# Understanding Restraint and Pressure Ulcer Initiatives

**Arizona Nursing Home Collaborative Workgroup**
**Learning Session 4**

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Health Services Advisory Group (HSAG)

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## Program Objectives

- Learn about Arizona Nursing Home Workgroup activities.
- Understand statewide restraint and pressure ulcer management trends.
- Learn about regulations related to restraint and pressure ulcer management.
- Understand components of successful restraint and pressure ulcer management programs.

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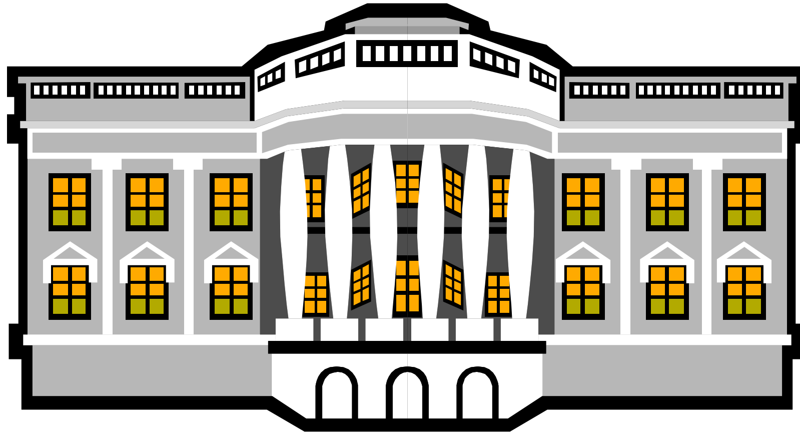
## What Does CMS Want?

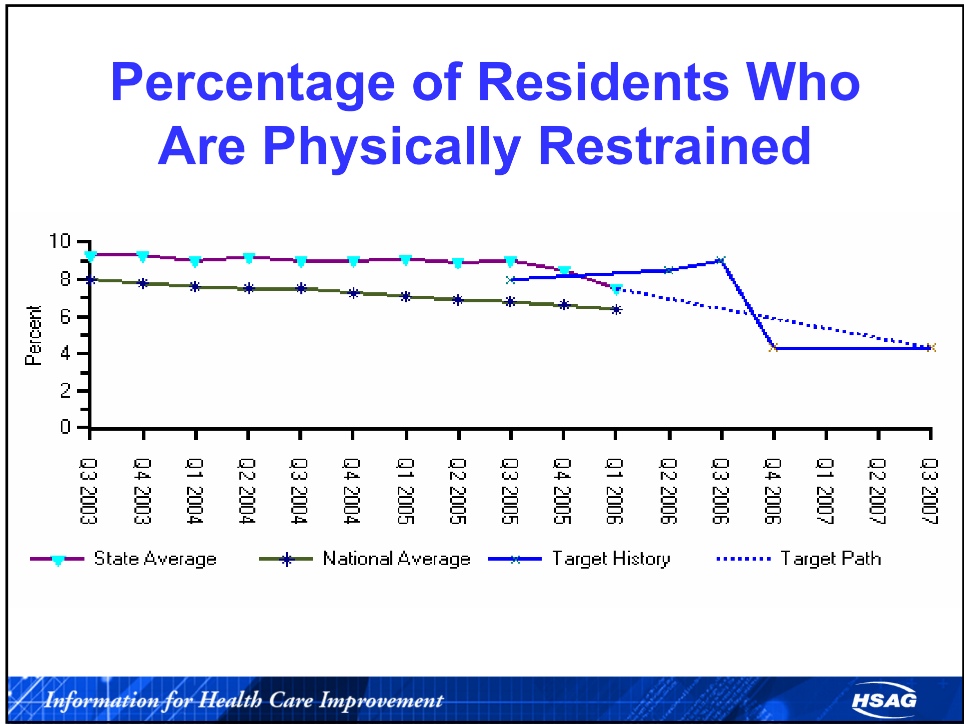




## Arizona Nursing Home Workgroup Core Measures

Work to reduce:

- **Restraints**
- **High-risk pressure ulcers**
- Depression
- Chronic-care pain


