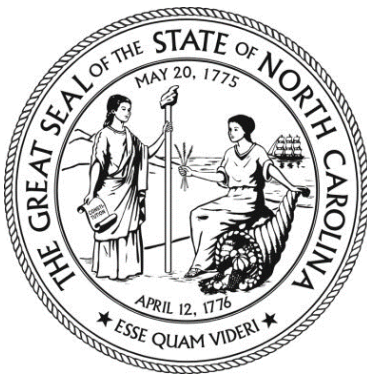


State-approved Curriculum Nurse Aide I Training Program

MODULE K Restraint Elimination, Reduction, Appropriate Use

Student Manual 2024 Version 2.0



NC DEPARTMENT OF **HEALTH AND HUMAN SERVICES**

Division of Health Service Regulation



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HUMAN SERVICES**



North Carolina Department of Health and Human Services
Division of Health Service Regulation
North Carolina Education and Credentialing Section

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Module K – Restraint Elimination, Reduction, Appropriate Use Definition List

Aspiration – breathing fluid, food, vomitus or an object into the lungs

Chemical Restraint – any drug that is used for discipline or convenience and not required to treat medical symptoms

Contracture – the lack of joint mobility caused by abnormal shortening of a muscle

Empathy – the ability to understand and share the feelings of another

Enabler – a device attached to the bed, similar to a short bedrail, that limits freedom of movement but is used to promote independence, comfort or safety

False imprisonment - unlawful restraint or restriction of resident's freedom of movement

Fracture – a broken bone

Pelvic Support – a physical restraint used between the thighs to keep a resident's hips from slipping forward

Physical Restraint – any manual method or physical or mechanical device, material, or equipment attached to or near the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body

Restraint – a physical or chemical way to restrict voluntary movement or behavior

Restraint Alternative – measures used instead of physical or chemical restraints

Restraint-free Care – an environment in which restraints are not kept or used for any reason

Seat Belt – a belt placed at a 45-degree angle over thighs when sitting to prevent falling from a chair or wheelchair

Soft Cloth Mitten – a physical restraint using a mitt that limits mobility of hands and use of fingers, frequently used for residents who could harm themselves by pulling at tubing, removing dressings, touching incisions or scratching a wound

Strangulation – the act of choking to death; serious or fatal obstruction of normal breathing

Vest or Jacket – a physical restraint put on the upper body to provide support in a wheelchair and limit mobility while in bed or in a chair

Wrist Restraint – a physical restraint that limits arm movement

Module K – Restraint Elimination, Reduction, Appropriate Use	
(S-1) Title Slide (S-2) Objectives <ol style="list-style-type: none"> 1. Understand the need for restraints and laws that regulate their use 2. Discuss Resident's Rights and the Nurse Aide's role 3. Identify alternatives to restraint use 4. Explore risks encountered from use of restraints 5. Discuss the use of different types of restraints used in health care 6. Discuss the importance of safe application and need for close observation 	
Content	Notes
(S-3) Restraints – Federal and State Laws <ul style="list-style-type: none"> • Federal and state laws are in place to protect residents • The accrediting agencies help oversee and enforce the laws <ul style="list-style-type: none"> – Code of Federal Regulations (CFR) – North Carolina Administrative Code – Centers for Medicare and Medicaid Services (CMS) – Food and Drug Administration (FDA) – The Joint Commission (TJA) – The Safe Medical Devices Act (SMDA) applies if a restraint causes illness, injury, or death 	
(S-4) Resident's Rights <ul style="list-style-type: none"> • The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms; per Federal Laws: CMS F604; F605. 42CFR483.10(e), 42CFR483.12(a)(2) • Unnecessary restraints are false imprisonment 	
(S-5) Restraint-free Care and Restraint Alternatives <ul style="list-style-type: none"> • Restraint-free care – an environment in which restraints are not kept or used for any reason • Restraint alternative – measures used instead of physical or chemical restraints 	
(S-6) Facility Restraints Practices <ul style="list-style-type: none"> • Facilities may unintentionally use methods to help ensure resident safety which may be viewed as restraints • It is important to recognize items that can restrict residents and prevent them from being mobile • Communicate concerns to the nurse in a professional manner • Consider the use of: <ul style="list-style-type: none"> – Over-bed table – placed across a resident sitting in a chair or wheelchair – Sheets - placed around and under a resident – Geri-chair 	

