

WHEELCHAIR RESTRAINT REDUCTION:

How Seating Professionals Can Meet Federal Mandates While Providing Appropriate Intervention

What are Wheelchair Restraints and Why the Need for Regulation?

What do you think of when you hear the word restraint for wheelchairs? I think of the device pictured on this gentleman who looks like he is tied to the wheelchair (*see Picture 1*). In essence, he is. This restraint is a diaper shaped piece of webbing which is placed between the person's legs with a portion in front of the person's stomach and the other half behind his buttocks. The straps are tied to the wheelchair. The purpose of this restraint is to keep him from getting out of the wheelchair. These restraints were prominent in the '60s and '70s and used to prevent the person from wandering away or falling. Although the intent may have been good, the result was anything but. Besides the degradation of being tied to the wheelchair in such a way, many individuals became agitated, hurt themselves, and some even died in the process of trying to get out. Documented problems attributed to the use of restraints include chronic constipation, incontinence, pressure sores, emotional problems, isolation and loss of ability to walk or perform other activities (*Atlanta Legal Aid Society*).

One of the major manufacturers of these devices is the Posey Company. Just as Kleenex became synonymous for a tissue, Posey became synonymous for this type of restraint. In fact, it was not unusual for a long-term care staff member to call out for someone to get a "Posey" or that someone needed to be "Posied" in their wheelchair. What was once given to any individual who was unruly or cognitively impaired in an effort to prevent unwanted behavior, these devices are now the last resort for patient safety when using a wheelchair. The Posey Company exists today and continues to make similar pelvic restraints, however, they are advocates for restraint reduction, make hundreds of other products which encourage independent movement, and offer courses in restraint reduction and safety in nursing homes (*see Picture 2*) (*Posey*).

Restraining individuals either physically or chemically (by drugging them into sedation) was a common method of keeping someone with dementia safely in a wheelchair or bed in the past. It is now very much agreed upon that such practices took away a person's dignity and rights. The Omnibus Budget Reconciliation Act (OBRA) mandate was passed by President Reagan in 1987. It recognized the detrimental effects of physical and chemical restraints and focused on increasing quality of life and practicing restraint reduction. Each state has state survey guidelines for long-term care. One aspect of the survey is to ascertain that there is a restraint reduction plan in place and that each person using any type of restraint has a physician order and consent from

the individual or guardian who is regularly monitored.

Restraints for wheelchairs include any form of strapping such as pelvic belts, anterior trunk supports, ankle and foot straps, and arm cuffs. Restraints also include anything that would impede someone from getting out of their wheelchair, such as trays or arm positioners, wedge or anti-thrust cushions, medial thigh supports, tilt or recliner wheelchairs, or anything that would prevent or impede voluntary movement up and out of the wheelchair. Even if the intended use of the device is not restraint, these interventions may still be considered restraints under certain regulations.

Complex Seating: Compliance with Regulations

As non-ambulatory individuals living in long-term care facilities began to receive complex seating

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systems and wheelchairs, concern about meeting the restraint reduction mandates grew. While most seating practitioners would not consider the equipment they recommend a restraint, the parameters of the OBRA mandate may include these devices.

The restraint reduction practice in long-term care or residential facilities is primarily for individuals with dementia who can walk, however, it is also considered for non-ambulatory wheelchair users, keeping in mind that all individuals should have the least restrictive device available to meet his or her needs.

Kathleen D. Weissberg is an occupational therapist with extensive experience working in long-term care facilities. She provides continuing education to long-term care practitioners throughout the country about restraint reduction and its benefits while following federal regulations. Weissberg states that the individual living in a long-term care or residential facility has the “right to be free from any physical or chemical restraint imposed for the purposes of discipline or convenience and not required to treat the person’s medical symptoms” (*Weissberg*).

Most administrators will acknowledge that Complex Rehab Technology is most likely recommended due to medical reasons rather than as a restraint. In some cases, a diagnosis and statement that the equipment is necessary for medical reasons is enough documentation. Other administrators will refer to the restraint reduction compliance regulation as a necessary avenue to assure that the physician, resident

and legal representatives are in agreement with the recommendations, and therefore follow the documentation requirements of anyone living in the facility. While reduction of the complex rehab seating equipment considered a restraint may not be a goal, agreement between all parties to use the equipment is mandatory.

