



Restraints: The Last Resort

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She was among the first group of nurses certified in Nursing Professional Development in 1992. She is a charter member of the National Nursing Staff Development Organization (NNSDO), served as its membership chairperson for 10 years, and currently chairs the Products & Services Committee. She is a member of the ANCC Content Expert Panel for Nursing Professional Development and is a board member of the National Board for Certification of Hospice and Palliative Nurses. She serves on the editorial board of The Journal of Continuing Education in Nursing.

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Purpose

The purpose of this continuing education course is to provide nurses with the knowledge they need to safely care for patients without the use of restraints, and safely and effectively care for those patients who are restrained.

Information about types of restraints and about seclusion, knowing when to use restraints, and the risks associated with restraints will be discussed. Interventions for restraint-free care will also be explored. Restraint criteria and standards from the Centers for Medicare and Medicaid Services (CMS) and the Joint Commission (TJC) will be discussed in detail. Additionally, documentation requirements regarding restraint use will be reviewed.

Objectives

After successful completion of this course, you will be able to:

1. Define physical restraints, chemical restraints, and seclusion.
2. Explain reasons for limiting the use of restraint or seclusion.
3. Identify interventions for restraint-free care in acute care and long-term care settings.
4. Identify risk factors and preventive strategies associated with restraint-related injuries and deaths.
5. Explain safe care and monitoring for the patient who is restrained or secluded.
6. Explain Joint Commission Standards related to restraints and seclusion, including orders for restraint and seclusion, staff training, and documentation.
7. Explain Joint Commission requirements which apply only to restraints or seclusion used to manage violent or self-destructive behavior.

Joint Commission Standards: Restraints and Seclusion

In 2010, The Joint Commission (TJC) updated standards for the use of restraint and seclusion in hospitals. The Joint Commission maintains two sets of standards pertaining to restraint and seclusion:

- One set for facilities that use TJC accreditation as a means of complying with Centers for Medicare & Medicaid (CMS) Conditions of Participation (CoP). Facilities that use TJC accreditation in this manner are referred to as using TJC accreditation status for **deemed status** purposes. These standards pertain to facilities that use TJC accreditation status for deemed status purposes.
- One set for facilities that **DO NOT** use TJC accreditation as a means of complying with Centers for Medicare & Medicaid (CMS) Conditions of Participation (CoP). These standards pertain to facilities that **DO NOT** use TJC accreditation status for deemed status purposes.

Because the great majority of acute care facilities participate in Medicare and Medicaid and use TJC accreditation as a means of satisfying CMS requirements, this course reflects the standards that pertain to facilities that use TJC accreditation status for deemed status purposes.

Introduction

Determining when to use restraints presents a dilemma for nurses and other healthcare providers in the acute care setting. Organizations establish standards and protocols to guide the use of restraints, including the Centers for Medicare and Medicaid Services (CMS), the Joint Commission (TJC), and hospital specific policies and procedures.

Although restraint use may appear to promote patient safety, studies have shown in some circumstances, restraint use can actually increase your patient's risk of injury. In addition, the restrained patient is susceptible to hazards of immobility and adverse psychological and emotional effects.

Accrediting organizations emphasize use of restraint is to be considered a last resort – to be employed **ONLY** when all other methods of preventing injury to the patient or others or of safely continuing necessary medical or surgical treatment have failed.

This course contains important information about the safe use of restraints, but also contains critical information about why restraint use is limited. The course presents alternatives to restraints for different settings, and statistical and anecdotal evidence that supports limiting restraint use to absolute "Last Resort" situations. The first two thirds of the course discusses standards of restraint use and restraint alternatives. The last portion discusses the safe use of various restraints.

When should you use restraints?

Restraints are used as a last resort when other methods of preventing injury to the patients or others are not effective.

TJC Required Policies

TJC requires accredited facilities to establish policies and procedures that address use of restraints in a comprehensive manner, including training requirements related to restraints and seclusion.

This requirement relates to Licensed Independent Practitioners (LIPs) and staff members. LIPs include physicians, psychologists, and Advanced Practice Nurses who are licensed to practice independently. These clinicians have the authority to:

- Order, initiate, and discontinue restraints or seclusion
- Monitor the patient who is in restraints or seclusion

The circumstances under which restraints or seclusion may be discontinued must be carefully documented, and restraints or seclusion must be discontinued as soon as safely possible. There are also pre-established time frames for assessing and monitoring patients in restraint or seclusion.

It is critical to comply with your organization's policies regarding restraints and seclusion. Compliance with P&Ps affords you legal protection and protects your organization's accreditation status and Medicare/ Medicaid provider status.

Code of Federal Regulations (CFR) Definitions

CMS has defined restraints and seclusion in the CFR. TJC uses these definitions (Joint Commission, 2010).

- A restraint is:
 - Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely;
 - A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
- A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings

or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

- Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior.

Examples of Potential Physical Restraints

- **Wrist, waist and leg restraints**
- **Jacket vest**
- **Hand mitts**
- **Lap buddies, belts, geri-chairs or trays**
- **Protective or therapeutic holds**
- **Comfort or safety blankets**
- **Side rails**
- **All other devices or human action that limits freedom of body movement or normal access to the body.**

Restraints: The Last Resort

TJC standards mandate that a facility uses restraint or seclusion only when clinically justified or when patient behavior threatens the physical safety of the patient, staff, or others.

In addition, TJC standards:

- Forbid the use of restraint or seclusion as a means of coercion, discipline, convenience, or staff retaliation
- Require that a facility:
 - Employs restraint or seclusion only after less restrictive interventions have proven ineffective
 - Uses the least restrictive, effective form of restraint possible
 - Discontinues the use of restraint or seclusion as soon as possible, regardless of the duration of an order

When Restraints Are Necessary

When restraint is deemed necessary:

- Use the least restrictive approach.
- Explain the reason for restraint and the procedure, including periodic release from restraints to the patient and any family members present.
- When applying or releasing restraints, anticipate a need for assistance of other staff members to assure safety and if needed, bring other staff members and give specific assignments to them.
- Assure that any physical restraint to be applied fits the patient properly.
- If applying leather restraints, assure that the straps are unlocked and that the key fits.

Restraints: A Therapeutic Failure

"The use of restraints should be viewed as a therapeutic failure. Conversely, it should never be viewed as 'therapeutic.' Most violence perpetrated by patients and inmates in psychiatric settings is the direct result of actions initiated by healthcare staff, including the use or threat of force, ridicule and humiliation, lack of respect for basic human needs and rights, and especially the failure to make a meaningful relationship with the individual."

"Before resorting to restraint, the staff should immediately examine the aggravating role of its own omissions or commissions, and especially focus on factors disrupting the relationship with the individual."

Peter Breggin, MD

Director and Founder of the International Center for the Study of Psychiatry and Psychology (ICSPP)

Test Yourself

Restraints are:

- A. The last resort when other measures have failed.
- B. Necessary when your patient is pulling at various tubes.
- C. Used only in children or adults with violent behavior.
- D. Acceptable in all post-surgical settings.