Module K – Restraint Elimination, Reduction, Appropriate Use	
<ul style="list-style-type: none"> — Wheelchair locked – when the resident is unable to unlock it 	
<p>(S-7) Facility Restraint Practices (2)</p> <ul style="list-style-type: none"> • Facilities have practices that are considered forms of restraints • Side rails - used to keep resident from voluntarily getting out of bed • Tucking in or using Velcro to hold a sheet, fabric, or clothing tightly is used to restrict a resident's movement • Placing a resident in a chair (such as a Geri-chair/recliner) to prevent from rising • Placing a chair or bed so close to a wall that the wall prevents the resident from rising out of the chair or voluntarily getting out of bed • Placing a walker out of reach to discourage the resident independence • Be aware of ways residents may be restrained 	
<p>(S-8) Restraints – Understanding the Need</p> <ul style="list-style-type: none"> • Communicate, explore, observe and inquire about the resident's current and past medical history to gain understanding of the need for restraints • Consider how the following may influence the decision for use of restraints: <ul style="list-style-type: none"> — Pain, mental or physical impairments, injury, discomfort — Uncomfortable clothing, wound dressings, body positioning — Anger/Loss of control — Fear of environment, family members, caregivers, self-image, death — Phobias, obsessions — Sleep disorders — Confusion, disorientation — Hunger, thirst, temperature changes 	
<p>(S-9) Restraints – Criteria for Use</p> <ul style="list-style-type: none"> • Restraints must protect the person • A doctor's order is required • Restraints are used only in the event other measures fail to protect the resident • The least restrictive method is used • Informed consent is required from the resident or designated legal representative • Residents' vital signs, respiratory and hydration status must be monitored 	

Module K – Restraint Elimination, Reduction, Appropriate Use	
<p>(S-10) Restraints – Risks</p> <ul style="list-style-type: none"> • The use of restraints may result in health risks or injuries to the resident: <ul style="list-style-type: none"> – Cuts, bruises, skin tears, skin breakdown, pressure ulcers and fractures – Aspiration – Death from strangulation – Dehydration, constipation, incontinence – Contractures, decreased ability to walk – Infections such as pneumonia and urinary tract infection – Swelling (edema) in limbs, nerve damage – Mental health issues may include agitation, anger, delirium, depression, reduced social contact, withdrawal – Self-esteem issues may include embarrassment, humiliation, loss of dignity, confidence and self-worth 	
<p>(S-11) Types of Restraints</p> <ul style="list-style-type: none"> • Chemical, physical or mechanical methods used to restrict freedom of movement or normal access to one's body <ul style="list-style-type: none"> – Chemical: drugs or drug doses used to control behavior or restrict movement – Physical: any manual method, physical or mechanical device, material or equipment attached to or near an individual that cannot be removed easily and restricts freedom of movement or normal access to one's body <ul style="list-style-type: none"> ○ Cloth or leather ○ Soft cloth or mesh is used most often ○ Leather is used for extreme agitation and combativeness and is applied to wrists and ankles 	
<p>(S-12) Restraints – Nurse Aide's Role (1)</p> <ul style="list-style-type: none"> • Follow the Nursing Care Plan • Whenever possible, schedule care to align with the resident's past routines, likes and preferences • Consider the resident's needs based on Maslow's Hierarchy of Needs 	
<p>(S-13) Restraints – Nurse Aide's Role (2)</p> <ul style="list-style-type: none"> • Nutrition, elimination, breathing, sleep, exercise <ul style="list-style-type: none"> – Take time with meals, encourage fluids – Assist to the bathroom, encourage self-hygiene, place bedpan or urinal within reach – Allow time for bathing, back rubs and grooming 	