According to Weissberg, the following must be documented:

1. If the individual using the device wants the device.
2. All the risks and benefits of the equipment.
3. The therapeutic intervention to enable or promote functional independence.
4. The reason why the particular device is the least restrictive for this particular person.
5. The restraint or supportive device needs to be justified in the care plan.

The following is an example of a situation requiring compliance to restraint regulations. John Jones is a 65-year-old male with spastic quadriplegia resulting from cerebral palsy. He is using a power wheelchair with a power tilt that is operated through a right handed joystick. His seating system consists of a molded seat cushion, molded back support and headrest. A pelvic belt is attached to the seat rail at an 85 degree angle superior to his thighs in front of his pelvis. Jones is unable to release the belt independently. However, it stabilizes him in the wheelchair, preventing him from sliding forward or thrusting outward during functional activities with his UEs. It is the least restrictive device because without it, he would not be able to maintain his functional posture in the wheelchair. John is his own guardian and his sister is power of attorney, if Jones should need one. Jones wants to use the pelvic belt whenever he is in the wheelchair. Jones, his sister and his physician agree it is beneficial to have the pelvic belt and sign an agreement form every quarter as is required by the state. Jones prefers to be in the wheelchair when he is out of bed due to the opportunity for independent mobility. He changes position through the seat functions on his wheelchair and does this as needed throughout the day.

Weissberg also states that even if a wheelchair and seating system is appropriate, there has to be some off time to allow freedom of movement or a change in position. The only alternative might be resting in bed, but if other sitting or standing opportunities are available and safe, it is strongly recommended that the person be allowed to change position. This parallels recommendations by Complex Rehab Technology professionals and seating literature stating that alternative positioning opportunities are recommended. Mandatory regulation assures the person has opportunity to change positions as is practical.

Restraint regulations might also provide justification for higher end products that would allow the person to remove the perceived barrier. For instance, a hinged desk style arm support for someone with hemiplegia may allow the person to independently flip up the support to get it out of the way

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during a transfer. Easy to release pelvic belt buckles might be recommended to allow the person to independently remove a belt. Removable or flip-up armrests might be recommended to allow a person to transfer more easily.

Administrators in long-term care settings, as well as state surveyors, are becoming more aware of individuals living in residential facilities who use complex rehabilitation equipment. It is the seating professional who must continue to educate administrators, nurses, therapists, direct care staff, and surveyors about the beneficial use of the equipment while fulfilling the documentation and regulatory requirements concerning products which might be considered restraints. The justification for an open seat to back angle, superior thigh belt, medial thigh support, or tilt wheelchair should be provided in a way anyone can understand. Pictures of the wheelchair seating system in use can be very helpful.

The Seating Professional's Role in Restraint Reduction for the Elderly person with Dementia Who Ambulates An Opinion

I have had the opportunity to see what type of products are used as restraints or as part of the restraint reduction program for people living in long-term care facilities who ambulate and have dementia. Often times, the products are purchased by administrators who have little or no involvement with a seating professional. Some of the products are therefore being used without considering physical and functional abilities. Therapists working in long-term care facilities may not see wheelchair seating as their role, especially for individuals who can ambulate. I am hoping this is beginning to change and see the role of seating professionals as educators and mentors to those serving this population. As the experts in wheelchair seating who dedicate ourselves to learning about new products and sharing evidence and experience in seating intervention, I feel we need to help people working in long term care facilities.

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PICTURE 1



PICTURE 2



PICTURE 3



PICTURE 4



PICTURE 5



PICTURE 6



PICTURE 7



PICTURE 8

PICTURE 1. 1995 use of restraint. Person living in long term care center requiring seating intervention.

PICTURE 2. 2014 Posey Breezeline Pelvic Holder.

PICTURE 3. Posey Soft strap. This strap is softer than a webbing strap and the individual may be able to release it more easily, however, placement might allow the pelvis to slide forward into a posterior pelvic tilt. Note there is no cushion on the wheelchair, which is not recommended by seating professionals.

PICTURE 4. When issuing a wedge cushion to prevent an ambulatory person with dementia from getting out of the chair, an evaluation should be performed to assure that the person has the hamstring range for this decreased seat to back angle.

PICTURE 5. Skil Reclining back with webbing strap as attachment. This allows for a more open seat to back angle, however, the uprights of the chair may interfere with UE function or rub against the shoulders.

PICTURES 6 & 7. The Posey self-releasing huggie or lap huggie for wheelchair desk arms are provided to discourage individuals from getting out of the wheelchair.