The correct answer is: A. Restraints are the last resort to be used. Other methods of restricting movement, making the patients feel safe, or involving the patient and family are attempted before restraint use is considered.

Legal Implications

When using restraints, follow your organization's policies and procedures to protect yourself from risk of legal exposure.

Courts have awarded damages for injuries suffered in restraint-related situations and have also evaluated whether restraints were appropriate.

Case Scenario 1

A long-term care resident unfastened her seat belt repeatedly. A nursing assistant calmed the resident and then turned away to assist another resident. The resident from whom the nursing assistant turned away then unfastened her belt again, stood, fell, and fractured her hip. The jury found the facility negligent but awarded no compensation. The court of appeals ordered a new trial (Legal Eagle Eye, 2007a).

Case Scenario 2

In a skilled nursing facility, a patient who had Alzheimer's disease fell and died not long afterward. Staff monitored the patient within their policy of 2-hourly checks. The court ruled that restraints were not appropriate and that the death was unrelated to the fall. The court dismissed the case (Legal Eagle Eye, 2009a).

Case Scenario 3

In a skilled nursing facility (SNF), a patient who had complete hemiplegia as a result of a third

cerebrovascular accident fell. She suffered a subdural hematoma and died. The hospital's discharge summary indicated that restraints had been used occasionally, though testimony indicated continuous use of a vest restraint. SNF staff were not alerted to fall risk by the hospital's discharge summary. SNF staff responded immediately to the fall, notified the physician, performed neuro checks hourly X4, and notified the physician when they could not arouse the patient. Though a pre-fall assessment was not documented, it would have placed the patient at low-risk for falling and restraints would not have been recommended. The jury found no negligence based upon the pre-fall assessment and quick post-fall response (Legal Eagle Eye, 2007b).

Ethical Concerns

Nurses often find themselves faced with an ethical dilemma – the conflict between protecting the patient's rights and what they perceive as protecting the patient's safety by using restraints. Researchers identified 3 coping mechanisms which nurses employ in this situation (Yamamoto & Aso, 2009):

- Initiating positive thoughts and behaviors, evidenced by holding a case conference to consult with others.
- Initiating negative thoughts and actions such as attempting to avoid situations that involve restraints or advocating for early discharge of the patient.
- Choosing not to act, such as acting on restraint orders without questioning the need for restraint and attempting to maintain the status quo.

In order to move toward restraint-free care and make restraints truly the last resort, more nurses will need to adopt the proactive approach of seeking alternatives and consulting with others.

Research Documents Restraint-Related Injuries

Traditionally, nurses have used restraints intending to provide a safe environment, but research findings indicate that injury and even death can result from use of restraints.

The Agency for Healthcare Research and Quality (AHRQ) summarizes research findings stating that, “there is growing evidence that physical restraints have a limited role in medical care. Restraints limit mobility, a shared risk factor for a number of adverse geriatric outcomes, and increase the risk of iatrogenic events. They certainly do not eliminate falls, and decreasing their use can be accomplished without increasing fall rates. In some instances reducing the use of restraints may actually decrease the risk of falling. Incorporating changes into physician and staff behavior may be easier if large, multicenter trials are successful in identifying safe alternatives to restraints that effectively limit falls risks for patients.” (AHRQ, 2001).

Additional research findings:

- **Physical restraints may even be a violation of your patient's rights (Evans & Strumpf, 1990; Evans, Strumpf & Williams, 1991; Strumpf & Evans, 1992, TJC, 2007).**
- **Physical restraints can weaken muscles, which increases the risk for functional decline, falls, and immobility-related problems, including skin breakdown and further loss of function. Additionally, restraints are associated with increased agitation (Rubin, Dube & Mitchell, 1993) and aggression.**

- **Physical restraints should never to be used for the purpose of increasing staff to patient ratios, although this has been documented as a reason for applying restraints (Strumpf & Evans, 1991).**

Restraint use can place your patient at risk for asphyxiation. Factors that place a patient at risk for asphyxiation include:

- Prone positioning while being restrained
- Agitated delirium syndrome
- Obesity
- Prolonged struggle or physical exertion may cause death from cardiac arrhythmias associated with decreased oxygen perfusion when they are struggling and actually need more perfusion.

Restraint-Related Death

Since 1999, CMS Conditions of Participation (CoP) for Medicare and Medicaid have required healthcare facilities to report all deaths that are related to restraint and seclusion. Between 1999 and 2004, CMS reports that there have been 104 deaths associated with restraints and seclusion within hospitals that reported deaths. CMS believes this is about 2/3 of the actual deaths that do occur (Department of Health and Human Services, 2006)

TJC documented a total of 198 deaths or severe injuries associated with restraints 1995 – 2009. This accounts for 3.1% of the 6,482 sentinel events reported to TJC (TJC, 2009). The majority of these deaths were in behavioral healthcare settings, followed by acute care hospitals, then long-term care facilities. Of the patients who died, most had a combination of physical impairment and confusion, physical impairment and poor judgment, or a history of violence. Some patients have increased risk of death or serious injury when restrained.

What percent of sentinel events are restraint related?

3.1%

Summary of Risk Factors for Restraint Related Death

Risk for restraint-related death increases when a patient has:

- A physical impairment and confusion
- A physical impairment and poor judgment
- A history of violence
- A habit of smoking
- A physical impairment which precludes the proper application of a restraining device (especially vest restraints)
- Been restrained in the supine position (increases risk for aspiration)
- Been restrained in the prone position (increases risk for asphyxiation)
- Been restrained in a room that is not under constant observation by staff

(Adapted from: Joint Commission on Accreditation of Healthcare Organizations (2002). Restraint and seclusion: complying with joint commission standards, p. 32)

Use of Physical Restraints in Adult Care

One study of prevalence of the use of physical restraints in 40 acute care hospitals in the U.S. found (Minnick, et al, 2007):

- Prevalence of 50 restrained patients per 1,000 patient days; an estimated minimum of 27,000 people are tied in restraints every day
- Chief reasons for restraint cited in decreasing order of frequency:
 1. Preventing disruption of therapy
 2. Managing confusion
 3. Preventing falls
- Highest rate: adult ICU accounted for more than 50% of the restraint use in the study
- Wide variation among units and among facilities
- Ventilator use was strongly associated with physical restraint
- Elderly patients were over-represented; however on many unit types, such as ICU, use was consistent with that of other adults

Patients' perceptions of the experience of hospitalization include perceptions of confinement (Shatell, et al, 2005 in Melnyk, 2006). The study identified the need to: keep patients informed and reassured about their physical and emotional safety, stay connected as often as possible, elicit concerns and fears with key strategies for how to cope with them, and to lessen feelings of confinement.