Module K – Restraint Elimination, Reduction, Appropriate Use	
<ul style="list-style-type: none"> — Make the bed comfortable, position pillows, provide warmth — Remove unwanted items from overbed/bedside table — Place items at arm's reach whenever possible — Reduce or eliminate noise, odors, other distractions 	
<p>(S-14) Restraints – Nurse Aide's Role (3)</p> <ul style="list-style-type: none"> • Safety and security <ul style="list-style-type: none"> — Observe, visit and check on the resident every 15 minutes or more often, per Nursing Care Plan — Position bed at lowest height, lock wheels — Place floor cushions next to bed, when applicable — Remove or relocate furniture with sharp corners — Provide or eliminate lighting to promote sleep — Place call bell within reach and respond promptly — Be attentive to the resident's fears/reaction to people, places or things — Report accurately and promptly concerns seen, heard, and communicated by the resident or others 	
<p>(S-15) Restraints – Nurse Aide's role (4)</p> <ul style="list-style-type: none"> • Love and belonging <ul style="list-style-type: none"> — Spend time with the resident, encourage pleasant conversation, walk with the resident — Provide diversion – TV, literature, books, videos, games — Encourage visits from family, friends and clergy • Self-esteem and Self-actualization <ul style="list-style-type: none"> — Encourage, compliment and reassure the resident 	
<p>(S-16) Restraints – Safety Guidelines</p> <ul style="list-style-type: none"> • Resident safety is the highest priority • Restraints must be applied properly <ul style="list-style-type: none"> — Check size and condition of restraint (must be free from defect) — Ensure the restraint fastens correctly and securely — Secure straps out of the resident's reach, under the seat or wheelchair — Secure the restraint to movable parts of the bed frame so it does not tighten or loosen when the head or foot is raised or lowered 	
<p>(S-17) Restraints – Safe Application</p> <ul style="list-style-type: none"> • Follow manufacturer's directions and the facility's policies and training • Leave 1 to 2 inches of slack in the straps to allow some movement of the part, unless instructed otherwise • Pad bony areas as instructed by the nurse to prevent pressure and injury • Observe the resident closely - every 15 minutes or as directed by the Nursing Care Plan 	

Module K – Restraint Elimination, Reduction, Appropriate Use	
<p>(S-18) Recording Time</p> <ul style="list-style-type: none"> Remove/release the restraint, reposition the resident and attend to their basic needs (food, water, elimination, comfort, safety, hygiene and skin care) at least every 2 hours for at least 10 minutes, or as often as directed in the Nursing Care Plan Monitor vital signs and perform range of motion (ROM) at intervals per the Nursing Care Plan 	
<p>(S-19) Restraints – Observe, Report and Act</p> <ul style="list-style-type: none"> Report observations and communication accurately Report to the nurse every time you check the resident and release the restraint Keep scissors with you at all times, in case the resident's safety is compromised as in choking, aspiration, strangulation, seizures or other emergencies Place the call light within the resident's reach at all times 	
<p>(S-20) Remember</p> <ul style="list-style-type: none"> Restraints are NEVER used as a convenience for the nursing staff or as an act of discipline/punishment Unnecessary restraint (physical, mechanical, chemical) is considered false imprisonment (unlawful restraint or restriction of resident's freedom of movement) Restraints are used as a last resort intended to protect the welfare and safety of the resident and others Restraints require a doctor's order Always ask for clarification before applying a restraint Practice patience, show kindness and be empathetic to residents who are restrained 	

Module K – Handout #K5

Restraint Definition: "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that he cannot remove easily which restricts freedom of movement or normal access to one's body."

The following information suggests ideas for reducing physical restraint use.

A carefully monitored use of the alternatives with frequent reassessment is suggested.

