

## PRACTICAL APPROACHES TO REDUCE RESTRAINTS

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*George is angry at his nurse, he was yelling and following her down the hall in his power wheelchair. The nurse turned around and turned off the power to his wheelchair, stranding him in the hallway and walked away. How could this situation be better managed? Would this classify as a restraint?*

Restraints are often applied to clients in mobility devices, out of a fear that without the restraint, the client may fall or injure themselves or others. Corfman et al<sup>1</sup> demonstrated that power mobility wheelchair users were less likely to be injured when traversing over obstacles if elevating leg rests and seatbelts were used. Fast et al<sup>2</sup>, also recommend the use of a lap belt when using a power wheelchair outdoors. Yet seatbelts or restraints may also endanger the client.<sup>3</sup>

### Definitions

The Ontario Ministry of Long Term Care has created a minimal restraint policy<sup>3</sup> for clients living in Long Term Care. This policy defines a number of terms which will form the basis of this discussion:

- A restraint is a device or chemical used to restrain a resident.
- To restrain is to place a resident under control by mechanical means, environmental means or by chemicals.
- A Personal Assistance Service Device is a physical or mechanical device designed to assist the resident with one or more activities of daily living as a byproduct of providing this assistance a PASD may restrict the resident's freedom of movement in some manner, but not all PASDs have a restraining quality. As result of the restraining quality, these devices may fall under the same criteria/legislation as restraints.<sup>3</sup>

### Staff Perspective

Physical restraints are often applied out of an attempt to reduce falls, or prevent other injuries. Unfortunately the application of a restraint may not prevent these injuries, or may increase the risk of injuries. At times, restraints may be applied as the staff may not be aware of other alternatives.

A series of education sessions is one way to help staff in care facilities explore the alternatives to restraints, and choose the approach best suited to the individual. Recommended objectives for these sessions include:

Participants in the session will:

- Assesses the causes that might lead to the need for restraints
- Discuss the importance of positioning and repositioning
- Identify the emotional impact of restraints on their resident
- Choose the approach most suitable to an individual client to promote their safety.

### Assessment and Options

The first step is to assess and understand the behavior leading to the perceived need for a restraint. Is it that the client is sliding? Are they trying to stand without the ability to do so? Is the client at risk of falling? Does the client wander?

One question to ask is; "who is the restraint for really?" Staff frustration ("this is the 4<sup>th</sup> time I've repositioned Mrs. Smith this hour") may mask the assessment of the underlying cause. Staff need to be encouraged to gain some distance from the situation and evaluate the potential cause and the

possible solutions. Restraints applied due to frustration are likely not the optimal approach to the client's behavior.

Key questions for staff to ask are:

- What are the relative risks (i.e. is the client at more risk with a restraint applied?)
- What is the underlying cause of the behavior?
  - Discomfort/pressure
  - Unable to reach/see a favorite thing
  - Boredom
  - Lack of comprehension/dementia
  - Personality conflict
  - Other concerns:
    - Have we done anything to increase the frequency of this behavior?
    - Has anything in the environment changed?
    - Has the staff significantly changed?

Once any underlying causes of the behavior have been examined, staff are in a better position to choose the approach that will promote the resident's safety while minimizing the use of restraints. The following table links the cause of the behavior with possible approaches/solutions.

Cause	Possible Solutions
<b>Poor positioning</b>	<ul style="list-style-type: none"> <li>• Ensure client is properly positioned in the wheelchair</li> <li>• Remove transfer slings and incontinence pads</li> <li>• Check that the client's seating system and wheelchair are assembled appropriately...i.e. is the cushion in the right way?</li> <li>• Assist the client to reposition regularly</li> <li>• Consider the need for staff training and education tools (see Appendix A – Keys to safer sitting, and Appendix B: Inflation of air cushions.</li> <li>• Consider the need for a seating assessment</li> </ul>
<b>Discomfort</b>	<ul style="list-style-type: none"> <li>• Consider changing the clients position</li> <li>• Ensure all surfaces are free from wrinkles</li> <li>• Ensure cushions and other equipment are appropriately positioned</li> <li>• Consider the amount of environmental stimulation (too much stimulation may cause agitation or an increase in concerning behavior)</li> </ul>
<b>Lack of comprehension, dementia leading to the resident trying to stand or wandering</b>	<ul style="list-style-type: none"> <li>• Distraction --can the client be engaged in another activity? Close supervision may still be required.</li> <li>• Make standing less "inviting" the use of a one way slide, calf pad, increasing the contour of the cushion, manual/fixed tilt, lowering the seat to floor height, or using some type of belt may make standing more difficult. Each of these approaches may increase other risks for the client and therefore must be considered carefully.</li> </ul>

### **When and how should we advocate for the use of a restraint?**

*Mary is a 76 year old woman with multiple CVAs. She has a history of pressure ulcers under her right ischial tuberosity. The Occupational Therapist has prescribed a manual tilt wheelchair, however staff refuse to use the tilt feature as it is considered a personal assistance service device, and limits her mobility. How would you handle this situation?*

Technically, tilting a client may restrict the client's movement or ability to propel the wheelchair and thereby be considered a restraint; however the total care plan of that client needs to be the focus. Implementing the use of manual tilt may improve the care of the client and help to treat the pressure ulcer. Staff need the education and support to be able to make these decisions.

