOP) require that restraints are the exception rather than the rule in nursing facilities. (L) SEC. 1819. [42 U.S.C. 1395i-3] Skilled Nursing Facilities; SEC. 1919. [42 U.S.C. 1396r] Nursing Facility; (R) 42CFR483, Subpart B; SOP Appendix PP 483.13 Resident Behavior and Facility Practices; Physical Restraints; 483.15 Quality of Life; 483.20 Resident Assessment and Comprehensive Care Plans; 483.25 Quality of Care; Memorandum L&C 22-07.
Good Care makes restraints unnecessary for people who are unsteady

If restraints don’t provide safety, then what kind of care should residents and their families expect? What would staff do for Mrs. Jansen who is “unsteady on her feet” after a hip fracture?

**Individual Assessment and Care Planning**
- Mrs. Jansen and staff talked and agreed she would try to walk again. That goal will be in her care plan. (A care plan is like a recipe for getting better.)
- The care plan will include ways to help her walk.
- Staff will assess or test her strength.
- Physical therapy will be given at her best time of day.
- Staff will assess and treat pain 24 hours a day.
- Pain control helps her in therapy and speeds recovery.
- Nursing will use a restorative program daily to strengthen all muscles and keep joints mobile.

**Staff will make her room as safe as possible.**
- Use a wheelchair that fits her, but for only as long as she needs it.
- Provide comfortable individualized seating (not in a wheelchair) where she spends time. Ex. dining room, bedroom, activities.
- Know and meet her lifelong schedule for using the toilet, especially at night.
- Lower the bed so she is able to get in and out safely; lock bed wheels.
- Be sure the bedrails are down or off to prevent a fall over them.
- Provide a call bell and make sure she can use it.

**Staff will know and use her customary time of waking and sleeping.**
- If your mother, Mrs. Jansen, agrees, they will welcome your help in planning care.
- Together you and your mother can tell staff the details of her past daily life. They will know her routine for getting up and going to bed.
- Staff will assign the same CNAs to care for her. They will know each other well.

**You are still skeptical the plan will work.**

| “Wouldn’t a half bedrail get her out of bed more safely?” | Maybe, but the risk of this tiny woman suffocating between the mattress and rail are too great. She might choke if her head got between the rails. Staff will use a grab pole instead. |
| “Wouldn’t a waist restraint keep her on the chair?” | She doesn’t get out her chair without asking for help. |
Myths and Realities about Physical Restraint Use

<table>
<thead>
<tr>
<th>Myths</th>
<th>Realities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restraints reduce falls</td>
<td>There is no evidence that restraints prevent or reduce falls. Physical restraints include side rails. Falls that occur when a person is restrained often result in more severe injuries. ¹</td>
</tr>
<tr>
<td>Restraints eliminate falls</td>
<td>Restraints eliminate the ability to move around. Activity strengthens muscles and bones. Decreasing restraint use can decrease falls. ²</td>
</tr>
<tr>
<td>There aren’t enough staff for restraint free care</td>
<td>It takes longer to care for restrained than unrestrained residents. The time needed for frequent releasing and retrying, monitoring, toileting, exercise, release, etc. is about 4 hours and 35 minutes in a 24 hour period. ³</td>
</tr>
<tr>
<td>Residents feel better and safer in restraints</td>
<td>Residents do not feel good about being restrained. ⁵</td>
</tr>
<tr>
<td>Staff don’t know how to care for people without restraints</td>
<td>Care teams in nursing homes have been learning how good care precludes restraint use. Those care teams that do not know have many resources in literature and on the web. See resources in Appendix G.</td>
</tr>
</tbody>
</table>

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How Safe is Safe?

Nursing Homes are not “Safe Deposit Boxes where a resident will be risk free.”1 Everyone falls and elders fall more often than younger adults. One-third of elders living at home fall every year.2 Once elders fall, they are more likely to fall again. As many as 3 out of 4 people in nursing homes fall each year.3

It is not possible to omit all chance of falling no matter where a person lives. Falls and restraints both pose a chance of injury. The use of restraints can increase fall injuries. Restraints usually are the riskiest choice.

Good Care Practices Preclude Restraints for People Living with Dementia

Question: Janice Fazoli fell for the first time yesterday. She had no injuries. Shouldn’t the nursing home have prevented it?

Answer: The answer is “yes,” the nursing home could have done more to prevent the fall. But, “no,” not all falls are preventable. Ms. Fazoli lives with Alzheimer’s Disease and can no longer communicate. She is a strong walker. There are many safe places for her to walk inside and out. The new nurse aide didn’t know Ms. Fazoli. She didn’t know that Ms. Fazoli was pleasant and easy going. Today she was grouchy and didn’t want to bathe. The CNA should have noticed her change in behavior. She should have reported the change to the nurse. Nurse assessment of Ms Fazoli after the fall found a urinary tract infection. The infection was probably the cause of her change in behavior.

What should the nursing home do to decrease behavior-related falls in the future?

- CNAs and the rest of the care team should take care of the same people every day (consistent assignment - See Appendix E).
- CNAs notice subtle changes in residents.
- CNAs report them to a licensed nurse who assesses the resident.
- New CNAs need very close supervision by a licensed nurse.

KEY POINTS: Assessment: People living with dementing illnesses (Alzheimer’s Disease and related disorders) may not be able to talk. They communicate through behaviors (ex. acting grumpy). The staff must find out what is causing the behavior (e.g. pain, loneliness, hunger, thirst, lack of sleep, infection, noise, cold, new medication, other medical event). Ms. Fazoli needs her infection treated. If Janice Fazoli had been restrained, it would have masked the infection until she was really sick.

1. Quote from Carter Williams, ACSW, Rochester NY
2. Centers for Disease Control(CDC), Department of Health and Human Services, Preventing Falls Among Older Adults, August 26, 2006 found at: www.cdc.gov/ncip/duip/preventadultsfalls.htm.
Safety of other residents and staff

**Question:** Shouldn't the staff restrain Mr. Dimitri who was so distressed today that he threatened to hit some residents in the dining room? Mr. Dimitri is younger than most residents. He has been in the nursing home six months. He has painful arthritis and many other physical and mental illnesses.

**Answer:** Not if Mr. Dimitri can be taken gently out of the dining room to a private place where he can be assessed for the cause of his behavior. Mr. Dimitri has been stable until today when the CNAs reported he refused care. The nurse talked to him. He said his arthritis was too painful to bear. They were waiting for the nurse practitioner to see him later today. In the meantime, they offered a whirlpool bath. He accepted. His pain medication was changed a few hours later, but not in time to prevent his outburst.

Safety of Residents living with dementia who wander

**Question:** Shouldn't Mrs. Thelma Johnson be restrained so she won't wander into other's rooms where she doesn't belong? Today another resident slammed the door in her face nearly injuring her.

**Answer:** No, Mrs. Johnson needs to wander to keep her legs strong. However, other people's privacy is equally important. Mrs. Johnson's family helped with the care plan. Mrs. Johnson had been a secretary. Staff put a small table and file at the end of one walking corridor. Staff and other residents gave her new papers to file each day. She was too busy filing to enter others’ rooms.

**Key Points:**
- *Assessment:* Untreated pain is often the cause of distressed behaviors. Chronic pain is assessed and treated around the clock. Residents with mental illnesses should not be restrained.

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When might restraints be helpful?

In an emergency when someone’s medical symptom needs assessment:

An emergency: Delirium
Mr. Jacobs acted very strangely when the CNA entered his room as his usual hour of going to bed at 9:30pm. He was unable to complete his normal bedtime routine. She remained with him and rang the call bell. The licensed nurse arrived and knew this was an emergency. As she started to examine Mr. Jacobs, he became very agitated. He hit the nurse hard. No other staff were available and she could not continue. He was delirious. The nurse used wrist restraints for the time it took her assess Mr. Jacobs and report to the physician. Mr. Jacobs’ medicines were changed the day before. The new drug caused the delirium. It was stopped. Mr. Jacobs was untied when the assessment was complete.