PICTURE 8. Invacare Geri chair.

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Demonstrating the need for a proper evaluation with measurements of range limitations allows the participants to understand why equipment needs to be customized for the user and why one solution may not work for someone else.

Certain products are intentionally used as restraints and are designed to fit within restraint regulations. Unfortunately, these products can have a negative impact on posture.

Belts or strapping - Belts or strapping can be easily removed by the individual. While this may provide independence in removing the strap, the placement is often questionable. Many times strapping or belts are in the abdominal region (with potential to cause soft tissue injury) or at an angle that allows the person to slide forward into a posterior tilt or under the strap (*see Picture 3*).

Wedge seat cushions - A wedge style cushion is a common alternative to a pelvic/hip belt and is designed to prevent someone from getting out of a wheelchair. Seating professionals may find the angle promoted by a wedge of this size a little extreme. Before using a wedge cushion, it is essential to determine if the person has adequate range of motion. If the person has tight hamstrings, a wedge is contraindicated and could lead to a posterior pelvic tilt. Many aging individuals tend to have tight hamstrings, often addressed by increasing the seat-to-back angle rather than decreasing it the way a wedge does (*see Picture 4*).

Recliner back - When an individual does need a greater than 90 degree seat-to-back angle, rather than opening the seat-to-back angle on the frame or using a reclining wheelchair, a foam and

vinyl back may be attached to the back canes with webbing which opens the seat to back angle. This is typically a cost saving measure, rather than an attempt to circumvent restraint regulations. The back may provide enough of a seat-to-back angle opening to accommodate the person's needs (i.e. fixed kyphosis). However, the client may not fit between the back canes (*see Picture 5*).

Elevating leg rests - Elevating leg rests have been used to keep someone in the wheelchair, rather than accommodate postural needs or range limitations. These can be removed or swung to the side on a regular basis to allow for freedom of movement and to allow the client to get out of the chair while supervised. A common problem with using elevating leg rests, as we know, is that the person may have tight hamstrings, limiting the available range of motion at the knees.

Trays - The foam style tray is very popular as a method to keep someone from getting out of the wheelchair, avoiding use of strapping. It is designed to release when squeezed (*see Pictures 6 and 7*). This obviously does not impact posture with the exception of supporting the arms.

Geri chairs - In a 2011 article, Eleanor Barbera, Ph.D., states, "The residents in geri-recliners are the dorks of the nursing home." The geri chair is still commonly used to provide seating in long-term care facilities and is difficult to get out of. It is hard to understand how these can be seen as comfortable or accommodating to a person's body. Geri chairs are often difficult to maneuver, take up extra room in the elevator (thus reducing the chance of being transported to activities), and make it virtually impossible for residents to go out on pass with their families to enjoy a meal at home or in a restaurant if another mobility base is not available. Additionally, people tend to assume residents in geri-recliners aren't "with it." The seating professional would note that the vinyl covered foam is often hard and unforgiving. The seat depth is usually very long, causing the person to be pulled into a posterior pelvic tilt. The knee angle is never less than 90 degrees, often pulling on tight hamstrings. Obviously, there is no opportunity for self-propulsion (*see Picture 8*).

My question is often, "how about providing the people who are ambulatory but may fall or wander when not supervised an opportunity

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to sit in a wheelchair and propel themselves?” This doesn’t seem to be an option in any of the solutions to restraint reduction I read. It would seem that rather than frustrate someone who may need to move, providing a means of safe self-propulsion rather than a geri chair might be one solution.

This article is not meant to justify complex seating intervention, as it is expected the seating specialist is aware of the benefits of optimal seating. Several articles and books are available for someone wanting to learn more about seating intervention and its benefits. This article is meant to explain that the OBRA mandate was meant to recognize the rights of individuals living in long-term care facilities and provide for freedom of choice while maintaining safety. While we advocate for the most optimal form of seating intervention, federal regulations and mandates must be followed in applicable settings. Documentation and education is critical to ensure complex seating is allowed in long-term care facilities while providing the individual using the equipment the opportunity to use the least restrictive seating to meet their needs and alternative positions outside of the wheelchair. The article also touches upon devices being recommended in nursing homes to prevent individuals from falling when supervision is not consistently available. Proper use of these devices may be overlooked due to lack of education and understanding of seating principles. As seating professionals we can reach out to people working and living in these facilities to ensure optimal interventions.

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