General Principles	<ul style="list-style-type: none"> ✓ Play to the resident's strengths. ✓ "Apply the 5 Magic Tools (Knowing what the resident likes to See, Smell, Touch, Taste, Hear)." ✓ Be calm and self-assured. ✓ "Use pets, children and volunteers." ✓ Distraction based upon their work/career. 	<ul style="list-style-type: none"> ✓ Provide for a sense of security. ✓ Know the resident's agenda. ✓ Encourage Independence. ✓ Involve the family - give them a task. ✓ Offer choices.
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Behavior/Medical Condition	Therapeutic Intervention	Environmental & Equipment Intervention
Sliding or leaning out of chair or bed	<ul style="list-style-type: none"> ✓ Evaluate medications that may produce lethargy or sluggishness. ✓ Increased visual monitoring. ✓ "Evaluate physical needs such as toileting, comfort, pain." ✓ Evaluate pain level. ✓ Evaluate sleep pattern. ✓ Place resident in bed when fatigued. ✓ Evaluate for a Restorative Program. ✓ PT/OT referral for screening. ✓ "Place the resident at the nurses station when not in activities, etc." ✓ Periodic exercise program throughout the day. ✓ Wheelchair/Chair pushups. ✓ Activities to assess. ✓ Encourage repositioning frequently. 	<ul style="list-style-type: none"> ✓ "Assistive devices (wedge cushion, 1/2 lap tray, solid seat for w/c, side or trunk bolsters, pommel cushion, dycem, etc.)." ✓ Appropriate size chair & proper fit. ✓ "Alternative seating such as Adirondack chair, high back chair." ✓ "Bean bag chair, reclining W/C, Non wheeled chairs, Wing back chair." ✓ Call bell in reach. ✓ Over bed table for providing diversional activities. ✓ Water pitcher in reach. ✓ Chair/bed alarm(s). ✓ Mat on the floor.

Behavior/Medical Condition	Therapeutic Intervention	Environmental & Equipment Intervention
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Unsafe Mobility Unsteady Gait	<ul style="list-style-type: none"> ✓ Evaluate medications that may produce gait disturbances. ✓ Evaluate for orthostatic hypertension and change positions slowly. ✓ Evaluate visual system and proper correction of eye glasses. ✓ Evaluate vestibular system - making sure ears are clear & balance system is intact. ✓ Reevaluate physical needs such as toileting program, comfort, pain. ✓ Exercise peddles while sitting. ✓ Generalized activity programs. ✓ Ambulation and/or exercise programs. ✓ Group ambulation and/or accompanied walks in or out of doors. ✓ 1:1 visitations. ✓ Encourage repositioning frequently. ✓ Identify customary routines (late sleepers and early risers) and allow for preferences. ✓ Evaluate for a restorative program. ✓ PT/OT referral for screening. 	<ul style="list-style-type: none"> ✓ Evaluate for proper fitting and appropriate condition of footwear. ✓ Non-skid socks. ✓ Evaluate ambulation devices for good working condition. ✓ Adequate lighting, especially at night. ✓ Remove wheeled furniture used for support. ✓ Bed lowered so resident can touch toes to the floor. ✓ Place glasses on daily to enhance visual acuity. ✓ Call bell in reach at all times. ✓ Evaluate need for bedside commode at night. ✓ Avoid use of throw rugs. ✓ Floor alarm. ✓ Motion detectors. ✓ Bed &/or chair alarms. ✓ Hip protectors. ✓ Merry Walker - fade use as strength increases.
Falling/Climbing Out of Bed	<ul style="list-style-type: none"> ✓ Evaluate medications that may produce gait or balance disturbances. ✓ Evaluate for orthostatic hypotension and change positions slowly. ✓ Reevaluate physical needs such as toileting, comfort, pain, thirst & timing of needs. ✓ Provide h.s. snack. ✓ 1:1 conversation. ✓ Touch if appropriate while recognizing personal body space. ✓ Anticipate customary schedules and accommodate personal preferences. ✓ Evaluate balance for sub-clinical disturbances such as inner ear infections. ✓ Validate feelings and mobilize the patient/resident. For instance "I want to get up." - - "You want to get up?" - - then get the patient/resident up. ✓ Evaluate hearing and vision. ✓ Evaluate for appropriate shoes/foot apparel. ✓ Evaluate for appropriate size and length of clothing. 	<ul style="list-style-type: none"> ✓ Low bed. ✓ Remove siderails. ✓ Put mat on floor at bed side. ✓ Bed or chair alarm. ✓ Evaluate accessibility of call lights. ✓ Nightlight. ✓ Visual cues for staff on the patient's/resident's door to identify patients/residents at risk for falling. ✓ Scoop mattress. ✓ Evaluate physical environment for excessive furniture, cluttered hallways, rooms. ✓ Visual cues to direct to toilet, use of gait devices, use call bell. ✓ Light, protective headgear. ✓ Use a trapeze for bed mobility.