An emergency: Life saving treatment
Janet Kozlowski lived with dementia. She developed an infection that was treated with IV antibiotics. Her family tried to be with her so she would not be restrained, but they had to work. Staff used a hand mitt only on the hand which she used to pull out the IV. They could have used an air splint on the elbow.

Assess the cause of restraint use. Long term use to prevent pulling out a feeding tube at the end of life is hard to justify. Residents’ written instructions, called, Advance Directives, may address that issue. Research shows that those with Alzheimer’s Disease do not live longer with a feeding tube.\(^1\) While Mrs. Kozlowski is restrained, she must be turned, toileted, fed and given water. Remove the restraint as soon as the emergency is over.

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KEY POINTS: Assessment: Elders are fragile. Small changes such as a new medicine, an infection, lack of fluids or even restraint use can cause a delirious state. Nursing home staff tries hard to prevent delirium.

Delirium: If the cause of delirium is not found and treated, death can result. Using the restraint for a short time outweighs the risk of death.

KEY POINTS: Use the least restrictive restraint. There was no reason to restrict both hands. Use the restraint for the least amount of time. Involve families in care planning. Restraints were used only while Mrs. Kozlowski’s family was not there with her.
Restraint Reduction

Some nursing homes have been slow to remove restraints. Restraint reduction requires careful planning with staff, residents and family.

Mrs. Wang was in a California nursing home where over half the residents were restrained. The Ombudsman had been there that morning and left fliers that said, “Expect and Promote Excellence in California Nursing Homes: PHYSICAL RESTRAINT FREE CARE.” It was a fact sheet and caught the Director of Nursing’s (DON) attention. (See Appendix B). The yearly state inspection would be soon. She worried that the home might be cited again for poor care. She used the “Fact Sheet” to begin educating CNAs, residents and family members. The DON asked one resident unit to volunteer to go first. A nurse leader had worked in a home that was restraint free. She was happy to lead the way. Over the next six weeks all restraints were slowly removed from each resident on one unit. Here is what they did.

Good Care Practices to Remove Restraints:
• Consistent assignments allowed the CNAs to know every detail of the residents’ lives.
• Residents got up when they wanted and ate family style - like home.
• Staff included restorative care such as strengthening exercise for those who needed it.
• Activities that residents or their families said they wanted were available-24/7 on the unit.
• Room and hall lighting were brighter.
• A variety of chairs were available that fit each resident. They liked to sit in the chairs.
• They used wheelchairs much less often. Staff even began to see wheelchairs as restricting mobility, because they kept people from walking. Once residents began to walk again, there were a few falls, but no one was injured.

Mrs. Wang’s nursing home:
Once Mrs. Wang’s unit became restraint free, other parts of the home began to follow. The staff on Mrs. Wang’s unit became the facility leaders and coaches. Families and residents understood that restraints do not protect and that bed rails are a hazard. When the surveyors came, only the one unit was completed. The surveyors saw the plan that was being used for each resident. They revisited in three months. All but one restraint was gone.

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**Laws and regulations**

The Nursing Home Reform Act of 1987 (NHRA) supports good care that precludes restraint use.

“Provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.” This part of the law means that a resident should not get worse while in the facility unless decline is a natural progression of disease. Since we know that restraints can cause decline, using other care approaches helps prevent that decline.

“Care for residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.” The dehumanizing effects of restraints are incompatible with quality of life. They limit socialization and independence. They cover up a resident’s real needs rather than meeting them.

<table>
<thead>
<tr>
<th><strong>Unlawful Reasons for Restraint Use</strong></th>
<th><strong>NHRA and Regulations Require that Facilities:</strong></th>
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</thead>
<tbody>
<tr>
<td>Not enough staff to care for residents</td>
<td>Have sufficient staff to meet the residents’ needs</td>
</tr>
<tr>
<td>Lack of staff knowledge about how to care for residents without restraints</td>
<td>Use competent and qualified staff to meet residents’ needs</td>
</tr>
<tr>
<td>Convenience of staff</td>
<td>Not use restraints for the convenience of staff</td>
</tr>
<tr>
<td>Punishment of resident for something over which they have no control such as wandering, anxiety, or hitting</td>
<td>Not use restraints for punishment of residents</td>
</tr>
<tr>
<td>Transfer from a hospital that has used restraints or a resident wants restraints</td>
<td>Assess each resident at admission to plan care that avoids restraints</td>
</tr>
<tr>
<td>Family/legal authority for health care decisions request a restraint when resident says or acts as if she does not want one</td>
<td>Respect each resident’s wishes not to be restrained.</td>
</tr>
<tr>
<td>Physician’s order when staff have not done a thorough assessment or used good care practices that preclude restraint use</td>
<td>Respect that each resident has the right to make health care decisions and be free of restraints, except to treat certain medical symptoms. Residents can refuse restraints.</td>
</tr>
</tbody>
</table>
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### Resident and Family Request for Restraints

Families, friends, surrogates (legal authority for health care decisions) and even residents sometimes request restraints. Physical restraints are like any other medical treatment such as a medication or therapy. A medical practitioner (MD/Advance Practice Nurse) should not order a restraint unless it is used to treat a “medical symptom.” Just as a patient can request a particular insulin to treat diabetes, the practitioner won’t order it unless the drug will treat the disease. A resident or surrogate should be involved in the discussion about restraint use. The resident or surrogate must give consent if a restraint is used. A resident who lives with dementia has the same right to refuse restraints unless there is a medical symptom requiring it, as described below.

The Federal Centers for Medicare and Medicaid Services (CMS) tells us what the NHRA means. CMS says that a restraint may be used to treat a “medical symptom.” They note that falls are NOT a medical symptom. CMS says emergency care can be a medical symptom. A restraint could be used for brief periods so medical treatment can proceed. Another emergency use of a restraint might be to protect a resident from self injury or injury to others. Falls are also not self-injurious behavior. Restraints are the exception, not the rule. As soon as the emergency is over, the restraint is removed.

California Law also protects residents from restraint use. The state requires staff to do and write the following:

- Reason for the restraint and the nature of the illness treated
- How long the restraint will be used
- How the patient’s condition will improve with use of a restraint
- Probable bad effects and increased risk of injury
- Reasonable other treatments have been tried and this is the best treatment
- All this is explained to the resident.
- Resident can accept or refuse the treatment. If accepted, he can change his mind.
- California also has an emergency exception for restraints.

Clearly the intent is not to use restraints. A clear reminder of why is found in Steven Miles, MD Consent Form for Restraints. (See Appendix D).
Keys to Caring for Residents Without Restraints

The real concern for residents, families, and staff is resident safety. This Guide tells how to care, without restraints, for:

- Mrs. Jansen after her hip surgery;
- Janice Fazoli who fell for the first time;
- Mr. Dimitri with threatening behavior; and
- Wandering Ms. Johnson who invaded others’ privacy.

**Assessment:** Each resident is assessed for strengths and needs on admission to the nursing home. An important part of the assessment is finding out, “Who is this person? What are her interests? What is her daily routine? and What makes a good day for this person?” Then, care is planned specifically for that person.

**Who does the Assessment?**

**Interdisciplinary Team:** Together the nurse, physician, various therapists, activities professionals, social workers, dietitians, pharmacists, nursing assistants and others do the assessment and care planning.

**Is anyone else involved?**

**Resident, family involvement:** Mrs. Jansen, Ms. Fazoli, Mr. Dimitri and Ms. Johnson all provided assessment information and helped with planning care. People living with dementia give clues about their unmet needs through their behavior. Families and friends also helped, sharing information about each residents’ daily routine, needs and wishes.