Restraints in ICU

Some critical care nurses believe that restraints are necessary to maintain therapy and protect patient safety. ICU nurses in an Ontario, Canada hospital took this position and in response to a legislative mandate to reduce restraint use expressed their belief that, "They can't possibly expect ICU patients to be included in this legislation! We're different. It just won't work here." (Hurlock-Chorostecki, Kielb, & Sipprell, 2003).

They undertook a study to support their position, but their review of the literature indicated that almost 70% of restrained patients successfully self-extubate and that restraints are ineffective in preventing unplanned extubations. They changed their focus toward identifying strategies to reduce the use of restraints. They created practice-oriented education and policy which they entitled "Knot So Fast". After initiating the least restraint program they reduced their use of restraints to prevent device removal, but continued some restraint use to prevent falls. (Keilb et al., 2005).

Test Yourself

Restraint use was found to INCREASE the number of unplanned extubations.

True

False

The correct answer is: True! When alternatives to restraints were put in place, unplanned extubation rates decreased.

Restraints in ICU

Other studies found:

- Use of midazolam and fentanyl led to delirium and longer duration of restraint and ventilator use. (Micek et al., 2005 in Melnyk, 2006).
- Physical restraint is not only inadequate in preventing extubation, but actually promoted unplanned extubation. (Chang et al., 2008) In a letter to the journal commenting on this published research, one nurse (Bryan, 2008) identified decreased use of restraint in her unit involving the use of sitters, minimal sedation, and untied mittens.
- ICU staff have negative perceptions of the use of restraints. After introducing the Freedom Splint® as an alternative to conventional restraints the total hours of restraint use decreased (Mijares A et al., 2007).

Clinical Protocols

Clinical protocols may govern restraint use in some hospitals and ambulatory care settings. In these instances, restraints are used as a last resort, after all other alternatives have proven unsuccessful. The clinical protocol must be consistent with the care of specific patients or procedures, such as:

- Ventilated patients.
- Patients with post-traumatic brain injury.
- During intubation.
- Potential for the patient to harm his/herself due to a specific treatment or procedure.

Protocols must be approved by the medical staff or medical director, must be ordered in writing by the physician, must be initiated based upon your patient's specific plan of care, and must list the specific conditions or procedures in which the restraint is and is not to be used.

The clinical protocol must identify alternatives to restraint use and must be consistent with the specific organization's policies and procedures. Additionally, staff must be educated and proven competent prior to using the protocol. Documentation of the failure of all other alternatives must be included in the patient's record. Restraints must be removed as soon as it is safe to do so, regardless of the duration of the order (TJC, 2009).

Restraint Free Care in Adult Acute Care

The evidence-based guideline, "Changing the Practice of Physical Restraint Use in Acute Care" recommends nursing interventions toward restraint-free care (Park, Tang, Adams & Titler, 2007):

Nursing Interventions

- Treat/eliminate the cause of the problem or risk behavior
- Meet the expressed need
- Collaborate with team members

The guideline calls attention to physical, physiological, psychological, and environmental factors to be investigated in attempt to avoid use of restraints.

Restraint Free Care in Adult Acute Care

Consider these physical, physiological, psychological and environmental factors:

Physical Factors

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- Referral: APN consultant
- Communication enhancement
- Comfort measures
- Positioning
- Exercise therapy
- Sleep enhancement
- Fall prevention

Physiologic Factors

- Neurological monitoring
- Reality orientation
- Respiratory monitoring
- Nutritional monitoring
- Pain management
- Medical management
- Drug effect and interactions

Psychological Factors

- Visitation facilitation
- Verbal intervention
- Explain all procedures
- Emotional support
- Coping enhancement
- Patient contracting
- Behavior management
- Medication administration

Environmental Factors

- Reduce stimuli
- Quiet environment
- Environmental management
- Room consideration
- Call bell
- Bedside commode
- Medical equipment adjustment

Learning Activity

Indicate what factor type is being impacted by the following activity:

Explain all procedures

Answer: **Psychological Factor**

Decrease the stimuli in the environment

Answer: **Environmental Factor**

Change patient's position

Answer: **Physical Factor**

Make sure patient has adequate fluid and nutrition

Answer: **Physiologic Factor**

Treat or Eliminate the Cause

Maintaining medical therapy is a frequent reason for the use of restraints. Patients may disrupt their medical treatment when agitated or confused by pulling out nasogastric tubes, indwelling urinary catheters, IVs, and may even extubate themselves.

Such interruptions in therapy are painful, costly and can be harmful to the patient. Instead of immediately restraining these patients, appropriate alternatives to restraints should be tried first.

Treat or Eliminate the Cause

Explore therapy alternatives

- Is the equipment of treatment really needed?
- Is there a therapeutically sound alternative that is acceptable to the patient?

Consider the following ways to eliminate the need for restraints.

Medical Therapy	Alternative to Medical Therapy
Peripheral IV maintenance fluids	Discontinuation of fluids Fluids by mouth IV heparin or saline lock
IV antibiotics	Oral antibiotics
Indwelling urinary catheter	Intermittent straight catheterizations Traditional bladder training program Use of bladder scanner with bladder training program
Nasogastric tube	Percutaneous gastrostomy tube
Feeding tube	Oral intake

Improve Acceptability and Safety of Medical Therapies

Examples of protective alternatives:

Educate and communicate with patients

- Establish eye contact and talk with the patient
- Listen and validate concerns
- Reorient the patient as needed
- Explain procedures and the reason for equipment, tubes, and other devices
- If possible to do so without alarming the patient, explain adverse effects of dislodging tubes, IVs, or other devices

Use of protect medical devices

- Move tubing or equipment out of the patient's sight
- Cover abdominal drains, tubes, dressings, and urinary catheters with an abdominal binder
- Switch to a capped IV line if possible
- Wrap an elastic compressor bandage around IV sites, tubing, and dressings

Improve Acceptability and Safety of Medical Therapies

Change the environment of care to facilitate patient compliance.

- Determine and adhere to the patient's routines and habits as much as possible

Assess the patient's physiological needs and medications.

- Keep the patient warm, dry, and comfortable
- Increase comfort if the device must remain in place, for example frequent oral and nasal care for the patient who has an NG tube

Identify and if possible correct underlying causes of behavior such as:

- Effects of medications
- Infection
- Electrolyte imbalance
- Hypoxia
- Pain
- Cold
- Hunger
- Thirst
- Need for toileting

Think "outside the box" for ways to help your patients remain safe and still decrease the use of restraints!