### **Pondering Points**

- *What do you do when the caregivers and therapists/vendor have a different opinion regarding whether or not the client should have a restraint?*
- *Do Velcro seatbelts count as a restraint?*
- *Is the client more or less at risk with the use of a restraint?*
- *If the therapist recommends a restraint, and it is not used appropriately who is accountable if the client is injured?*

### **Summary and Recommendations**

Whenever a client demonstrates a behavior which puts themselves or others at risk, staff must consider the underlying factors contributing to that behavior and choose an appropriate approach. Regardless of which approach is chosen, the impact of that approach needs to be evaluated.

### **References**

1. Corfman TA, Cooper RA, Fitzgerald SG, Cooper R. Tips and Falls During Electric-Powered Wheelchair Driving: Effects of Seatbelt Use, Legrests, and Driving Speed. Archives of Physical Medicine and Rehabilitation. 2003; 84(12):1797.
2. Fast A, Sosner J, Begeman P, Thomas M, Drukman D. Forces, Moments, and Acceleration Acting on a Restrained Dummy during Simulation of Three Possible Accidents Involving a Wheelchair Negotiating a Curb: Comparison between Lap Belt and Four-Point Belt. American Journal of Physical Medicine Rehabilitation. 1997; 76(5):370.
3. Ontario Ministry of Health and Long Term Care. Policy: Least Restraints. Ontario: Ontario Ministry of Health and Long Term Care, November 2004

**Appendix A: Educational Resources**

**Keys to Safer Sitting<sup>(1)</sup>**

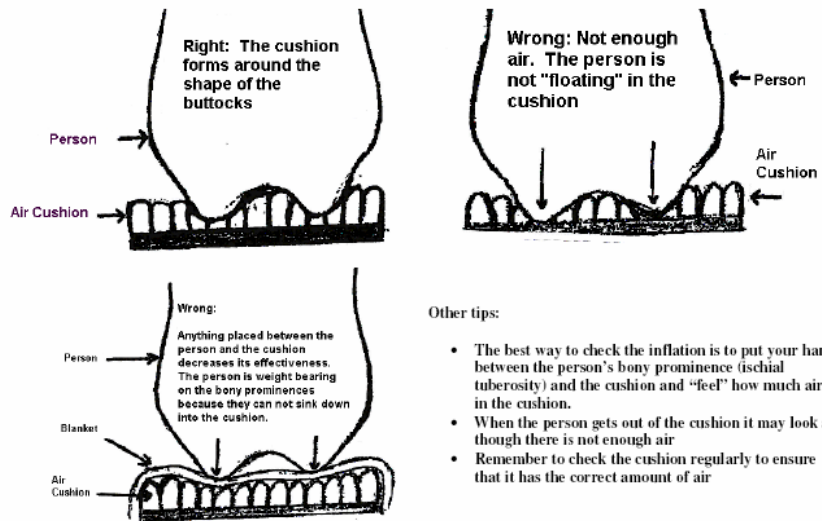
- ✓ All clients who spend time in a wheelchair should be evaluated by an Occupational or Physical therapist who is experienced in seating assessments
- ✓ Make sure the cushion is positioned correctly (contours facing up, pommel at the front etc)
- ✓ Make sure the cushion is properly maintained.
- ✓ Encourage the client to engage in weight shift behavior (i.e. lift off, shift from side to side, or lean forward etc).
- ✓ Seating should be **re-evaluated** by an Occupational or Physical Therapist for each client every 2 – 3 years or with any one of the following
  - Development of redness
  - Increased use of the wheelchair
  - Change in client's physical status
  - Client is unable to maintain an upright posture
  - Cushion appears worn, develops leaks, etc.

Adapted from:

1. Norton L, Sibbald RG. Is Bed Rest an Effective Treatment for Pressure Ulcers? *Ostomy Wound Management* 2004; 50(10):40-52

**Inflation of Air Cushions**

Concept: The person should be "floating" in the cushion not sitting "on top of" the cushion.



**Other tips:**

- The best way to check the inflation is to put your hand between the person's bony prominence (ischial tuberosity) and the cushion and "feel" how much air is in the cushion.
- When the person gets out of the cushion it may look as though there is not enough air
- Remember to check the cushion regularly to ensure that it has the correct amount of air

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