**What is individualized care?**

**Individualized Care:** Ms. Fazoli and Ms. Johnson both lived with dementia. Staff depended upon family and each other to understand the subtle changes in behavior that indicated an unmet need. Ms. Fazoli was easy going and pleasant. When she was irritable, staff assessed her and found an infection. Ms. Johnson bothered other residents until the staff assessed an unmet need. She needed something meaningful to do.

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How does each nursing home staff member know what to do for each resident?

**Care Plan:** Each resident has an individualized care plan, written on a special form. The care plan is developed at a care plan meeting. Each resident is encouraged to attend, and may choose to bring someone with him. The interdisciplinary team members attend. The care plan should be written in language that residents, families, nursing assistants and others can understand. (More details on resident and CNA involvement in care planning are in Appendix C)

Who carries out the care plan?

**Consistent Assignment:** The majority of care is provided by Certified Nursing Assistants (CNAs). Assigning CNAs to care for the same group of residents on most days strengthens relationships. Relationships are the cornerstone of restraint free care. Consistent assignment means that CNAs have the same residents 85% of the time. (See Appendix E on Consistent Assignment)

What is needed for individualized care that avoids restraints?

**Restorative Programs:** Individualized restorative nursing was useful in strengthening Mrs. Jansen’s legs and arms as she recovered from her broken hip. The activities for Ms. Johnson kept her in the lifelong occupation of filing papers. The walking club was another activity individualized within a group of walkers. Ms. Johnson always went the whole distance, others stopped just before becoming too tired. Some activities should be available around the clock for people who wake up or whose lifelong work was at night.

**Supportive Devices:** Special equipment can maintain or improve a resident’s ability to function. Elders who need a wheelchair for mobility should have physical and occupational therapists assess their ability to sit without sliding out. Their wheelchairs should be modified to support strengths and weaknesses. Many residents have bent backs forcing them to look at the floor when sitting. This posture makes wheeling about, socializing or eating very difficult. It also makes them fall forward out of the chair. The chair may need a contoured seat and a back, which tilts back slightly raising the resident’s eyes. People who don’t need a wheelchair should not have one.¹

Residents need regular chairs that fit them in the places they spend time. Examples are in their room, at meals, and during activities. Many nursing homes buy the same chair for everyone, yet each resident is a different size. Encourage chairs to be brought from home. Encourage homes to buy mixed chair sizes.

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¹ Joanne Rader, Guidelines for placing a mattress on the floor, From Individualized Wheelchair Seating: For Older Adults, Part I: A Guide for Caregivers, Joanne Rader, RN, MN, FAAN; Debbie Jones, PT and Lois Miller, RN, PhD. Shared with Quality Partner of Rhode Island.
What is needed for Individualized Care that avoids restraints, continued.

**Bed Safety:** Residents are rightly fearful of the high narrow beds used in nursing homes. Even knowing that bedrails are dangerous, residents still feel safer with the bed rails up. One solution is high-low beds that adjust so that residents can get in and out more safely.

The bed level should put their feet flat on the floor with their knees at a ninety degree angle. The wheels on the bed should be locked, to prevent the bed from sliding away from the resident as he gets up or down. The floor should be non-slippery and padded if the person falls. The bed rails should be off. A floor to ceiling pole can aid in getting up from the bed safely. Knowing and meeting a person’s night needs precludes unattended getting out of bed. e.g. cold, thirst, pain, loneliness, hunger, need to toilet.

If there is no hi-low bed, use a metal frame (14-18 inches high) with plywood to support the mattress. If the person can’t stand safely and gets out of bed, put a mattress next to the low bed.¹

**There is no place like home:** The sights, sounds, and smells of today’s nursing home should be closer to home. Silence background noise of call systems, bells, alarms. Use vibrating machines for calling. Residents should be engaged with one another and staff. Plaintive resident calls from unanswered lights should cease. Lighting should be bright without glare. Reading lights should be available where people do activities or read. The smells of cooking and baking should fill the units daily. Coffee and drinks should be available to welcome family and friends. Large units are hard for elders. Break older 30-40 bed units into smaller units. Cleaning should be done during the day so residents can sleep at night. Lack of sleep is an unmet need that increases distress and restraint use. Staff can wear street clothes.

**Walking paths:** Safe places to walk inside and out are needed. Most residents live with a dementing illness. Many of these people need to exercise often. Others may have always walked as part of their daily routine. The inside places must protect others’ space with barriers and floor markings. Dangerous areas should be disguised. The outside areas should be welcoming and safe. There should be plenty of places to sit.

**Special Care Units:** Some nursing homes care for people with dementia in special care units. This implies that the staff recognize the special needs of these residents and offer programs to meet those needs. These units must provide individualized care. A special care unit with security but few services will not help residents. In fact, one might almost consider the unit a restraint if staff and services are poor. Contact your local, state or national Alzheimer's Association for information.

¹ Joanne Rader, Guidelines for placing a mattress on the floor, From Individualized Wheelchair Seating: For Older Adults, Part I: A Guide for Caregivers, Joanne Rader, RN, MN, FAAN; Debbie Jones, PT and Lois Miller, RN, PhD. Shared with Quality Partner of Rhode Island.
How does Staff know whether a restraint is needed?

Staff answer these questions:

- What are the medical symptoms that led to consideration of physical restraints?
- Are these medical symptoms caused by a failure to:
  - Meet individual needs and adjust to each resident’s lifelong routine?
  - Use aggressive rehabilitative and restorative care?
  - Provide meaningful activities?
  - Adjust the resident’s environment, including seating?
- Can the cause of the medical symptom be removed?
  - (ex. Can using a residents’ lifelong time of arising at 9 am instead of waking her at 6:30 am stop her striking the CNA every morning?)
- If the cause cannot be removed, has the facility used good care approaches that preclude restraints?
  - (ex. Distraction of a person who wants to leave the facility with a spouse.)
- If good care practices that preclude restraints don’t work, does the staff use the least restrictive restraint, for the shortest time?
  - Does the staff monitor and adjust care to prevent a decrease in mental, physical, psychosocial functioning (ex. prevent incontinence, injury, pressure sores, depression.)
- Does the resident or legal surrogate make an informed choice about restraint use? Were risks, benefits, and other approaches to care discussed?
- Has the staff used the required assessment system with all the supporting information to evaluate the restraint?
- Is there a plan for gradual removal of the restraint?

Federal law (L), regulations (R) and State Operations Manual (SOP) require that restraints are the exception rather than the rule in nursing facilities. (L) SEC. 1819. [42 U. S. C. 1395i-3] Skilled Nursing Facilities; SEC. 1919. [42 U. S. C. 1396r] Nursing Facility; (R) 42CFR483, Subpart B; SOP Appendix PP 483.13 Resident Behavior and Facility Practices; Physical Restraints; 483.15 Quality of Life; 483.20 Resident Assessment and Comprehensive Care Plans; 483.25 Quality of Care; Memorandum L&C 22-07.
Decision making: Restraints are the exception not the rule

Sometimes it is hard to know whether a device is a restraint or not. Residents have the right to be free of restraints, but that does not mean that everything you see is a restraint.

Question: Mr. Black had a stroke with paralysis on his left side. He has a special wheelchair with a half tray for positioning his left arm. He holds his special suctioned cup with a straw in his left hand, which prevents finger contractions. He uses a lap belt for safety while he propels himself with his right hand and foot. Is he restrained?

Answer: No, the criteria for restraints are:
- That the device is attached or adjacent to his body,
- that he cannot remove easily, and
- that restricts movement or the ability to get to a part of the body.

Mr. Black cannot move his left side, so the half tray actually makes his hand more functional. Mr. Black can remove the lap belt easily.

Question: Mrs. Yu lives with dementia and is constantly moving. Everyday she tries to leave the nursing home. She is in a wheelchair with the foot peddles off so she can move around. She picks at her lap belt. Her chair is alarmed in case she gets up.