Examples of Protective Alternatives

Medical Therapy	Protective Intervention
IV lines	<ul style="list-style-type: none">• Hide IV poles, solutions and insertion site from patient.• Use a saline or heparin lock when possible.
Endotracheal tubes	<ul style="list-style-type: none">• Use tube holders or tape to secure tube.• If awake, allow your patient to manipulate a safe object with his or her hands to provide distraction.
Indwelling urinary catheters	<ul style="list-style-type: none">• Place the tube between your patient's legs.• Place the bag at the end of the bed.• Allow your patient to wear underwear.
Percutaneous gastrostomy (PEG) tubes	<ul style="list-style-type: none">• Utilize tube stabilizing devices.• Use abdominal binders to hide tube.
Nasogastric tubes	<ul style="list-style-type: none">• Provide meticulous mouth care.• Lubricate nostrils to decrease discomfort.• Safely allow patient to familiarize himself with the tube.
Oxygen tubing	<ul style="list-style-type: none">• Lubricate nostrils to minimize discomfort.• Place gauze over ears where oxygen tubing lies.• Use humidified air or oxygen when medically appropriate.

Restraint Free Fall Protection

Though nurses often think of restraints as a means of preventing falls, restraints actually significantly

increase the number of falls and the seriousness of injury when patients do fall (Tinneti & Williams, 1991).

Historically nurses have initiated the use of side rails to prevent falls. Many serious injuries or deaths occur due to head and body entrapments in side rails. The majority of the deaths and injuries involve elderly patients with confusion or an alteration in their level of consciousness (Parker & Miles, 1997).

Restraint Free Fall Protection

Assess for factors that may contribute to an increase risk of falls include:

- Vision or hearing problems
- Mobility problems
- Adverse effects of medications
- Cognitive impairment
- Agitation
- Medical disorders

Thoroughly assess, anticipate, and address potential problems that may contribute to falls, including:

- Needs for nutrition, fluids, and toileting
- Adverse effects of medications
- Pain
- Disorientation
- Electrolyte imbalances and dehydration
- Proximity of call bell and personal effects

Do whatever is necessary to decrease your patient's falls risk, while simultaneously decreasing your patient's need for restraints (TJC, 2002).

Managing Aggressive Behavior Without Restraints

Managing aggressive behavior is a key element in decreasing behavioral restraint use. Preventing increasing anger and utilizing de-escalation techniques will often diffuse a hostile situation. Effective communication, empathy, and gaining an understanding of your patient's perceptions are excellent ways to diffuse an unstable situation.

De-escalation techniques center on one-on-one communication with the patient. Encourage and allow patients to verbalize their feelings. Use active listening to assure that you understand the patient's meaning. You might call a "time out" or offer relaxation, exercise, and other diversionary activities.

Other strategies include:

- Focus your patient on something positive
- Change the subject
- Use humor, if appropriate, to lighten the mood
- Give your patient choices
- Offer your patient alternatives
- Set limits on your patient's behavior

Phrases that facilitate de-escalation and often help your patients feel that they are being truly heard include:

- “Tell me what the biggest problem is right now.”
- “I really want to help.”
- “I am listening.”

If you frequently deal with potentially violent or aggressive patients, check out RN.com's course on Managing Assaultive Behavior.

Meet the Expressed Need

Make every effort to respond to needs that the patient and family express. Often, accommodating a request may calm the patient and prevent the agitation that may result when the patient or family concentrates on some particular issue of importance to them.

If the patient is not clearly identifying a need but demonstrates restlessness and agitation, investigate to identify the need. Involve family in clarifying unmet needs that may produce agitation.

Sometimes family members request restraints because they believe restraints will maintain safety. Educate family members about restraint alternatives and the benefits of restraint-free care.

Team Collaboration

Accreditation regulations and research literature emphasize the importance of staff education in creating a culture in which restraints are truly the last resort and alternatives to restraint are plentiful and used effectively. Staff members also need to learn how to prevent situations that lead to restraint by learning how to avoid triggering inappropriate or uncooperative behavioral responses from patients.

A team approach works effectively to assure consistency and take advantage of the perspectives and skills of all members of the team, including the patient and family.

In one facility, a multidisciplinary team reviewed the cases of patients who had multiple incidents of restraint in a behavioral health setting. They trained staff in person-centered positive reinforcement and introduced ward life-management meetings, a calming room, and measures to reduce noise. They supported staff with a clinical presence of the team, staff coaching, commendations, and support groups. These efforts reduced the use of restraint and seclusion significantly (Sclafani, et al., 2008).

Continuous Evaluation of Restraints

Nurses often report that they received the patient in restraints and maintained restraints without continuous evaluation of the need for restraint. Ludwick, et al., (2008) advise that:

- The nurse should evaluate any restrained patient who is new to that nurse – including the type of restraint being used and the appropriateness of continuing restraints. More importantly, the nurse should actively identify rationale and methods for discontinuing restraint use if at all possible.
- Clinical nurse specialists might consider rounding to evaluate all newly admitted/transferred patients who are restrained.

Families and volunteers may also reduce the need for restraints by comforting and monitoring your patient. They may gently remind your patient not to pull at an IV or other medical devices. They can also play a key role in distracting your patient from the medical therapy being used (TJC, 2002). Audiotaped messages from family members may provide comfort.

Allow visitors at the bedside for as much time as possible after patient admission, especially in the evening, to create an atmosphere of comfort and familiarity.

Test Yourself

Which of the following can decrease the need for restraint use:

- A. Allow family members to stay with patient.**
- B. Evaluate newly admitted restrained patients for the need for restraints.**
- C. Both A and B**

The correct answer is C. Both A and B.

Physical Factors

Measures to improve function can reduce the need for restraint. Active efforts to restore and preserve function in activities of daily living (ADLs) can reduce risk of falling and can also have a positive psychological effect. Encourage patient activity, as medically indicated. Activity can reduce aggression and promote improved nighttime sleep, decreasing the need for restraints. All equipment, such as wheelchairs, must be maintained in good working order and the correct size for the patient.

Creating an environment to promote sleep during the night can reduce the need for restraint. The most frequently reported noise disturbances were sounds from other patients, such as coughing, gagging, snoring; alarms on equipment; loud talking in the hallway, and TVs. Patients' most frequent preferred sleep hygiene activities included turning off lights, washing face and brushing teeth, smoothing linens, and finding a position of comfort. Researchers recommend that nurses take noise reduction measures and incorporate patients' usual nighttime routines in order to prevent restlessness which might lead to use of restraints (Ludwick et al., 2008).

Methods that are useful in supporting sleep at night include the initiation of bedtime routines, provision of a cool, quiet environment, use of "white noise" to drown out unit noise, and limiting liquids, hypnotics, caffeine, or other stimulants before bed (TJC, 2002).

Physiologic Factors

Assessing restlessness and agitation in any patient is necessary to monitor for medical complications such as pain, decreased oxygenation status, or a change in neurological function.

Regularly address your patient's physiologic needs. Attention to toileting, hydration, and nutritional needs will help prevent falls and the need for restraints. Often patients try to get out of bed to go to the bathroom or get a drink of water and consequently fall.

To minimize your patient's falls risk, use nightlights, bedside commodes, and hand-held urinals. Place the call bell, water, eye glasses, and other essentials within the patient's reach.