Percentage of Residents Who Are Physically Restrained
10
8
6
4
2
0
Percent
Q3 2003
Q4 2003
Q1 2004
Q2 2004
Q3 2004
Q4 2004
Q1 2005
Q2 2005
Q3 2005
Q4 2005
Q1 2006
Q2 2006
Q3 2006
Q4 2006
Q1 2007
Q2 2007
Q3 2007
State Average
National Average
Target History
Target Path
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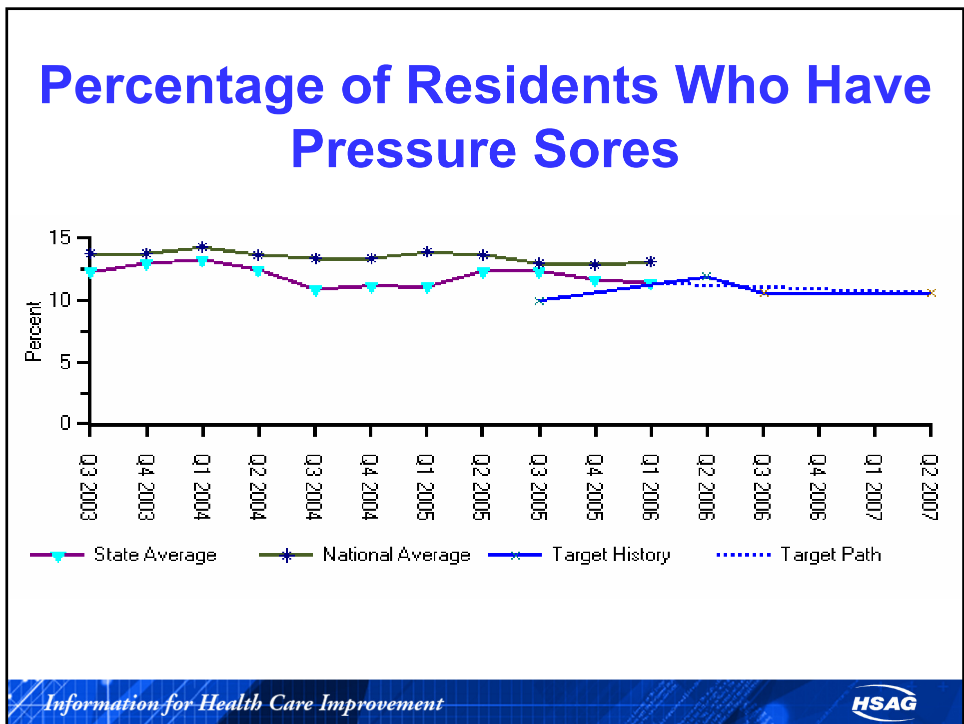
Percentage of Residents Who Have Pressure Sores
15
10
5
0
Percent
Q3 2003
Q4 2003
Q1 2004
Q2 2004
Q3 2004
Q4 2004
Q1 2005
Q2 2005
Q3 2005
Q4 2005
Q1 2006
Q2 2006
Q3 2006
Q4 2006
Q1 2007
Q2 2007
State Average
National Average
Target History
Target Path
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## Nursing Home Survey Climate In Arizona

- Ten Immediate Jeopardy (IJ) citations related to restraints and pressure ulcers in 2005
- Nine total IJ citations in the previous five years