Answer: Yes, Mrs. Yu is restrained. Using the three criteria above both the chair and the belt are restraints. Mrs. Yu can walk, so she should not be in a wheelchair. She will lose the ability to walk if she stays in the wheelchair. Picking at the lap belt is her way of telling staff she feels restrained. It is her way of saying, “I do not give my informed consent to this restraint.” Staff should have assessed and made an individualized care plan for Mrs. Yu. The exit door could be disguised with wallpaper. A stop sign in front of the exit door works for some residents. Staff should know when and why Mrs. Yu leaves. She leaves in the morning after breakfast and in the early evening. Family told staff those were the times she always went to and from work. Mrs. Yu could help staff fold laundry or set the table at those times. She wears an Alzheimer’s “Safe Return” bracelet. All staff throughout the building know and interact with her all the time. The exit door alarm is tested regularly.

Question: Ms. Hudgens lives with dementia and is very frail. She uses an especially well padded small wheelchair with a chair alarm. She tries to get up about every hour. The alarm goes off and staff and even other residents say, “sit down.” Is Ms. Hudgens restrained?

Answer: In effect, Ms. Hudgens feels restrained. Something makes Ms. Hudgens want to get up about every hour. She has an unmet need. Staff must assess her to know whether she is in pain, needs toileting, a drink, food, company, sleep, exercise or something meaningful to do. Staff should know her well enough to meet her needs before she gets up. She also needs to walk daily.
If you and/or your family cannot solve a restraint problem, follow the guidelines below and remember:

**Help Is Available**
You can ask for help in solving a restraint problem by:
- Working with the facility to solve the problem
- Contacting the State Long-Term Care Ombudsman Program
- Contacting the surveyors at the California Department of Public Health, Licensing and Certification Division

**Working with the facility:**
First, try to work together with the staff to resolve restraint issues. Start with the licensed nurse on the unit. If she is unable to help, talk to the director of nursing or the administrator. Use this guide and the appendices to help you. Facilities must have resident councils and many have family councils. Work with the councils on these issues. Go to [www.medicare.gov](http://www.medicare.gov) or Google “Nursing Home Compare.” Put in your facility name and see the restraint rate for your home. You will also see the state and national rates. If the rate is high, offer to work with the facility on the problem.

**Working with the Ombudsman**
Some nursing home staff may not yet know how to do an assessment. They may not know ways to develop a care plan with care that avoids restraints. They may not know how to respond to your restraint reduction requests. Ask your ombudsman for help. Ombudsmen are consumer advocates. They are authorized by Congress to help residents and their families to resolve problems in long term care. They can help resolve problems by:
- Gathering facts objectively and confidentially
- Analyzing the facts and presenting them to the staff from a consumer perspective
- Organizing and negotiating for a plan to resolve the issues. This may include asking staff for a care plan conference, which they can attend with a resident. Each nursing home is required to have the ombudsman’s telephone number and address posted in a place where residents and their families can see it. Or call your Area Agency on Aging to find your local ombudsman.

**Working with Surveyors**
Surveyors inspect Medicare and Medi-Cal certified homes every year. When they visit facilities, they talk with some residents and families. Residents and families should tell surveyors if:
- They are restrained or not getting care to preclude restraints
- Staff are not meeting their individual needs
- Residents are not involved in the care planning, or
- There is not enough staff to meet resident needs.

Residents and families may also contact the survey agency whenever a problem arises. Information on how to contact the state licensure agency should be posted in the nursing home. It is also given to each resident and family at admission.

*Federal law (L), regulations (R) and State Operations Manual (SOP) require that restraints are the exception rather than the rule in nursing facilities. (L) SEC. 1819. [42 U.S.C. 1395i-3] Skilled Nursing Facilities; SEC. 1919. [42 U.S.C. 1396r] Nursing Facility; (R) 42CFR483, Subpart B; SOP Appendix PP 483.13 Resident Behavior and Facility Practices; Physical Restraints; 483.15 Quality of Life; 483.20 Resident Assessment and Comprehensive Care Plans; 483.25 Quality of Care; Memorandum L&C 22-07.*
Appendix A - Physical Restraints

The Nursing Home Reform Law of 1987 (NHRL) and the regulations apply to all Medicare and Medicaid Certified nursing homes. Most nursing homes are certified. Freedom from physical restraints is a resident right in the law:

**Free from Restraints:** The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed-

(I) to ensure the physical safety of the resident or other residents, and

(II) only upon written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary) until such an order could reasonably be obtained.

**Quality of Care and Quality of life:** The law also requires the nursing home to provide for both quality of care and quality of life. The use of physical restraints make meeting these requirements almost impossible.

**Quality of Care:** Each resident must receive and the facility must provide the necessary care and services to attain or maintain the *highest practicable physical, mental, psychosocial well-being*, in accordance with the comprehensive assessment and plan of care, which … is initially prepared, with participation to the extent practicable of the resident or the resident’s family or legal representative.

**Quality of life:** The facility must care for its residents in such a manner and in *such an environment as will promote maintenance or enhancement of the quality of life* of each resident.

**The regulation for quality of care says that:** A resident’s condition does “not diminish unless circumstances of the individual's clinical condition demonstrate that diminution is unavoidable in activities of daily living, pressure sores, incontinence, range of motion, and psychosocial functioning.” Restrained residents risk these complications.

**Surveyor Guidelines:** Clarify and interpret the law. Nursing homes should provide care that meets these guidelines. Surveyors use them to assure residents receive quality of care and life.

**Physical restraint:** “…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.”

**Discipline:** “any action taken by the facility for the purpose of punishing or penalizing residents.”
Convenience: “any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest.” Staff cannot use restraints in place of good care and there must be enough staff to provide that care.

Medical Symptom: “an indication or characteristic of a physical or psychological condition.” The guidance says that medical symptoms should not be viewed in isolation, but as part of the residents condition, circumstances and environment including-
- Objective findings from the clinical evaluation
- The resident's subjective symptoms cannot be the sole bases for restraints.
- Staff have to determine the specific medical symptom that cannot be addressed by another less restrictive intervention. There must be a link between the restraint use and how it benefits the resident by treating that symptom, protects resident safety and assists in attaining and maintaining his highest practicable mental, physical and psychosocial well-being.
- The physician's order alone cannot justify restraint use.

Physical restraints do not treat the underlying causes of medical symptoms. Therefore, staff must seek to identify and address the physical or psychological condition causing the medical symptom. Restraints can be used for temporary symptomatic intervention while the actual cause of the medical symptom is being evaluated or managed. Physical restraints may be used as a symptomatic intervention when they are immediately necessary to prevent a resident from injuring himself or others and/or to prevent the resident from interfering with life-sustaining treatment and no other less restrictive or less risky interventions exist.
- Falls are not a self-injurious behavior or a medical symptom
- There is no evidence that physical restraints prevent or reduce falls
- Falls that occur while a resident is restrained often result in more severe injuries

Emergency: A resident who is injuring himself or others or is threatening physical harm to others may be restrained in an emergency to safeguard the resident and others. A resident whose unanticipated violent or aggressive behavior places him/her or others in imminent danger does not have the right to refuse the use of restraints, as long as the restraints are used as a last resort to protect the safety of the resident or others and use is limited to the immediate episode.

This guidance describes the narrow instances when physical restraints may be used. Growing evidence supports that physical restraints have a limited role in medical care. Restraints limit mobility and increase the risk of a number of adverse outcomes. Physical restraints do not eliminate falls. In fact in some instances reducing the use of physical restraints may actually decrease the risk of falling.

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Federal law (L), regulations (R) and State Operations Manual (SOP) require that restraints are the exception rather than the rule in nursing facilities. (L) SEC. 1819. [42 U.S.C. 1395i-3] Skilled Nursing Facilities; SEC. 1919. [42 U.S.C. 1396r]Nursing Facility; (R) 42CFR483, Subpart B; SOP Appendix PP 483.13 Resident Behavior and Facility Practices; Physical Restraints; 483.15 Quality of Life; 483.20 Resident Assessment and Comprehensive Care Plans; 483.29 Quality of Care; Memorandum L&C 22-07.
Appendix B
Physical Restraint Free Care
Expect and Promote Excellence in California Nursing Homes:
PHYSICAL RESTRAINT FREE CARE

EVERYONE DESERVES DIGNITY AND FREEDOM
Restraint-free individuals can eat, dress and move independently; maintain their muscle and strength; interact with others; and maintain their freedom and dignity.