Timed toileting at night may be especially effective for your patient taking diuretics or those who have urge incontinence (TJC, 2002).

Medication Profile

Numerous medications can alter how your patient walks, acts, and interacts with their surroundings.

Potential debilitating effects of medications may place your patient at risk for falls, altered mentation, and subsequently the need for restraints.

Children and the elderly are most susceptible. When assessing your patient's medication history, consider the side effects of their current medications, but also monitor the side effects of new and PRN medications (TJC, 2002).

Medications that place your patients at risk for falls and subsequent restraint use are numerous and include the following:

- Anti-arrhythmics
- Neuroleptics
- Anti-depressants
- Non-steroidal anti-inflammatory agents
- Anti-hypertensives
- Psychotropics
- Diuretics
- Sedatives/Hypnotics
- Hypoglycemics
- Vasodilators
- Laxatives

True or False?

Assessing your patient's physiologic needs will help to prevent falls and the need for restraints.

True!

Psychological Factors

Communicating with patients about their care greatly reduces the need for restraints. Explain to your patients why a medical therapy is being used and its importance. Speak in a calm, reassuring manner that comforts your patient. Explain how the therapy will feel or sound prior to its initiation. Reminding patients about these therapies may reinforce the patients understanding of the particular therapy. When possible, give your patient choices about therapy. For example, allow your patient to choose which arm for an IV may decrease behavior that would necessitate restraints (TJC, 2002).

Identify, incorporate, and support the patient's familiar routines and preferences.

Distraction and diversionary activities can divert the patient's attention from medical devices and other sources of agitation. Such activities include:

- Ambulation
- Looking at pictures or cards from family or friends
- Participation in activities of daily living
- Squeezing someone's hand
- Reminiscing
- Allowing your patient to hold the tape during the insertion of an IV
- Listening to music

(Selekman & Snyder, 1996)

Psychological Factors

Some patients may exhibit a need for tactile stimulation. Giving your patient a simple task to complete will help them to focus on the task and decrease their attempts of getting out of bed unassisted or pulling out a tube. Folding washcloths or pillow cases, repairing a phone receiver that has been taken apart, tying yarn around a ball, or manipulating an activity apron may distract and occupy your patient, thereby preventing falls and the need for restraints (TJC, 2002).

Some patients, especially children and the elderly, may awaken frightened and confused about their surroundings after surgery or even after an acute illness or injury. Increased anxiety and depression about illness may predispose an already physically weak patient for falls and/or aggressive behavior when sedated or pain medications are being taken. Active listening and empathy will play a key role in alleviating anxiety. When your patient becomes confused or awakens at night unsure of their surroundings, reorient them in a calm, soothing voice. This reassurance will often allow them to settle back to sleep.

Distract your patient by having them roll a ball of yarn, fold washcloths or other simple activities.

Environmental Factors

Adjust the environment to prevent falls:

- Use safety devices that trigger an alarm when a wandering patient tries to leave a safe protected environment.
- Keep adequate lighting in your patient's room.
- Maintain a comfortable temperature to prevent your patient from attempting to get out of bed for a blanket or cooler clothes.
- Maintain a clean and neat environment.
- Keep all tubes and equipment out of the path to the bathroom and door.
- Place the call bell within your patient's reach. Frequently reorient the patient on its use.
- Place your patient close to the nurse's station to facilitate observation and interaction.
- Implement changes in the agitated or confused patient's environment to reduce the likelihood of falling, attempting to ambulate independently, or pulling at medical devices or therapies.
- Use rocking chairs or gliders to distract confused patients from pulling at tubes or trying to ambulate alone (TJC, 2002).

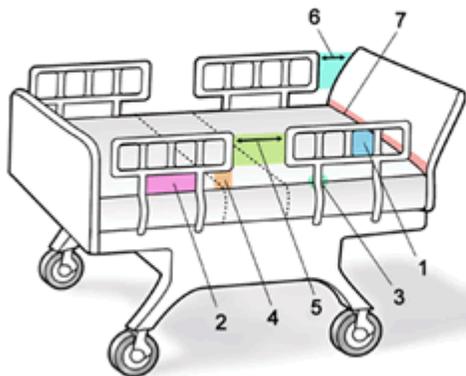
Environmental Factors

The use of sitters has proven to be an effective method to reduce restraints, but not necessarily patient falls (Tzeng et al., 2008).

One study in the long-term care setting demonstrated that the use of bilateral side rails had significantly increased over 1-year study and did not significantly reduce the likelihood of falls, recurrent falls, or serious injury, affirming that bilateral side rails do not promote a safer environment for the resident (Capezuti et al., 2002). Some long-term care facilities raise the edges of the mattress to prevent rolling

off the bed in lieu of using side rails.

The seven areas in the bed system where there is a potential for entrapment are identified in the drawing below.



Zone 1: Within the Rail

Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support

Zone 3: Between the Rail and the Mattress

Zone 4: Under the Rail, at the Ends of the Rail

Zone 5: Between Split Bed Rails

Zone 6: Between the End of the Rail and the Side Edge of the Head or Foot Board

Zone 7: Between the Head or Foot Board and the Mattress End

Image courtesy of fda.gov

Elderly Patients

Older adults are three times more likely to be restrained than younger persons (Evans & FitzGerald, 2002).

Eliminating restraints in the elderly begins with a thorough assessment. When an elderly patient is admitted to the acute care setting, it is usually because there is an exacerbation of a chronic illness or a new illness or injury. Common acute geriatric problems include:

- Urinary tract infection
- Fecal impaction
- Pneumonia
- Medication issues
- Confusion

Elderly Patients

In addition to chronic illness, new problems in the geriatric patient may manifest as:

- Increased confusion
- Incontinence
- Poor appetite
- Increased edema
- Pain

When you observe these symptoms, it is important to complete a thorough assessment of your geriatric patient to determine variations from their baseline.

Restraining a patient may increase agitation and confusion.

Complications Among Elders

Restraining elderly patients can produce catastrophic physical and psychological ramifications,

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including:

- Urinary incontinence
- Increased agitation
- Circulation impairment
- Skin breakdown
- Decreased mobility
- Abnormal changes in body chemistry
- Changes in basal metabolic rate
- Orthostatic hypotension

- Contractures
- Edema
- Decreased muscle mass, tone, and strength
- Nosocomial infections
- Cardiac stress
- Loss of dignity
- Increased confusion and combativeness

(Evans & Strumpf, 1990).

Long-Term Care: Legal Requirements

The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) states that "residents have the right to be free from any physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms" [42 CFR 483.13(a)].

To participate in the Medicare and Medicaid programs, nursing homes must be in compliance with the federal requirements for long term care facilities as prescribed in the U.S. Code of Federal Regulations (42 CFR Part 483). These regulations emphasize residents' rights and focus on maintaining dignity and maximum quality of life and function. They also require facilities to pay particular attention to preventing complications that arise from immobility and also from restraint, such as dehydration and pressure sores. CMS requirements also include monitoring for unnecessary use of medication and for adequate staffing (CMS, 2009).