Collins-Pagels, K., "AHCA Update"
December 23, 2005

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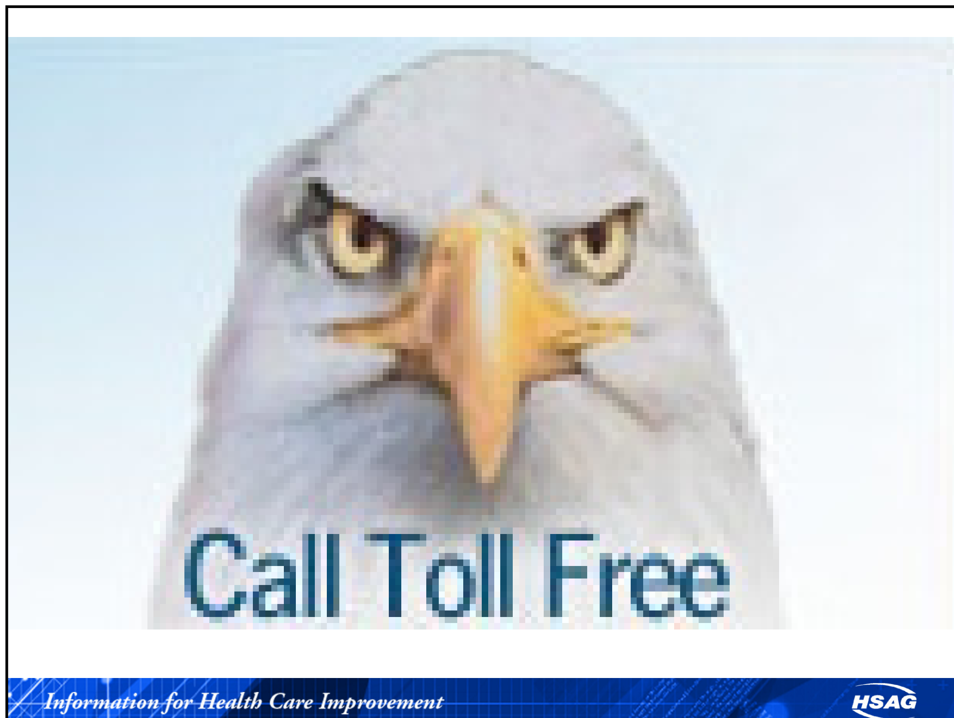


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Dangerous Drugs
Contraceptives
Vioxx
Celebrex
Bextra
COX-2 Inhibitors
Crestor
Zyprexa
Ephedra
Strattera
Remicade
Accutane
Serzone
Serevent
Tamoxifen
Permax
Anti-Depressants
OxyContin
Tysabri
Pemoline

Defective Medical Devices
Guidant Defibrillators
Guidant Ancure Device
Sulzer Hip Replacement

Toxic Substances
Welding Rods
Asbestos

**Nursing Home Negligence**
**Let us help evaluate your nursing home abuse or negligence claim**

After a fire broke out in a Nashville, Tennessee nursing home in September 2003, much attention was directed to the safety of the nursing home environment. It was discovered that the nursing home's residential area lacked sprinklers entirely. Yet such devastating events at nursing homes are often not the first sign of a compromised care environment for elderly extended family.

In fact, many injuries and incidents occur in nursing homes across the country. Nursing home abuse and neglect have become an all too common reality for some families. It is a serious problem affecting thousands of nursing home residents, complicated by the fact that abuse and neglect are often difficult to diagnose and are often covered-up by nursing home staff.

Abuse implies the maltreatment, misuse or wrongful treatment of a person; especially when in a compromised physical or mental state. Abuse includes: assault, battery, sexual assault, sexual battery, rape, unreasonable physical constraint, or prolonged or continual deprivation of food or water.

Neglect implies the negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care which a reasonable person in such a position would exercise. Nursing home neglect includes: Failure to provide medical care for physical (malnutrition) and mental health needs; failure to assist in personal hygiene, or in the provision of food, clothing, or shelter; and the failure to protect from health and safety hazards. See "Grading Nursing Homes," below.

Internet

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# Restraint Factoids

- July 15, 1992—FDA issues a safety alert regarding other restraints
  - Estimated 100 deaths annually associated with restraint usage
- From 1995 through 2001, the FDA received 381 entrapment reports of deaths, injuries, or near-misses involving bed rails*
  - 237 deaths, 73 injuries, and 71 near-misses

* **53 percent of the above events occurred in nursing homes**

Balistreri, S., "A Fresh Look at the Use of Side Rails as Restraints", 2005

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## Definition of a Restraint

## 483.13 Resident Behavior and Facility Practices

**F-Tag 221 Restraints**

"Physical Restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's own body.

Balistreri, S., "A Fresh Look at the Use of Side Rails as Restraints" 2005

# WARNING—Implementing Reductions in Side Rail Use!

"As with other restraints, for residents who are restrained by side rails, it is expected that the process facilities employ to reduce the use of side rails as restraints is systematic and gradual to ensure the resident's safety while treating the resident's medical symptom."