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<tr>
<th>PHYSICAL RESTRAINTS</th>
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<tr>
<td>WHAT ARE PHYSICAL RESTRAINTS?</td>
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<td>A physical restraint is any object or device that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body. Examples include vest restraints, waist belts, geri-chairs, hand mitts, lap trays, and siderails.</td>
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<tr>
<th>POOR OUTCOMES OF RESTRAINTS</th>
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<tr>
<td>• Accidents involving restraints which may cause serious injury: bruises, cuts, entrapment, siderail deaths by strangulation and suffocation.</td>
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<tr>
<td>• Changes in body systems which may include: poor circulation, constipation, incontinence, weak muscles and bone structure, pressure sores, agitation, depressed appetite, infections, or death.</td>
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<tr>
<td>• Changes in quality of life which may include: reduced social contact, withdrawal, loss of autonomy, depression, disrupted sleep, agitation, or loss of mobility.</td>
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<th>PHYSICAL RESTRAINTS ARE USED IN PLACE OF GOOD CARE BECAUSE</th>
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<tr>
<td>• Facilities or family members mistakenly believe that they ensure safety;</td>
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<td>• Facilities fear liability;</td>
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<td>• Facilities may use them in place of adequate staff.</td>
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<th>RESTRAINTS ARE MOST OFTEN USED ON</th>
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<tr>
<td>• Frail elderly residents who have fallen or may fall.</td>
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<td>• Residents with a dementing illness who wander unsafely or have severe behavioral symptoms.</td>
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<th>PHYSICAL RESTRAINT USE IN CALIFORNIA:</th>
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<td>California nursing home residents are more likely to be restrained (over 13%) than residents in nursing homes nationally (over 6%). The Advancing Excellence in America’s Nursing Homes Campaign has set a goal of 5% or less for all nursing homes in the country. In many nursing homes across the country, residents are restraint-free without any increase in serious injuries. It is unrealistic to expect that all falls and injuries can be prevented.</td>
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<th>LAWS and REGULATIONS</th>
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<td>The Nursing Home Reform Act of 1987 (OBRA ’87) states the resident has the right to be free from physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident’s medical symptoms. This law also includes provisions requiring:</td>
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<td>• quality of care—to prevent poor outcomes;</td>
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<tr>
<td>• assessment and care planning—for each resident to attain and maintain her/his highest level of functioning;</td>
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<tr>
<td>• residents be treated in such a manner and environment to enhance quality of life.</td>
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| CALIFORNIA |
| The California Code of Regulations states that the resident has the right to accept or refuse proposed treatments (including restraints) and to know: |
| • the reason for the restraint; |
| • the nature and seriousness of their illness; |
| • the type of restraint recommended and how often and for how long it will be used; |
| • the likely extent of improvement or remission expected from the use of restraints, and how long it will last; |
| • the type, likelihood, and duration of side effects and significant risks of restraint use; |
| • alternative treatments and their risks; |
| • why restraints are recommended; and |
| • the resident’s right to accept or refuse the proposed treatment (i.e.: restraints), and to revoke consent for the treatment for any reason at any time. |
RERAINT REDUCTION STRATEGIES

Twenty years of experience provide many strategies for safe restraint reduction and elimination. Restraint reduction involves the whole facility, including administrators, nursing directors, physical and recreational therapists, nursing assistants, and housekeeping personnel. Family members and advocates can encourage the facility’s efforts, and expect and insist that the facility:

- Complete a comprehensive resident assessment that identifies strengths and weaknesses, self care abilities and help needed, plus lifelong habits and daily routines.
- Develop an individualized care plan for how staff will meet a resident’s assessed needs. It describes the care goals (e.g. safe walking), and when and what each staff person will do to reach the goal. The care team includes staff, residents and families (if the resident wants), and devises the plan at the quality care plan conference. The resident may also invite an ombudsman to attend. Care plans change as the resident’s needs change.
- Train staff to assess and meet an individual resident’s needs—hunger, toileting, sleep, thirst, exercise, etc.—according to the resident’s routine rather than the facility’s routine.
- Make permanent and consistent staff assignments and promote staff flexibility to meet residents’ individualized needs.
- Treat medical conditions, such as pain, that may cause residents to be restless or agitated.
- Support and encourage caregiving staff to think creatively of new ways to identify and meet residents’ needs. For example, a “night owl” resident could visit the day room and watch TV if unable to sleep at night.
- Provide a program of activities such as exercise, outdoor time, or small jobs agreed to and enjoyed by the resident.
- Provide companionship, including volunteers, family, and friends by making the facility welcoming.
- Create a safe environment with good lighting, pads on the floor to cushion falls out of bed; a variety of individualized comfortable seats, beds and mattresses; door alarms; and clear and safe walking paths inside and outside the building.

Nursing homes can implement specific programs for reducing physical restraints, including:

- Restorative care, including walking, and independent eating, dressing, bathing programs;
- Wheelchair management program—including correct size, and seat cushion good condition;
- Individualized seating program—chairs, wheelchairs, tailored to individual needs;
- Specialized programs for residents with dementia, designed to increase their quality of life;
- Videotaped family visits for distant families;
- Wandering program—to promote safe wandering while preserving the rights of others;
- Preventive program based on knowing the resident—to prevent triggering of behavioral symptoms of distress;
- Toileting of residents based on their schedules rather than on staff schedules.

FIND AN ADVOCATE:
Contact your local or state ombudsman if you have concerns about the care a resident is receiving. An ombudsman is a state-certified advocate for residents of nursing and residential care facilities who is familiar with the local facilities and often with the staff and residents. All conversations with an ombudsman are confidential unless permission is given to use a person’s name.

CONTACT the California Ombudsman
Program to find your local Ombudsman Program:
Office of the State Long-Term Care Ombudsman
California Department of Aging
1300 National Drive, Suite 200
Sacramento, California 95834
Voice: (916) 419-7510 Fax: (916) 928-2503
Statewide CRISISline (800) 231-4024
Website: http://www.aging.ca.gov/html/programs/ombudsman.html

Supported by a grant from the California HealthCare Foundation, based in Oakland, California. The grant, Voices for Quality: Strategies in the National Campaign for Excellence in America’s Nursing Homes, enables NCCNHR to provide training, consultation and support to the California Ombudsman Program.
Appendix C
Assessment and Care Planning: The Key to Good Care
Each and every person in a nursing home has a right to good care under the 1987 Federal Nursing Home Reform Law. The law, which is part of the Social Security Act, says that a nursing home must help each resident “attain or maintain” his or her highest level of well being - physically, mentally, and emotionally.

To give good care, staff must assess and plan care to support each resident’s life-long patterns, current interests, strengths, and needs. Care planning conferences are a valuable forum for residents and families to voice concerns, ask questions, give suggestions, learn nursing home strategies, and give staff information (such as resident background and daily routine). This requirement in the law is vital to making sure residents get good care.

Resident Assessment
Assessments gather information about the health and physical condition of a resident and how well a resident can take care of themselves. This includes assessing when help may be needed in activities of daily living (ADLs) or “functional abilities” such as walking, eating, dressing, bathing, seeing, hearing, communicating, understanding, and remembering. Assessments also should examine a resident’s habits, activities, and relationships in order to help him or her live more comfortably and feel at home in the facility.