OBRA-87 guidelines were updated to include guidelines from the Nursing Home Reform Act of 1990 which includes the mandate that "restraints were to be imposed only to ensure the physical safety of the resident or that of other residents and only on the written order of a physician. Orders for restraints were required to be specific with regard to the duration and circumstances for their use" (Guttman, Altman, & Karlan, 1999).

The law guarantees residents the right to be free from all unnecessary physical restraints beyond the treatment program prescribed by physicians or unless their physical safety is in jeopardy.

Restraint Use in Long-Term Care (LTC)

Use of physical restraints is declining residents in long-term care.

- **1991:** 21.1%

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- **2003:** 8.5%
- **2004:** 7.7%
- **2005:** 7.0%
- **2006:** 6.4%
- **2007:** 5.5%

Although restraint use is decreasing across the board, there is great variability across organizations and across the country.

Physical restraints were used on 20% or more residents at 665 homes out of about 14,800 reviewed nationwide.

Twenty-five states used restraints on 4% or fewer residents on average.

State averages ranged from a low of 1.7% of nursing home residents in restraints in Alaska to a high of 11.8% in Louisiana. Restraint use also topped 10% in three other states: Arkansas, California and Oklahoma.

(USA TODAY analysis of Centers for Medicare & Medicaid Services data in Appleby & Gillum, 2009)

Most commonly used physical restraints in long-term care include siderails, lap sash, and recliner chair.

Hazards of Restraints in LTC

Despite the well-known hazards of restraint use, particularly for elderly persons, and despite significant reductions in restraint use in long-term care, there is evidence that restraint use and prolonged restraint use continues. In one study of cognitively impaired nursing home residents, researchers found that staff routinely used restraints and 90% of restrained residents had been restrained for more than 3 months (Hamers et al., 2004).

Patients who have dementia may experience feelings of injustice, frustration, distress, being “like a prisoner” or “in jail” (Moore et al., 2003).

Falls and accidents are a serious concern for nursing home residents. Approximately 50 percent of residents fall annually and 10 percent of these falls result in serious injury, especially hip fractures (CMS, 2002). The use of chemical restraints creates risk for falling. Researchers have found that elderly persons who receive benzodiazepines have a 24% greater chance of hip fracture than those who do not (Wagner et al., 2004).

Restraint Reduction in LTC

Nursing home researchers and policy makers have focused on limiting use of restraints as one of five clinical conditions and related processes crucial to safe care. Other conditions include pressure ulcers, falls, limited use of infections, and medication safety practices (Scott-Cawiezell & Vogelsmeier, 2006).

Researchers have demonstrated that the use of side rails in nursing homes can be reduced, particularly where advanced practice nurses (APNs) are utilized. Findings suggest that an APN consultation model can effectively be implemented through comprehensive, individualized assessment without incurring substantial costs to the nursing home (Wagner et al., 2007).

One 87-bed Tennessee nursing home reduced restraint use to zero in 2006, exceeding the government’s goal by 7.8%. They achieved zero-restraint through staff education, careful evaluation of all residents, adequate staffing, and use of bed alarms. Their ongoing evaluation program targets root

problems related to restraint use, just as medications to treat symptoms of an underlying cause. They analyze behaviors to determine whether restraints should be used or if alternative measures can eliminate the need. They consider the use of sitters as a last resort.

Barriers to reducing restraint use in long-term care include fear of resident injury, staff and resource limitations, lack of education and information about alternatives to restraints, environmental constraints, policy and management issues, beliefs and expectations of staff, family and residents, and inadequate review practices and communication (Moore & Haralambous, 2007).

To promote a calm environment for residents, long-term care facilities use a variety of techniques including music, lighting, aroma therapy, and going outdoors.

LTC-Specific Alternatives

Nursing homes must examine risk factors that cause falls and accidents and take these steps to limit the risks:

- Keep the resident environment as free of accident hazards as possible;
- Give each resident adequate supervision to prevent accidents, and
- Use assistive devices that help improve resident safety. [42 CFR §483.25(h)].

Recommendations for LTC, in addition to suggestions made previously in the course include:

- Use pads and pillows to support the resident in a comfortable and safe position.
- Adapt and tailor chairs used to ensure comfort and safety.
- Tailor care and caregiver assignments to residents' preferences.
- Provide therapy and restorative care to improve residents' abilities to stand, transfer and walk safely.
- Help residents to get in and out of bed as often as needed and desired.
- Increase staffing levels to improve supervision.
- Adapt the environment through good lighting, safe beds, alarms, and other features.
- Remove accident hazards, such as over-bed tables with wheels and cluttered dining rooms.
- Provide safe areas for residents to walk.
- Train staff on methods to calm residents who are anxious or agitated.
- Arrange mental health treatment for residents who need it.

(CANHR, 2009)

Psychotropic Drugs in LTC

Federal law prohibits nursing home staff from administering antipsychotics, antidepressants, and anti-anxiety medications without a prescriber's order, a patient's consent, and justification that the treatment is needed. Additionally, most commonly used antipsychotics carry black box warnings.

Inspection reports revealed that 2/3 of one state's 742 nursing homes were cited since 2001 for incidents involving psychotropics. Many facilities received multiple violations (Roe, 2009).

Nursing home residents who receive psychotropic drugs are more likely to fall or experience general decline than other residents. An FDA scientist testified before Congress in 2008 that thousands of nursing home residents die each year because psychotropic drugs are administered to persons who are not mentally ill (Roe, 2009).

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Unfortunately, nursing home staff often seek orders for psychotropic medications rather than persisting in less restrictive and less invasive measures to manage residents. Prescribers often oblige and in some instances have given an unwarranted diagnosis to justify the order. Some residents have received psychotropics and not received treatment for an underlying cause of anxiety such as pain or infection (Roe, 2009).

Use of Restraints with Violent, Self-Destructive Patients

Qualified staff may place a patient in restraints or seclusion after exhausting all other alternatives and less restrictive means and acting in accordance with the organization's policy. When staff restrains a patient who exhibits non-violent, non-self-destructive behavior, the organization's policy governs notifying the patient's provider and obtaining an order.

When staff initiates restraints or seclusion to control violent, self-destructive behavior, TJC requires that a qualified staff member evaluate the restrained patient within one hour of placing the patient in restraint or seclusion. The staff member may be a licensed independent practitioner (LIP), such as an MD, or a specially trained RN or Physician's Assistant (PA). The evaluation must include:

- An evaluation of the patient's immediate situation
- The patient's reaction to the intervention
- The patient's medical and behavioral condition
- The need to terminate restraint or seclusion (TJC, 2010)

Use of Restraints with Violent, Self-Destructive Patients

When the evaluation is conducted by the RN or PA, that individual must consult with the LIP as soon as possible after the evaluation and according to hospital policy.