SOM, Appendix PP, Guidance to Surveyors, 483.13(a), Restraints

Balistreri, S., "A Fresh Look at the Use of Side Rails as Restraints" 2005

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# CMS Guidance to Surveyors

**F221-Restraints**

- Revised September 2000
- Included enhanced guidance regarding the use of side rails as restraints
- Same device may have effect of restraining one individual, but not another, depending on the individual resident's condition and circumstances
  - Partial rails may assist one resident to enter and exit the bed independently and act as a restraint for another (resident).

Balistreri, S., "A Fresh Look at the Use of Side Rails as Restraints", 2005

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# CMS Guidance to Surveyors

**F221-Restraints (continued)**

- Before a resident is restrained, the facility must determine the presence of a specific medical symptom that would require the use of restraints, and how the use of restraints would treat the medical symptom.
- Before using a device for mobility or transfer, assessment should include a review of the resident's bed mobility.

  -Ability to transfer between positions, to and from bed or chair, to stand and toilet (does proposed device increase risk to the resident?)

Balistreri, S., "A Fresh Look at the Use of Side Rails as Restraints", 2005

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# CMS Guidance to Surveyors

**F221-Restraints (continued)**

- The facility must design its interventions not only to minimize or eliminate the medical symptom, but also to identify and address any underlying problems causing the medical symptom.
- Surveyors are directed to determine if the facility follows a systematic process of evaluation and care planning
  – Are they attempting to eliminate the medical symptoms, or are the symptoms a failure to meet individual needs, use restorative care, provide meaningful activities, etc.?

Balistreri, S., "A Fresh Look at the Use of Side Rails as Restraints", 2005

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## Myths and Facts of Side Rail Usage

**Myth**

- Side rails are not restraints

**Fact**

Side rails can be:

- Restraints
- Mobility devices
- Both mobility devices and restraints

Balistreri, S., "A Fresh Look at the Use of Side Rails as Restraints", 2005

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## Myths and Facts of Side Rail Usage (continued)

**Myth**

- Side rails are a safe and effective means of preventing residents from falling out of bed

**Fact**

- "Residents who attempt to exit a bed through, between, over, or around side rails are at risk of injury or death. The potential for serious injury is more likely from a fall from a bed with raised side rails than from a fall where side rails are not used."

(SOM, Appendix PP, 483.13(a) Interpretive Guidelines)

Balistreri, S., "A Fresh Look at the Use of Side Rails as Restraints", 2005

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# Myths and Facts of Side Rail Usage (continued)

**Myth**

- Partial side rails are never restraints

**Fact**

- Partial rails may assist one resident to enter and exit the bed independently, while acting as a restraint for another (resident).

Balistreri, S., "A Fresh Look at the Use of Side Rails as Restraints", 2005

(SOM, Appendix PP, 483.13(a) Interpretive Guidelines)

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# Myths and Facts of Side Rail Usage (continued)

**Myth**

- Safe alternatives to side rails do not exist

**Fact**

Alternatives include:

- Low-height beds
- Pain management
- Floor mats
- Motion sensors
- Bed alarms
- Individualized toileting schedules
- Resident activity involvement

Balistreri, S., "A Fresh Look at the Use of Side Rails as Restraints", 2005

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## Side Rail Entrapment Zones

The FDA's release of: "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," provides recommendations for:

- Manufacturers of new hospital beds.
- Hospitals.
- Nursing homes.
- Private residences.

http://www.fda.gov/cdrh/beds/

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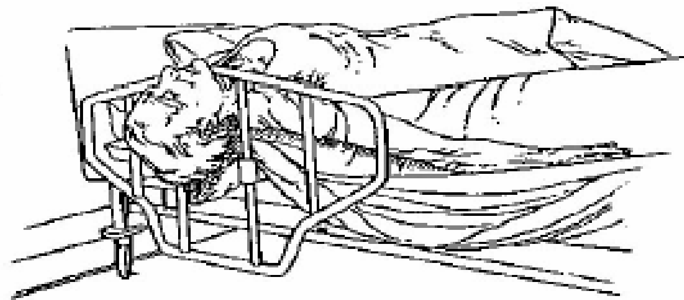
Zone 1 – Entrapment within the rail