The assessment helps staff to be aware of strengths of the resident and also determine the reason for difficulties a resident is having. An example of where a good assessment helps: A resident begins to have poor balance. This could be the result of medications, sitting too much, weak muscles, poorly fitting shoes, or a urinary or ear infection. Staff must find out the cause of a problem in order to give good treatment. Figuring out the cause is much easier with a good assessment.

Assessments must be done within 14 days of the resident’s admission to a nursing home (or 7 days for Medicare residents) and at least once a year after that. Reviews are held every three months and when a resident’s condition changes.

Plan of Care
After the assessment is completed, the information is analyzed and a care plan is developed to address all the needs and concerns of the resident. The initial care plan must be completed within seven days after the assessment. The care plan is a strategy for how the staff will help a resident every day. This care plan says what each staff person will do and when it will happen (for example, a nursing assistant will help Mrs. Jones walk to each meal to build her strength). Care plans must be reviewed regularly to make sure they work and must be revised as needed. For care plans to work, residents must feel they meet their needs and must be comfortable with them.

Care Planning Conference
The care plan is developed by an interdisciplinary team -- nurse, nurse aide, activities and dietary staff, and social worker, with critical input from the resident and/or family members. All participants discuss the resident’s care at a Care Plan Conference to make certain that all medical and non-medical issues, including meals, activities, therapies, personal schedule, medical and nursing care, and emotional needs are agreed upon and addressed. Resident and family member concerns should be listened to by staff and addressed in the care plan. A good Care Plan Conference takes time. It should not be rushed, and could take at least one hour. Every 90 days after development of the initial plan, or whenever there is a big change in a resident’s physical or mental health, a Care Plan Conference is held to determine how things are going and if changes need to be made.
Good Care Plans Should

- Be specific to that resident;
- Be followed as an important guideline for providing good care for the resident;
- Be written so that everyone can understand it and know what to do;
- Reflect the resident’s concerns and support his or her well-being;
- Use a team approach involving a wide variety of staff and outside referrals as needed;
- Assign tasks to specific staff members;
- Be re-evaluated and revised routinely.

Steps for Residents and Family Participation in Care Planning

Residents and family members have the right to be involved in the care plan conference in order to make choices about care, services, daily schedule, and life in the nursing home. Even if a resident has dementia, involve them in care planning as much as possible. Be aware that they may understand and communicate at some level and help the staff to find ways to communicate and work with them. They can express when they hurt or suffer if they are actively listened to. Participating in care plan conferences is a way to be heard, raise questions, and come to a clear agreement with the facility about how the resident will be cared for.

Before the meeting:

- Ask staff to hold the meeting at a convenient time for you and/or your family member;
- Ask for a copy of the current care plan (if one already exists) so that you can examine each aspect thoughtfully;
- Know about or ask the doctor or staff about your or your loved one’s condition, care, and treatment;
- Plan your list of questions, needs, problems, and goals, and;
- Think of examples and reasons to support changes you recommend in the care plan.

During the meeting:

- Make sure the resident is involved and listened to carefully.
- Discuss options for treatment and for meeting your needs and preferences;
- Ask questions if you need terms or procedures explained to you;
- Be sure you understand and agree with the care plan and feel it meets your needs;
- Ask for a copy of the care plan;
- Find out who to talk to if changes in the care plan are needed, and;
- Find out who to talk to if there are problems with the care being provided.

After the meeting:

- Monitor whether the care plan is being followed;
- Inform the resident’s doctor about the care plan if s/he was not directly involved;
- Talk with nurse aides, staff or the doctor about the care plan, and;
- Request another meeting if the plan is not being followed.
- See NCCNHR’s “Resolving Problems in Nursing Homes” for additional information.
Appendix D

Given current research about the restraints in long term care facilities, a scientifically supportable consent form would read as follows:

INFORMED CONSENT FOR RESTRAINTS
My physician and clinical care team recommend that I be restrained with the following devices______________________________________. This recommendation is based on their professional judgment and on a fall-predicting test that identifies me as being at an increased risk of falling due to (circle all that apply): history of falling, sedating medications, impaired mobility, impaired cognition, or impaired sight.

Though fall-related injuries are a major cause of accidental disability and death in long-term care facilities, research does not show that restraints prevent fall-related injuries. Studies suggest that restraints usually increase, rather than decrease, the chance of serious injuries. Because the ability to predict the time of a fall-related injuries is imprecise, I consent to be restrained long durations when I will not be falling. Being restrained will cause physical deconditioning and may decrease my functional ability and independence; it, may predispose me to pneumonia and aggravate bedsores. Research suggests that people who are restrained often receive sedating medicines to treat restraint-induced agitation, and that the use of these drugs, and exposure to their potentially harmful effects, decreases when restraint use is decreased. Confused or frail persons’ efforts to escape restraints have caused skin injuries, nerve damage, gangrene of the limbs, falls while escaping from a restraints and death from positional asphyxia.

I understand that restraints often cause people to feel angry, afraid, demoralized, and humiliated. Both my appearance as a restrained person and the regressed or aggressive behavior that may be caused by the restraint pose a risk that others will see me as the kind of impersonal being that needs to be tied. If this occurs and with a decreased ability to humanly present myself or to assert my needs, restraints may decrease the likelihood that my physical, emotional, and social needs will be met. With these understandings, I consent to be restrained as recommended.

Signature and Date

1. This consent form does not apply to instances where a restraint is used to hold a person in proper alignment for life support or for immobilization to allow healing of a fracture or as part of post-operative management.
2. Dr. Steven Miles, M.D., Professor of Medicine, Geriatrics and Bioethics, University of Minnesota. Printed in Quality Care Advocate/Special Report, April-May, 1996. Modified September 16, 2003.
Appendix E
Consistent Assignment: A Key Step to Individualized Care
Consistent Assignment: A Key Step to Individualized Care

Research has found that providing residents with the same caregiver results in more individualized care, which leads to better clinical outcomes and quality of life. Implementing a consistent assignment system also leads to greater staff satisfaction and lower staff turnover rates. This FastFacts summarizes the evidence supporting consistent assignment and offers a pragmatic method to make the change.

**Consistent Assignment vs. Rotating Assignment**

Ninety percent of nursing homes require staff to rotate assignments. Consistent assignment (sometimes called primary or permanent assignment) is defined as using the same caregivers (registered nurses, licensed practical nurses, certified nurse’s aides) to care for the same residents on every shift. Consistent assignment allows staff to develop closer relationships with residents in their care and with co-workers. Conversely, rotating staff assignment continually interrupts the formation of relationships and inhibits staff’s ability to recognize resident decline and optimally address care needs.

There are many reasons why leaders believe that rotating staff assignment is effective. Some of the most common reasons for rotating assignments are centered on fairness, preventing staff burnout, and making all staff familiar with the needs of all residents. Some facilities discourage strong relationships between staff and residents to help shield staff from grief when residents die. Some resist consistent assignments because they do not want staff to be stuck with particularly challenging residents. However, such reasons for rotating staff assignments are not supported by research. In fact, rotating assignment exacerbates low staff morale—leading to staff burnout, call-outs, and turnover.

**Benefits of Consistent Assignment**

- **Residents receive better care.** Residents feel more comfortable and secure with consistent assignments. One study compared two nursing homes with permanent assignments to two nursing homes with rotating assignments. Residents living in permanent assignment nursing homes rated significantly higher for personal appearance and hygiene than residents in rotating assignment homes. In another study, one facility saw a 75 percent reduction in the incidence of decubitus ulcers after implementing consistent assignments.

- **Improved job satisfaction.** Studies found that nurse’s aides working in consistent assignment homes reported higher job satisfaction than those working in rotating assignment homes. Facilities found that after a year of using consistent assignments, staff turnover rates fell by 29 percent.

- **Staff feel valued.** One study found that rotating staff made certified nurse’s aides (CNAs) feel less valued for their skill, experience, and knowledge of the residents. CNAs defined good care based on establishing good relationships with residents. Any disruption to these relationships was detrimental to the quality of care and the quality of residents’ lives.

