

Collaborative Framework

Introduction

The Centers for Medicare & Medicaid Services' (CMS) Quality Initiative is challenging providers in long-term care settings to continually enhance an environment that promotes transformational change in the area of quality of care and quality of life.

Transformational change occurs through collaboration, partnership, and commitment to a paradigm shift—in this case, a person-directed care (PDC) approach to quality improvement. The foundation of transformational change rests on a positive organizational culture that is directed and supported by the administrator, director of nursing, and countless other leaders in today's nursing home. The PDC model is an innovative approach in long-term care, enhancing residents' quality of life by changing the culture in nursing homes. An integrated PDC approach supports an environment that ideally promotes residents' freedom, independence, and autonomy in a restraint-free environment. The purpose of this framework is to provide the foundation necessary for staff to reduce and/or eliminate physical restraints in their facility.

Problem Statement

Nursing homes have taken significant steps to reduce the use of physical restraints since the 1987 Omnibus Budget Reconciliation Act (OBRA). In 1988, the Healthcare Financing Administration, now CMS, reported the use of physical restraints in nursing homes at 41%. Although the prevalence rate has dropped over the last 14 years to a national average of 7.3% in the second quarter of 2004, with Tennessee's rate at 11%,¹ the use of physical restraints with nursing home residents is still considered too high by many residents, families, advocates, healthcare practitioners, and government officials.

Background

CMS' Quality Initiative, launched in November 2002, seeks to assist nursing homes in improving the quality of care and quality of life for all residents. The regulations protect and promote the resident's right to participate in and direct his/her own care. More importantly, as a society we have a moral and ethical responsibility to support an environment that promotes respectful caring for our frail elders. It is, therefore, necessary to facilitate the residents' autonomy and sense of control over their lives and move away from our current system, which is unintentionally designed to foster dependence "by keeping residents well cared for, safe, and powerless."²

According to federal regulations, “the resident has the right to be free from any physical or chemical restraints imposed for the purpose of discipline or convenience, and not required to treat the resident’s medical symptoms.”³ Therefore, a physical restraint may only be used to treat a medical symptom and only after a comprehensive assessment identifies interventions that allow the resident to reach his/her highest practicable level of functioning.

Current Use of Restraints

In a nursing home population, where the majority of residents are frail, elderly, medically complex, and cognitively impaired, physical restraints are typically applied in nursing homes for any of three main reasons:

- Safety
- Convenient management of situations that may be difficult or time-consuming for staff (such as altered mental status, disruptive behavior, and functional dependence)⁴
- Prevention of treatment interference (such as removing intravenous tubing or scratching a wound)

Quality measure (QM) scores indicate continued, yet varied, restraint use in the nation’s nursing homes. For example, the QM in Tennessee ranges from a low of 0% at one nursing home to a high of 58% in another.⁵

Factors contributing to the wide variation in restraint use include the individual facility’s staffing mix and workload; the facility’s leadership support; the availability (actual or perceived) of restraint-free alternatives; differing methods of staff education and organizational change; beliefs whether restraints provide a safer environment; and preferences of families and residents.

Safety

In the past, physical restraints were viewed as preventative measures. However, research studies have provided evidence to the contrary—using physical restraints does not lower the risk of falls or fall-related injuries,⁶ and removing restraints does not increase those risks.⁷ Further, Tinetti et al found that restrained residents were three times more likely to be injured during a fall or related incident than were unrestrained residents.⁸

It is estimated that as many as 200 deaths occur every year as a result of strangulation or suffocation from restraints, even when they are applied according to manufacturer’s instructions.⁹ While Miles and Irvine estimate a number much higher, as many as 1 in 1,000 deaths of nursing home residents are a result of restraint use.¹⁰

Adverse Effects and Quality of Life

Research identifies many adverse impacts of restraint use, not only in terms of negative health outcomes, but also in the consumption of financial resources necessary to address those poor outcomes. Physical restraint use has the

potential to negatively impact the resident's physiological and psychological health status.

Concerns include:¹¹

- Urinary incontinence
- Increased agitation
- Circulation impairment
- Skin breakdown
- Decreased mobility
- Physiologic stressors
- Social isolation
- Reduced sensory and perceptual input
- Abnormal changes in body chemistry, basal metabolic rate, and blood volume
- Orthostatic hypotension
- Contractures
- Edema
- Decreased muscle mass, tone, and strength
- Nosocomial infection
- Cardiac stress
- Problems with elimination
- Loss of dignity
- Increased confusion and combativeness

Staff Resources

Research has shown that residents who are restrained consume more staff resources than do unrestrained residents.¹² This is due, in part, to federal law which mandates that restrained residents be freed from the restraint and exercised every two hours. After repositioning and reapplying the restraint, staff must then document accordingly to be in regulatory compliance. Not only does the documentation and care of restrained residents take considerable staff time, but infections, pressure ulcers, and other medical conditions resulting from prolonged restraint use will require additional (avoidable) care.