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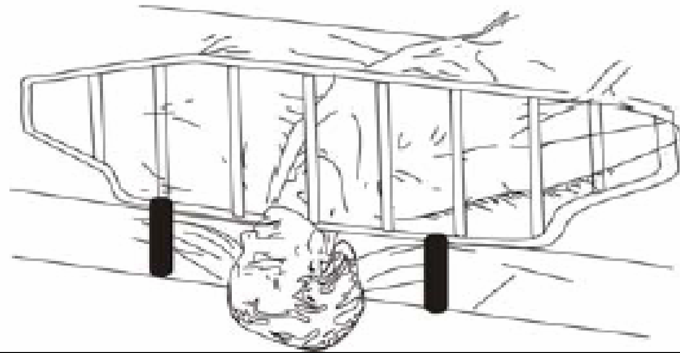
## Zone 2 – Entrapment between top of compressed mattress and the bottom of rail, between rail and supports



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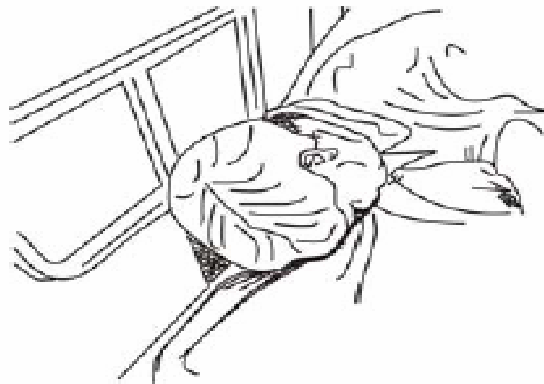
## Zone 3 – Entrapment in the space between the bedrail and mattress



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## Zone 4 – Entrapment between top of compressed mattress and bottom of rail at end of rail

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## Zone 5 – Entrapment between split rails

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## Zone 6 – Entrapment between the rail end and edge of head/foot board

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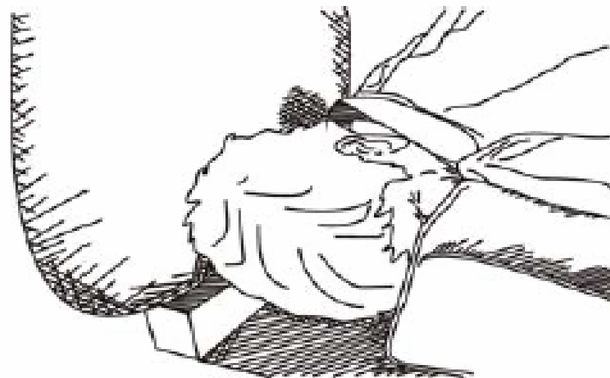
## Zone 7 – Entrapment between head or foot board and mattress



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## Restraint Thoughts

After 10 years of aggressive studies, researchers have come to the following conclusion:

**"There is no found evidence to support restraint use for fall prevention. Restraint usage has major, serious drawbacks and can contribute to serious life-threatening injuries."**

- American Geriatrics Society
- British Geriatrics Society
- American Academy of Orthopedic Surgeons
- *JAGS* May 2001-Vol. 49, No. 5

Kubala, D., "Developing A Plan To Reduce Restraint Usage", 2005

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## Getting Started

Staff awareness:

- Make the commitment: "Restraint-Free Environment"
- Identify the Restraint Team and their roles
- Purchase equipment: motion detectors, position pillows, hip protectors, low beds, floor pads, etc.
- Educate: staff, residents, families
- Get everyone involved—Call your peers today!!

Kubala, D., "Developing A Plan To Reduce Restraint Usage", 2005

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## Call to Action

- Complete a full-house “sweep”and identify all physical restraint devices used
- Develop documentation tools that will be utilized (least-restraining assessment)
- Use a systematic approach to reduction
- Care plan effective interventions
- CELEBRATE each step of the way!