- **Staff feel empowered.** With consistent assignments, staff feel more responsible for the care of residents. They feel more accountable for their residents and take pride in helping them improve. Aides also report feeling more accountable and are better able to make and implement nursing decisions.

- **Strong foundation for person-directed care.** With consistent assignments, residents form close bonds with the people who care for them and consider them “family.” These relationships are the cornerstone of person-directed care. Relationship bonds form over time—we do not form relationships with people we see infrequently.
Consistent Assignment: A Key Step to Individualized Care

- More familiarity with residents’ needs and desires. When staff care for the same people daily they become familiar with residents’ needs and desires and can anticipate their needs. As a result, their work becomes easier because they are not spending extra time getting to know what each resident prefers—they know from experience, which only develops from being in a consistent, caring relationship.

- Fewer call-outs. When staff care for the same residents every day they are less likely to “call-out.” As one CNA said, “I don't call-out now, because my residents would miss me.” Create an in-house pool of staff who can take over when call-outs do occur.

How to Switch to Consistent Assignment

When switching from rotating assignment to consistent assignment, leaders should expect some resistance from staff. Remember, they have been told that the rotating staff model is better for them. Share new research with them and note that new information means better practices. Addressing their concerns will be the key to success. Consider the following example of a process to make the change:

1. Call separate meetings with all of the day shift and night shift CNAs.
2. Begin each meeting by explaining that nursing homes that have switched to consistent assignment have improved resident quality of care and life as well as improved work life for the staff. Suggest that the facility try consistent assignment and see how it works.
3. Write each resident’s name on a Post-it note and place the notes on a wall.
4. Ask the CNAs to rate the residents by their degree of “challenge to care for,” with number 1 being relatively easy to care for and number 5 being very difficult to care for (time-consuming, emotionally draining, etc.). Let the CNAs discuss each resident and come to an agreement. Write the number on each resident’s Post-it note.
5. Allow the CNAs to select their assignments. Make assignments fair by allowing CNAs to care for different numbers of residents depending on their “challenge to care for” number. For example, if one CNA has six residents and another has eight residents but both “degree of challenge” numbers total 27, then the assignments are fair. Also consider existing relationships with residents as part of the decision-making process.
6. Meet every three months (or sooner) and re-examine assignments to ensure that staff feel they are still fair and the relationships with the residents are going well.

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References

Web Resources
Change Ideas for Consistent Assignment
www.nhcqf.org/QI_Services/NursingHomes/Jan2006Files/Change_Ideas_Consistent_Assignment_0805-292.pdf

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Appendix F
Common Challenging Situations Requiring Interventions
## Common Challenging Situations Requiring Interventions

<table>
<thead>
<tr>
<th>Exhibited Behavior</th>
<th>Considerations</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attempts to rise from chair unaided</td>
<td>Pain&lt;br&gt;- Is the resident in pain?&lt;br&gt;- Is it acute or chronic?&lt;br&gt;- “Read” the behavior instead of the words</td>
<td>- If resident has cognitive deficits, begin with supposition that resident may have chronic pain.&lt;br&gt;- Assess resident for pain.&lt;br&gt;- Pain may be best managed with around-the-clock analgesic or anti-inflammatory therapy rather than waiting until it becomes extreme.</td>
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<td>Elimination&lt;br&gt;- Does resident need to go to the bathroom?&lt;br&gt;- Does the resident have a urinary tract infection?&lt;br&gt;- Is the resident constipated?</td>
<td>- Urinalysis, culture and sensitivity.&lt;br&gt;- Monitor frequency of urination... bed alarm can be a tool to determine pattern from which an individualized toileting program can be developed.&lt;br&gt;- Provide adequate diet and supplements in response to constipation.</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Are the resident’s basic needs being met... hunger, thirst, cold, hot, etc?&lt;br&gt;- “Read” the behavior instead of the words&lt;br&gt;- Is the resident fearful of being left alone?&lt;br&gt;- Is the resident bored?&lt;br&gt;- Are there times when the anxiety is elevated?&lt;br&gt;- Is the resident acting out of emotional discomfort; losses, loneliness, etc.?&lt;br&gt;- Are there environmental factors causing the anxiety, such as noise from other residents calling out?</td>
<td>- Vary the locations where a person sits. Sometimes quiet areas are appreciated but often residents want the security of being “where the action is.”&lt;br&gt;- Engage in meaningful activities such as listening to music, assisting staff with simple tasks, or executing a repetitive task that satisfies a personal need.&lt;br&gt;- Offer residents adequate stimulation such as reading materials, talking books or an activities cart placed strategically on each unit.&lt;br&gt;- Allow residents to surround themselves with personal furniture and possessions. This helps in recognition of one’s room and provides a comfortable, secure haven in an often strange environment.&lt;br&gt;- Allow nursing staff to wear regular clothing rather than uniforms... normalizing the environment.&lt;br&gt;- Eliminate the use of public address system. Voices coming over these systems are stressful and confusing for frail residents.</td>
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<tr>
<td>Exhibited Behavior</td>
<td>Considerations</td>
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<tr>
<td>Discomfort</td>
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| - Is the resident sitting in a chair that does not fit, a chair that is not comfortable?  
- Is the resident spending long periods of time in a wheelchair?  
- Would the resident benefit from a brief rest period?  
- Does the resident have redness or soreness on buttocks or coccyx area?  
- Does the resident have a degenerative joint or bone condition such as arthritis or osteoporosis? | - Remember, wheelchairs are for transportation only.  
- Assessment by PT/OT for appropriate seating and adaptive devices.  
- Provide flexion at hips and knees and lateral support with wedge cushions, positioning pillows, and/or deep inclined seats to minimize slumping, falling to the side or sliding out of chair. (Therapists should be consulted to avoid problems with adaptations.)  
- Ensure that the most comfortable seating is available and that the resident is not expected to sit for prolonged periods.  
- Offer a variety of seating options, such as recliner loungers, rockers, deep-seated high-backed chairs, or soft comfortable wing chairs.  
- Alter seating environments, determine multiple chairs that could be appropriate for each person. Consider developing a chart of all possible seating environments on a unit and check off all comfortable chairs for each person. This will aid staff when a resident needs to be moved.  
- Get pressure off dependent areas. Provide appropriate medical treatment to all stages of decubiti. | |
| Attempts to climb out or egress from bed | - Why is the resident trying to get out of bed?  
- Is the resident anxious, afraid of being alone in a bedroom?  
- Are bedrails being used to keep the resident from getting out of bed? (See “A Guide to Bed Safety - Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts”)  
- Is the resident alert and oriented?  
- Has the resident been going to bed too early because of lack of meaningful activities in the evening?  
- Is the resident experiencing delirium?  
- What were the resident’s sleep patterns prior to admission? | - Our responsibility is to provide a safe, comfortable sleeping environment; therefore, proper assessment of resident’s needs is important.  
- The need to go to the bathroom is the most frequent reason why residents attempt to get out of bed without assistance.  
- Have the resident sit in an area with other people to reduce anxiety.  
- Remember, many older people do not sleep through the night. Provide snack, soft music, or other activity that could be relaxing.  
- Determine if bed environment is comfortable. Perhaps sleeping in a recliner near the staff would be better.  
- If bedrails are being used, explain potential risks associated with them.  
- Use bed alarm to track pattern and develop routine for staff to intervene prior to resident’s attempt to egress from bed unaided.  
- Once resident’s elimination needs have been addressed, provide snacks, review medications and times of dispensing them, offer back rubs and other non-medical interventions.  
- When appropriate, provide low bed without rails to allow safer egress.  
- Provide mat on floor to soften possible fall and prevent serious injury.  
- Try a concave mattress for a more defined mattress perimeter.  
- Consider meaningful activities throughout the evening hours. |
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<tr>
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</table>
| History of falls or potential for falls | • Is there a change in the resident’s vital signs?  
• Is there a change in the resident’s stamina, gait, cognition, balance?  
• Has the resident become weaker?  
• Is there sudden loss of muscle tone?  
• Is the resident receiving proper nutrition and fluids?  
• Is the resident involved in regular exercise?  
• Is the resident in a safe environment?  
• Is an ambulation device in use that the resident cannot operate?  
  Has the resident been trained on its use?  
• What is the resident’s usual routine?  
• Is the resident suffering from a sensory problem?  
• Is the resident feeling vulnerable or fearful because of previous falls?  
• Is the resident impulsive?  
• Does the resident have poor safety awareness?  
• Is the resident trying to maintain independence?  
• Is alcohol use impacting on ability to ambulate safely? | • Remember, there are usually multiple factors that increase the risk of falls.  
• Clinical assessment by physician, nurse, dietician and therapists is critical to detect any acute or chronic illness that has not been managed adequately.  
• Maintain good hydration; offer fluids frequently.  
• Review medications for appropriateness, dosage and interactions.  
• Track and document time, location, pre-falls’ occurrences (such as medication administration, activity, meal, interaction with others, etc.). Alter one or more variables if a pattern exists.  
• Monitor environment for safety hazards.  
• Provide direct visual observation or frequent checks by staff.  
• Coach resident to ask for help and to rise slowly if unsteady.  
• Provide opportunities to ambulate with staff assistance.  
• Modify environment with optimal lighting in resident’s room and bathroom. Appropriately place safety bars, remove wheels from over-the-bed table and other furniture that resident may lean on for support.  
• Consult with podiatrist for possible foot problems, possibility of needing better fitting shoes.  
• Consult with an audiologist, ophthalmologist, or other specialist.  
• Discuss resident’s concerns about vulnerability and potential loss of independence |
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| Attempts to wander into unsafe areas or out of the    | › Why is the resident wandering?  
› Is the resident trying to get somewhere or is it aimless wandering?  
› Is the resident new to the facility?  
› Is there an unmet need such as the need to go to the bathroom?  
› Is the resident in pain, possibly searching for some relief? Could comfort measures be offered? Is a change in medications warranted?  
› Is there too much noise or crowding?                                                                 | › Observe the resident’s wandering to determine if the path is safe.  
› Camouflage potentially unsafe areas, simplify signs to ease resident’s recognition of bathrooms, bedrooms, etc.  
› Often the resident is in search of a parent who is deceased. Do not add to the person’s anxiety by saying the individual has died, rather allow the resident to talk about the individual. This is giving the person the security needed and an outlet to share fond memories with you.  
› Review medications to determine if they are increasing the resident’s anxiety.  
› Have a staff person or volunteer regularly walk with the resident.  
› Provide activities that meet the resident’s personal interests.  
› Help staff and other residents respond in a consistent, non-threatening manner. This will create a supportive environment in which everyone can play a part.  
› Reduce excessive stimulation.  
› Provide familiar surroundings for reassurance.                                                                 |
| facility                                                |                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                           |
| Abusive to self or others                               | › Is the resident anxious or angry?  
› Is the anger/abuse provoked or unprompted?  
› Is a lifelong pattern?  
› Is the resident in pain or other discomfort?  
› Is the resident tired?                                                                                                                                  | › Approach the resident calmly.  
› If the resident may strike out, back off until the resident appears more approachable.  
› Remove precipitating provoking factors.  
› Maintain a regular routine.  
› Use a mirror technique... remain calm, move slowly, speak quietly... often the resident will unconsciously respond in a similar manner.  
› Don’t let the situation escalate; if necessary, remove the resident from the situation.  
› Assess the resident for sources of pain, infection, constipation, full bladder.  
› Provide adequate rest.  
› Review medications for possible adverse effect.  
› Help family members cope with abuse issues.                                                                                                            |
## Appendix G - Internet Resource List