Behavior/Medical Condition	Therapeutic Intervention	Environmental & Equipment Intervention
	<ul style="list-style-type: none"> ✓ Check blood sugar levels. ✓ Evaluate sleep/wake patterns. ✓ Evaluate for a Restorative Program. ✓ PT/OT referral for screening. 	
Verbally Abusive Physically Abusive	<ul style="list-style-type: none"> ✓ Begin with medical evaluation to rule out physical or medication problems. ✓ Evaluate for acute medical conditions such as UTI, URI, ear infections or other infections processes. ✓ Evaluate for pain, comfort and/or other physical needs such as hunger, thirst, position changes, bowel and bladder urges. ✓ Attempt to identify triggering events or issues that stimulate the behavior. ✓ Consider using behavior tracking form to assist in identification of triggers trending patterns. ✓ Consult with family regarding past coping mechanisms that proved effective during times of increased stress levels. ✓ Provide companionship. ✓ Validate feelings such as saying "You sound like you are angry." ✓ Redirect. ✓ Active listening. Address potential issues identified. ✓ Set limits. ✓ Develop trust by assigning consistent caregivers whenever possible. ✓ Avoid confrontation. Staff to decrease voice levels. ✓ Approach in calm/quiet demeanor. ✓ Provide rest periods. ✓ Social Services referral. ✓ Psychologist/Psychiatrist referral. ✓ Touch therapy and/or massage (hand or back). ✓ Reduce external stimuli (overhead paging, TV, radio noise, etc.). ✓ Evaluate staffing patterns/trends. ✓ Evaluate sleep/wake patterns. ✓ Maintain regular schedule. ✓ Limit caffeine. ✓ Punching bag. ✓ Avoid sensory overload. 	<ul style="list-style-type: none"> ✓ Relaxation techniques (tapes, videos, music etc.). ✓ Theme/Memory/Reminiscence Boxes/Books. ✓ Magnification box to create awareness of the patient's/resident's voice level and provide feedback. ✓ Lava lamp, soothe sounders, active mobile. ✓ Tapes of family and/or familiar relatives or friends. ✓ Move to a quiet area, possibly a more familiar area. Decrease external stimuli. ✓ Fish tanks.

Behavior/Medical Condition	Therapeutic Intervention	Environmental & Equipment Intervention
Pacing/ Wandering At Risk for Elopement	<ul style="list-style-type: none"> ✓ Find ways to meet resident's/patient's needs to be needed, loved, busy while being sensitive to their personal space. ✓ Diversional activities that correspond with past lifestyles/preferences. ✓ Consider how medications, Dx, ADL schedule, weather, or other patients/residents effect or relate to wandering. ✓ Evaluate need for a "Day Treatment Program" for targeted residents. ✓ Theme/Memory/Reminiscence Boxes. ✓ Companionship. ✓ Provide opportunities for exercise particularly when waiting. ✓ Pre-meal activities. ✓ Singing, rhythmic movements, dancing, etc. ✓ Identify customary routines and allow for preferences. ✓ Photo collage or album of memorable events. ✓ Structured high energy activity and subsequent relaxation activities. ✓ Alternate rest and activity periods. ✓ Distraction/redirection. ✓ Written/verbal reassurance about where he/she is and why. ✓ Alleviate fears. ✓ Ask permission before you touch, hug etc. ✓ Assess/Evaluate if there is a pattern in the pacing or wandering. ✓ Assess for patients/residents personal agenda and validate behaviors. ✓ Ask family to record reassuring message on tape. ✓ Evaluate for a Restorative Program. ✓ Perform physical workout. 	<ul style="list-style-type: none"> ✓ Remove objects that remind the patient/resident of going home (hats, coats, etc.). ✓ Individualize the environment. Make it homelike. Provide familiar objects. ✓ Large numerical clock at bedside to provide orientation to time of day as it relates to customary routines. ✓ Safe courtyard. ✓ Decrease noise level (esp. overhead paging at h.s.). ✓ Door guards, barrier stripes. ✓ Warning bells above the doors to alert staff of attempted elopement. ✓ Camouflaging of doors. ✓ Visual cues to identify safe areas. ✓ Cover door knobs. ✓ Put mirror at exits. ✓ "Stop" and "Go" signs. ✓ Wanderguard system. ✓ Relaxation tapes. ✓ Visual barriers, murals. ✓ Wandering paths. ✓ Room identifiers. ✓ Rest areas in halls. ✓ Floor patterns.