Curran (2007) cautions against the use of restraint or seclusion as punishment or as a matter of enforcing rules which are the same rules for all aggressive behavior. She asserts that even if staff have made the decision to use restraint or seclusion and are preparing the bed or the room, efforts should continue to calm the patient and avoid restraint or seclusion. She identifies a need for staff to learn to evaluate each situation individually rather than seek to enforce disciplinary rules. In her view, when staff fail to consider individual circumstances, patients feel disrespected and their agitation and aggressive behavior is likely to escalate.

Nurses and Patients Reflect on Use of Restraints

As a nurse, you probably have cared for patients in restraints before. Examine your feelings toward the patient you were caring for. Many nurses caring for restrained patients report feeling guilty and anxious during and after their shift (Difabio, 1981 & Scherer et al., 1991). This is not unusual and is another disadvantage for restraint use.

The following statements were made by nurses regarding the care of their restrained patients:

- "Sometimes it bothers me when the patient cannot understand the need for the restraint."
- "I feel guilty at times because you take away the patient's freedom and that bothers me."

The following statements were made by geriatric patients after being restrained:

- "I have done nothing to deserve this! To think, you fought a war—now I am a POW!"

- “If there was a fire, I’d be caught. When someone is tied and chained in a fire, how will you save the person? How would I get out?”
- “I felt like a dog and cried all night. It hurt me to have to be tied up. The hospital is worse than a jail!”
- “After a while I gave up. I became a mouse” (Strumpf & Evans, 1988).

Sometimes Restraints are the Only Option

The first, and longer part of this course discussed both theoretical and practical ways to avoid the use of restraints.

However, as healthcare professionals, you realize that there are situations where restraints are required to keep the patients, visitors and families, and/or the staff safe. The following section of the course discusses the safe use of restraints and the standards required when using restraints.

Safe Use of Physical Restraints

- Never restrain a patient in the prone position. The prone position creates a risk for aspiration, restricts the patient’s vision, and increases feelings of helplessness and vulnerability.
- Initiate nursing measures to prevent skin breakdown and other hazards of immobility.
 - Release restraints safely at intervals according to your organization’s policy and assist with ROM.
 - Anticipate the need and assure that staff assistance is available when you release restraints at intervals.
 - Address needs for nutrition, hydration, toileting, and ambulation.
- When using 4-point restraints, never secure all 4 restraints to the same side of the bed. Doing so increases the risk for falling.
- If the patient is at risk for aspiration, position the patient on his side before restraining.
- Follow your organization's policy and manufacturer’s instructions completely for application procedure.
- Follow your organization's policy strictly for monitoring and documenting.
- Secure restraints **ONLY** to the bedframe or immovable part of a chair, stretcher, wheel chair, or other equipment and **NEVER** to side rail or other movable part.
- **ALWAYS** tie restraints using a quick release knot, slip knot, or bow.
- Leave 1 – 2 inches slack in restraint straps to allow movement.
- Assist the patient in whatever ways possible to meet the criteria for discontinuing restraints.

Vest Restraints: Safety Tips

Use the following guidelines for patients with vest restraints:

- Restrain the patient in sitting position
- Place the restraint over the gown
- Crisscross the restraint in the front; Doing so in the back creates a choking hazard
- Pay particular attention to respiratory rate and breath sounds when assessing the patient

- Release the restraint at intervals and instruct or assist the patient to stretch, turn, and deep breathe

Limb Restraints: Safety Tips

Limb restraints require that you consider the following safety tips:

- Leave a space of 1 or 2 fingers between the restraint and the patient's skin to permit adequate circulation.
- Pay particular attention to circulation checks when assessing the patient every 2 hours, including skin temperature, skin color, pulse, and sensation.
- During release from restraints every 2 hours, stimulate circulation in the extremity and instruct or assist the patient with range of motion.
- If the patient has an IV site, apply the restraint distal to the site ONLY.

Belt Restraints: Safety Tips

Belt restraints are commonly used for patients sitting up or in a wheelchair. Follow the safety tips below:

- Leave a space of your hand between the patient's skin and the restraint.
- Apply so that restraint is secure and comfortable. Too tight will cause abdominal discomfort. Too loose creates a risk for slipping to the chest level.

Leather Restraints: Safety Tips

Leather restraints are used less frequently than in years past, however there are serious potential consequences with their use. Therefore, the safety tips listed are of utmost importance:

- Restrain the patient in a supine (face up) position with head elevated to facilitate respiration and a clear airway.
- Immobilize the patient at the joints.
- Place a pad between the skin and the restraint.
- Leave a space of 1–2 fingers between the patient's skin and the restraint. Too tight will impair circulation Too loose may allow the restraint to slip off or irritate the skin.
- After securing the restraint, tug gently to assure that it remains secure.
- Place the key in an accessible location known to all staff.

Chemical Restraints

Even when used properly, most psychoactive drugs have numerous potential side effects. The dangers multiply quickly when these drugs are used as chemical restraints. Although the risks vary by the drug, some common side effects include:

- Agitation, confusion, and delirium
- Sedation
- Disordered thinking
- Decreased appetite
- Constipation

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- Low blood pressure
- Muscle disorders
- Endocrine changes
- Drug-induced Parkinsonism
- Cardiac slowing
- Acute glaucoma

One problem tends to lead to another. For example, elderly patients or LTC residents who are over-sedated face most of the side effects caused by physical restraints (CANHR, 2009).

Note! Medical symptoms that warrant the use of restraints must be documented in the medical record, assessments, and care plans.

Chemical Restraints

An advisor to the Relatives and Residents Association in the UK observed that in LTC, “the money spent on inappropriate medication could make a huge difference if used to train staff, who would then be better placed to do a demanding job, giving residents an improved quality of life.” (L. Bright, 2008)

Common agents used to chemically restrain patients include:

- Haloperidol (Haldol®)
- Diazepam (Valium®)
- Lorazepam (Ativan®)
- Midazolam (Versed®)

All may be given intramuscularly (IM) and intravenously (IV). Haloperidol (Haldol®) may be given IV with caution. Onset of action of IM medications is within 30-60 minutes and within 15 minutes for IV administration.

Be aware that haloperidol may increase agitation and that benzodiazepines (diazepam, lorazepam, and midazolam) have a higher incidence of inducing respiratory depression, especially when given IV. Flumazeril (Romazicon®) is the antidote for benzodiazepine overdose.

Seclusion

Seclusion is physically less restrictive than physical restraints because the patient has the ability to move around within the defined space. It is most often used in behavioral healthcare settings.

One primary goal of seclusion is to keep the patient away from others. Similar to physical restraints, seclusion in a non-behavioral healthcare setting such as an emergency department or acute care hospital unit, should be initiated only in an urgent situation when the patient is at risk for harming themselves or others and only after all other non-physical attempts at controlling the behavior have failed (TJC, 2007).