**NCCNHR:** The National Consumer Voice for Quality Long-Term Care.

*February 2008*

<table>
<thead>
<tr>
<th>Resource</th>
<th>How Residents and Families Can Use It</th>
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</table>
| **www.nccnhr.org**<br>Click on left column of choices | About NCCNHR, The National Voice for Quality Long Term Care  
Consumer Center with Fact Sheets on quality care  
Quality Initiatives with California HealthCare Foundation Restraint Reduction materials  
Quality Initiatives – *Advancing Excellence Campaign* initiative to reduce restraints and increase consistent assignment |
<p>| <strong><a href="http://www.ltcombudsman.org">www.ltcombudsman.org</a></strong>&lt;br&gt;Click on the left column of choices | Find your local ombudsman by clicking on “Ombudsman Locator.” Home page tells about the Ombudsman program. Can reach the NCCNHR website from there. |
| <strong><a href="http://www.nhqualitycampaign.org">www.nhqualitycampaign.org</a></strong>&lt;br&gt;Click on right column and join as a “consumer.” Have the nursing home click on “Nursing Home Registration.” | <em>Advancing Excellence in America’s Nursing Homes</em> is a collaborative effort among providers, consumers, regulators, and professionals to target 8 goals. One clinical goal is restraint reduction. A related goal is increasing consistent assignment of staff. Have your facility join the campaign and get free help with these two goals. |
| <strong><a href="http://www.medicare.gov">www.medicare.gov</a></strong>&lt;br&gt;Google “Nursing Home Compare.” Put in your facility name and see what the restraint rate is in your home. You will also see the state and national rates. | This government site provides consumers with information about every Medicare and Medicaid certified nursing home in the U.S. Put the name of your facility in find the restraint rate. See how it compares with the rest of the state and nation. If it is high, then start to work on restraint reduction. |
| <strong><a href="http://www.lumetra.com">www.lumetra.com</a></strong>&lt;br&gt;Go to Professionals and download “Fast Facts.” | This site has good materials for nursing home professionals. Go to “Fast Facts” and download “Consistent Assignment” and Restraint Free Nursing Homes.” Give it to the DON or Administrator to help them. The tools for how to do it are also on this website. Help the DON and/or Administrator to get the tools. Click on “Resources,” then “Tools,” then “All Tools.” Scroll down and you will find a big section on Physical Restraints. Then click further to “Resident Satisfaction” and click on “Consistent Assignment.” |</p>
<table>
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<tr>
<th>Resource</th>
<th>How Residents and Families Can Use It</th>
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</thead>
<tbody>
<tr>
<td><a href="http://www.ute.kendaloutreach.org">www.ute.kendaloutreach.org</a></td>
<td>The first nursing home in the country to become restraint-free since 1973 has many training materials and programs on their website. Order the consumer part of the film, “Everyone Wins” to show to resident and family councils.</td>
</tr>
<tr>
<td><a href="http://www.cms.hhs.gov">www.cms.hhs.gov</a></td>
<td>To get to the CMS Interpretive Guidelines on restraints go to 413.13 Resident Behavior and Facility Practices. These are what the nursing homes should be following. Print the Memorandum on Restraint Definitions, L&amp;C 22-07 out for nursing home to use. Your advocacy will improve when they know you have this document.</td>
</tr>
<tr>
<td><a href="http://www.fda.gov/cdrh/beds/">www.fda.gov/cdrh/beds/</a></td>
<td>Bed rails are very dangerous for elders. This brochure explains why in simple terms. It includes ideas about how to provide care without bed rails. This site has all the information the DON or Administrator will need to improve bed safety.</td>
</tr>
<tr>
<td><a href="http://cms.internetstreaming.com">http://cms.internetstreaming.com</a></td>
<td>This is a series of three programs on restraint reduction. The second one is an hour long and follows two facilities that are making the change from using restraints to good care without restraints. It is an excellent example of team work and innovative thinking.</td>
</tr>
<tr>
<td><a href="http://www.canhr.org">www.canhr.org</a></td>
<td>California Advocates for Nursing Home Reform website provides information including consumer fact sheets and publications related to long term care issues, including physical restraints.</td>
</tr>
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</table>