Kubala, D., “Developing A Plan To Reduce Restraint Usage”, 2005

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## Pressure Ulcer Management in the Nursing Home

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## 483.25(c) Quality of Care

**F-Tag 314 Pressure Ulcers**

- "A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable."
- "A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing."

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## F-Tag 314 Pressure Ulcers

- F309—added language for skin ulcers/wounds
- F314—revised entire guidance to surveyors
- Protocol—revised old pressure ulcer protocol in Appendix P

Balistreri, S., "New Pressure Ulcer Guidelines", 2005

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## Intent of Regulation

Three elements:

- Promote prevention
- Promote healing of current ulcers
- Prevent development of additional ulcers

Balistreri, S., "New Pressure Ulcer Guidelines", 2005

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## Overview of Key Elements

Guideline Element

- Residents at risk can develop a pressure ulcer within 2–6 hours

Facility Practice Tip

- Identify residents at risk and provide prompt intervention
- Implement procedures for new admissions

Balistreri, S., "New Pressure Ulcer Guidelines", 2005

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## Overview of Key Elements (continued)

Guideline Element
- Significant number of pressure ulcers develop within four weeks after admission

Facility Practice Tip
- Implement aggressive procedures for new admissions

Balistreri, S., "New Pressure Ulcer Guidelines", 2005

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## Overview of Key Elements (continued)

Guideline Element

Assessments should

Address, at a minimum:
- Risk factors
- Pressure points
- Under-nutrition
- Hydration deficits
- Moisture on the skin

Facility Practice Tip
- Be sure your assessment tools/forms address the minimum requirements

Balistreri, S., "New Pressure Ulcer Guidelines", 2005

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## Overview of Key Elements (continued)

**Guideline Element**

- Repositioning every two hours may not be frequent enough
- Changing position—"off loading" hourly may be needed for those sitting or in bed/recliner with head at 30 degree angle

**Facility Practice Tip**

- Make each resident's plan specific to them
- The cookie-cutter approach is not necessarily going to work when it comes to pressure ulcer management

Balistreri, S., "New Pressure Ulcer Guidelines", 2005

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## Overview of Key Elements (continued)

**Guideline Element**

- Hydration is essential to maintain adequate body functions

**Facility Practice Tip**

- Look for any and all ways to keep residents hydrated

Balistreri, S., "New Pressure Ulcer Guidelines", 2005

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## Overview of Key Elements (continued)

Guideline Element

- Pain that hinders movement can contribute to pressure ulcer development
- An individual's report of pain is a generally valid indicator of pain

Facility Practice Tip

- Develop protocols regarding the assessment of pain
- Assess and treat pain before dressing changes
- Assess pain regularly. Don't wait for residents to ask—many won't ask!

Balistreri, S., "New Pressure Ulcer Guidelines", 2005

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## Overview of Key Elements (continued)

Guideline Element

- "If a pressure ulcer fails to show some evidence of progress toward healing within 2–4 weeks, the pressure ulcer and the resident's overall clinical condition should be reassessed."

Facility Practice Tip

- Set up a tickler system for pressure ulcers to trigger the reassessment—at two weeks, three weeks, or four weeks.

Balistreri, S., "New Pressure Ulcer Guidelines", 2005

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## How Can I Help Reduce Pressure Ulcers?

- Head-to-toe skin assessment at time of admission
- Complete Braden or Norton Plus skin risk assessment at time of admission
- Hardwire prevention in your organization's culture
- Relentless monitoring of skin integrity
- Create common care practices across the continuum

Balistreri, S., "New Pressure Ulcer Guidelines", 2005

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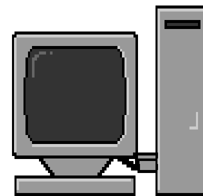
## Helpful Web Sites

Food and Drug Administration:
**http://www.fda.gov/cdrh/beds**

Quality Improvement Tools:
**http://www.medqic.org**



Health Services Advisory Group (HSAG):
**http://www.hsag.com**

Nursing Home Quality Initiative (NHQI) on HSAG:
**http://nhqi.hsag.com**

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## Acknowledgements

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## Questions?

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