Seclusion should only be initiated and monitored by staff who have successfully completed education regarding the care of patients in seclusion.

Monitoring the Restrained Patient

TJC requires facilities to establish policies regarding monitoring the restrained patient. Know and abide by the organization's policy. Many facilities use checklists to facilitate assessment.

- The restrained patient requires continuous monitoring by a designated person.
- If a patient poses a threat of violence or self-destructive behavior and therefore is simultaneously restrained and placed in seclusion, staff members must continually monitor the restrained and secluded person, either in person or via audio and video monitoring.

Monitoring the Restrained Patient

Assess all parameters and perform all interventions which your organization's policy dictates. These typically include:

- Release of restraints at specified intervals
- Circulation
- Vital Signs
- Physical and psychological status
- Evaluation for readiness to discontinue restraint
- Any injury or indication of injury associated to the restraint
- Nutrition
- Hydration
- Inspection for any injury by restraint
- Hygiene
- Elimination
- Comfort
- Range of Motion

When monitoring your patient:

- Determine if your patient's physical and emotional well-being are being maintained.
- Ensure that your patient's rights, dignity, and safety are maintained.
- Identify if less restrictive methods are feasible.
- Assess for changes in your patient's behavior or physical status that would require the interruption or termination of the restraints.
- Assess the appropriate application, removal, and re-application of the restraint.

Critical Thinking Activity - Restraint or Not?

Critical Thinking Activity

Indicate whether the method being used in the following scenarios is considered a restraint.

Scenario 1: An elderly, confused patient in an acute care setting has a bed sheet wrapped tightly under his mattress to prevent him from getting out of bed and falling. Restraint or not?

- **Answer:** The bed sheet is considered a physical restraint because it restricts the patient's movement and normal access to his body.

Scenario 2: A 7-year-old boy's arm is being held by staff assisting a nurse inserting an IV. The boy and his mother agreed to having his arm held still. He is not actively resisting the hold. The boy's arm is held for approximately 3 minutes.

- **Answer:** This use of therapeutic hold is not considered a restraint. The boy and his mother consented to having his arm held still. He is not actively resisting the hold. It is less than five minutes and is intended for medical treatment purposes.

Scenario 3: A 48-year-old female is given 2 mg of midazolam IV to control anxiety and movement that occurred during prior attempts of PICC line insertion. The patient agrees pre-procedurally for the administration of the drug.

- **Answer:** This is not a chemical restraint. It is used for procedural purposes with the patient's consent as IV conscious sedation.

Scenario 4: Staff in the emergency department are being physically threatened and attacked by a 50-year-old intoxicated male brought in for face and eye lacerations. The staff places the patient in a locked, empty room while obtaining physical restraints.

- **Answer:** This is an example of seclusion. The patient is physically prevented from leaving the locked room. It is used in an emergency situation used to protect others from harm.

TJC Standards: Safety Precautions, Plan of Care, Individual Orders

TJC Standards require that:

- Facilities use safe restraint and seclusion techniques as described in hospital policy and state and federal regulations
- Restraint and seclusion is included in the patient's written plan of care
- An MD or licensed independent practitioner (LIP) orders restraint or seclusion in accordance with hospital policy and state and federal law
- No standing orders or whenever necessary (PRN) orders be used
- The LIP receive notification as soon as possible if a patient is restrained or secluded without an order
- Orders for restraints or seclusion to manage a non-violent, non-self-destructive patient are renewed according to facility policy
- Orders for restraints or seclusion used to manage violent or self-destructive patients may be renewed within the following time limits:
 - 4 hours for patients 18 years of age or older
 - 2 hours for patients age 9–17
 - 1 hour for patients less than 9 years of age
 - Orders may be renewed according to the time limits for a maximum of 24 hours
 - The LIP must see and evaluate the patient before writing a new order

TJC Standards: Documentation

TJC Standards for documentation of restraint and seclusion include documentation of:

- In-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior
- Description of the patient's behavior and the intervention used
- Any alternatives or other less restrictive interventions attempted

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- Condition or symptom that warranted the use of restraint or seclusion
- Patient response to interventions used, including rationale for continued use of restraint or seclusion
- Individual patient assessments and reassessments
- Intervals for monitoring
- Revisions of plan of care
- Patient behavior and staff concerns regarding safety risks to patient or staff that necessitated use of restraint or seclusion
- Injuries to the patient
- Death associated with restraint or seclusion
- Identity of LIP who ordered restraints or seclusion
- Order for restraint or seclusion
- Notification of use of restraint or seclusion to the attending physician
- Consultations

When restraint is used as part of a protocol, your patient's chart must contain a reference to the particular protocol.

TJC Standards: Training

TJC Standards require that facility staff receives training on the use of restraint and seclusion and that assessment of their competence is documented at orientation, before participating in use of restraint and seclusion, and on a periodic basis.

Training is appropriate to the patient population served and includes:

- Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require use of restraint or seclusion.
- Use of nonphysical intervention skills.
- Methods for choosing the least restrictive intervention based on assessment.
- Safe application and use of all types of restraint or seclusion used in the facility, including recognizing and responding to signs of physical or psychological distress.
- Clinical identification of specific behavioral changes that indicate that restraint may be discontinued.
- Monitoring physical and psychological well-being of the patient who is restrained or secluded, including but not limited to:
 - Respiratory and circulatory status
 - Skin integrity
 - Vital signs
 - Any special requirements specified by hospital policy, including in-person evaluation conducted within one hour of restraint or seclusion
- First-aid techniques and cardiopulmonary resuscitation, including periodic recertification.

Persons who provide the training must have education, training, and experience in the safe use of restraints.

Staff records must contain documentation of training and demonstration of competence.

TJC Standards: Death in Restraints

In concert with CMS requirements, TJC requires that facilities report to CMS:

- Each death that occurs while a patient is in restraint or seclusion
- Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion
- Each death known to the facility that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of restraint or seclusion may have contributed to the death

Facilities are required to report deaths to CMS by telephone no later than the close of the next business day following knowledge of the patient's death. Date and time of the reporting must be included in the patient's record.

Conclusion

Due to the potential for physical and psychological consequences, restraints should be considered only as a last resort in managing a patient's care. All patient-appropriate alternatives should be attempted prior to initiating restraints. Once restraints are initiated, you must comply with TJC standards and your organization's policies and procedures.

While the patient is restrained, ongoing assessments to determine the patient's physical and psychological well being must occur at specified intervals. These assessments will also help you to determine if your patient no longer needs to be restrained.

Additionally, documentation standards should be followed to be in compliance with TJC requirements. When restraints are necessary to protect your patient, follow your organization's policy and use the information in this course and other educational sources to practice safe use of restraints for your patients.

Make restraints "The Last Resort" in your care of patients.

At the time this course was constructed all URL's in the reference list were current and accessible. rn.com. is committed to providing healthcare professionals with the most up to date information available.

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