A number of studies have found the number of full-time staff remains the same in a restraint-free environment. The nature of the staff's activities do change, though, as restraint use declines.¹³

Litigation

Staff mistakenly use physical restraints as a risk management tool to reduce the possibility of lawsuits. However, the use of physical restraints to prevent injury is not the standard of care. Furthermore, there is a growing trend of lawsuits filed against nursing homes for restraint-related injury or death.¹⁴

Liability insurance rates for nursing homes have dramatically increased in the past decade. According to one national survey, the average amount awarded to plaintiffs involved in suits against nursing homes is also on the rise.¹⁵ This means that substantial financial savings may be possible when just one lawsuit due to a restraint-related injury is prevented.

The lack of consistency in nursing homes, state survey agencies and court rulings has contributed to the confusion about restraint use and classification. Widespread educational programs, for both healthcare professionals and consumers, are needed to call attention to residents' rights regarding physical restraints and raise awareness of the risks in using, or not using, them.¹⁶

Benefits of Removing Restraints

Residents who are not restrained tend to be less agitated, less fatigued, and more social. They are able to attend activities and social gatherings with friends and families, which increases communication and appropriate physical and sensory stimulation. Unrestrained residents exhibit greater independence with toileting, mobility, feeding, dressing, and strength—which decreases the burden of care and saves time and supplies as well. The resident's autonomy and dignity improves without the confinement of physical restraints.

Achieving restraint-free care also results in a sense of pride for caregivers. Staff gain a reputation for providing high quality care to their residents, serious injuries significantly decline, staff turnover decreases, staff morale increases, and families support restraint-free care.¹⁷ Restraints can be significantly reduced without increases in serious injuries, staffing, or substitution of psychoactive drugs.¹⁸

Reducing the number and type of physical restraints not only meets the federal regulation requirements, it also improves daily life for residents and staff. It is a start toward creating the ideal nursing home environment.

Overcoming the Barriers

Best practices in nursing homes are based on individualizing care: tailoring the environment and staff support to the unique needs of each resident. The goals of individualized care include promoting comfort and safe mobility, optimizing function and independence, and achieving the greatest possible dignity and quality of life. Individualized care not only reduces restraint use, it also lowers specific fall risk factors and minimizes difficult behavior. Staff immediately investigate whether residents who are exhibiting behaviors which precipitate consideration of restraint use are experiencing changes in health status or expressing unmet needs.

However, nurses and certified nurse assistants (CNAs) identify a host of barriers to individualized care—including cost, insufficient staff, safety and regulatory concerns, lack of team cooperation and communication, lack of input by the nursing assistants for care planning, and staff and family attitudes.¹⁹ Furthermore, our legal environment and fear of negative state and federal survey consequences impede the widespread application of standardized, effective strategies to promote restraint elimination. The interaction of all these factors, only a portion of which are controlled by the nursing home, contribute to the complexity and challenge of implementing non-restraint efforts.

To reach the goal of a restraint-free environment in all nursing homes, changes must occur at several levels, including clinical practice, leadership support, regulatory re-alignment, and risk management consideration of financial and legal implications.

The impetus for change, however, is the responsibility of facility administrators, directors of nursing, and other leaders. The success of a restraint elimination program is dependent upon the support of the owners, governing board, administrator, director of nursing, family, and health team members.²⁰ According to Williams and Finch, administrator support may be the single most important element of a successful restraint-free program.²¹ Likewise, Dunbar et al, observed that “one of the most important factors in reducing the use of restraints was the attitude and commitment of administrators to be knowledgeable about restraint-free care, willing to advocate for its implementation, and able to guide and lead their facilities through the process.”²²

Mission

The mission of this improvement effort is to achieve a decrease in the use of physical restraints while working towards the elimination of all physical restraints in long-term care. This collaborative will support nursing homes in the creation of effective, interdisciplinary restraint reduction programs—resulting in a constant level of comfort and safety for residents.

The QSource staff will help each nursing home achieve this mission and their facility-specific aim. The QSource staff will support the team in meeting the Collaborative goals by sharing the best available scientific knowledge and experience on creating safe systems in clinical areas and by teaching and applying methods for organizational change and improvement.

Improvement Goals

The ultimate objective is to eliminate all physical restraints in long-term care. For nursing homes participating in a collaborative, initial goals to support that challenge are:

- No more than 2% of residents are in daily restraints for greater than six consecutive days.
- All (100%) of the eligible resident population receives appropriate assessment, care planning, and monitoring for the management of falls, behavioral symptoms, and other associated resident care issues.
- Deepen the organizational commitment to improved systems of care for the frail elderly by minimizing or eliminating physical restraint use.

Further, participating organizations will set additional goals based on: a) their own QM score and b) other issues they identify as priorities.

Methods

Each participating nursing home facility is expected to develop an aim statement (a statement on what the team expects to accomplish) that includes the specific goals stated above and any others that relate to reducing physical restraints. Nursing facilities may begin restraint reduction efforts for a small group of currently restrained residents within their facility and should select initial populations of focus based on the need for improvement in care processes or outcomes. Overall, the population of focus for this improvement effort will be all residents. The ultimate goal is to spread the improvements to other populations either within or beyond the facility.

Both process and outcome measurement strategies will be used to assess progress toward achieving the goals.

Nursing facilities will learn an improvement strategy that includes breakthrough goals and a method to develop, test, and implement changes in their processes of care and infrastructure. Teams will be expected to collect well-defined data on a monthly basis that relate to their aim and to plot these data over time. Run charts (see Glossary) will be used to assess the impact of changes.