

When and how to use restraints

Learn about possible indications for restraint, types of restraints, and how to monitor patients in restraint.

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Few things cause as much angst for a nurse as placing a patient in a restraint, who may feel his or her personal freedom is being taken away. But in certain situations, restraining a patient is the only option that ensures the safety of the patient and others.

As nurses, we're ethically obligated to ensure the patient's basic right not to be subjected to inappropriate restraint use. Restraints must not be used for coercion, punishment, discipline, or staff convenience. Improper restraint use can lead to serious sanctions by the state health department, The Joint Commission (TJC), or both. Use restraints only to help keep the patient, staff, other patients, and visitors safe—and only as a last resort.

Categories of restraints

Three general categories of restraints exist—physical restraint, chemical restraint, and seclusion.

Physical restraint

Physical restraint, the most frequently used type, is a specific intervention or device that prevents the patient from moving freely or restricts normal access to the patient's own body. Physical restraint may involve:

- applying a wrist, ankle, or waist restraint
- tucking in a sheet very tightly so the patient can't move
- keeping all side rails up to prevent the patient from getting out of bed
- using an enclosure bed.

Typically, if the patient can easily remove the device, it doesn't qualify as a physical restraint. Also, holding a patient in a manner that restricts



movement (such as when giving an intramuscular injection against the patient's will) is considered a physical restraint. A physical restraint may be used for either nonviolent, nonself-destructive behavior or violent, self-destructive behavior. (See *What isn't a restraint?*)

Restraints for nonviolent, non-self-destructive behavior. Typically, these types of physical restraints are nursing interventions to keep the patient from pulling at tubes, drains, and lines or to prevent the patient from ambulating when it's unsafe to do so—in other words, to enhance patient care. For example, a restraint used for nonviolent behavior may be appropriate for a patient with an unsteady gait, increasing confusion, agitation, restlessness, and a known history of dementia, who now has a urinary tract infection and keeps pulling out his I.V. line.

Restraints for violent, self-destructive behavior. These restraints are devices or interventions for patients

who are violent or aggressive, threatening to hit or striking staff, or banging their head on the wall, who need to be stopped from causing further injury to themselves or others. The goal of using such restraints is to keep the patient and staff safe in an *emergency* situation. For example, a patient responding to hallucinations that commands him or her to hurt staff and lunge aggressively may need a physical restraint to protect everyone involved.

Chemical restraint

Chemical restraint involves use of a drug to restrict a patient's movement or behavior, where the drug or dosage used isn't an approved standard of treatment for the patient's condition. For example, a provider may order haloperidol in a high dosage for a postsurgical patient who won't go to sleep. (If the drug is a standard treatment for the patient's condition, such as an antipsychotic for a patient with psychosis or a benzodiazepine for a patient with alcohol-withdrawal delirium, and the ordered dosage is appropriate, it's *not* considered a chemical restraint.) Many healthcare facilities prohibit use of medications for chemical restraint.

Seclusion

With seclusion, a patient is held in a room involuntarily and prevented from leaving. Many emergency departments and psychiatric units have a seclusion room. Typically, medical-surgical units don't have such a room, so this restraint option isn't available. Seclusion is used only for patients who are behaving violently. Use of a physical restraint together with seclusion for a patient who's

behaving in a violent or self-destructive manner requires continuous nursing monitoring.

Determining when to use a restraint

The patient's *current* behavior determines if and when a restraint is needed. A history of violence or a previous fall alone isn't enough to support using a restraint. The decision must be based on a current thorough medical and psychosocial nursing assessment. Sometimes, addressing the issue that's underlying a patient's disruptive behavior may eliminate the need for a restraint.

Also, caregivers must weigh the risks of using a restraint, which could cause physical or psychological trauma, against the risk of *not* using it, which could potentially result in the patient harming himself or herself or others. Input from the entire care team can help the provider decide whether to use a restraint.

Alternatives to restraints

Use restraints only as a last resort, after attempting or exploring alternatives. Alternatives include having staff or a family member sit with the patient, using distraction or de-escalation strategies, offering reassurance, using bed or chair alarms, and administering certain medications.

If appropriate alternatives have been attempted or considered but have proven insufficient or ineffective or are deemed potentially unsuccessful, restraint may be appropriate. A provider order must be obtained for patient restraint. Be sure to update and revise the care plan for a restrained patient to help find ways to reduce the restraint period and prevent further restraint episodes.

Reducing restraint risks

Restraints can cause injury and even death. In 1998, TJC issued a sentinel event alert on preventing restraint deaths, which identified

What *isn't* a restraint?

The following items aren't considered restraints:

- devices used to immobilize a patient temporarily during a diagnostic procedure
- orthopedic supportive devices
- helmets or age-appropriate protective equipment, such as strollers and cribs.

Keeping all side rails up on a bed for seizure precautions and placing the patient on a narrow stretcher are considered safety interventions, not restraints.

the following risks:

- Placing a restrained patient in a supine position could increase aspiration risk.
- Placing a restrained patient in a prone position could increase suffocation risk.
- Using an above-the-neck vest that's not secured properly may increase strangulation risk if the patient slips through the side rails.
- A restraint may cause further psychological trauma or resurfacing of traumatic memories.

To help reduce these risks, make sure a physical restraint is applied safely and appropriately. With all types of restraints, monitor and assess the patient frequently. To relieve the patient's fear of the restraint, provide gentle reassurance, support, and frequent contact. Monitor vital signs (pulse, respiration, blood pressure, and oxygen saturation) to help determine how the patient is responding to the restraint.

Changing the culture

The American Psychiatric Nurses Association's position statement on the use of restraint suggests a unit's philosophy on restraint use can influence how many patients are placed in restraints. Interacting with patients in a positive, calm, respectful, and collaborative manner and intervening early when conflict arises can diminish the need for re-

straint. Facility leaders should focus on reducing restraint use by supporting ongoing monitoring and quality-improvement projects.

To help ensure a restraint is applied safely, nurses should receive hands-on training on safe, appropriate application of each type of restraint before they're required to apply it. Such training also should occur during orientation and should be reinforced periodically.

The goal is to use the least restrictive type of restraint possible, and only as a last resort when the risk of injury to the patient or others is unacceptably high. Consider using restraint only after unsuccessful use of alternatives, and only as long as the unsafe situation occurs. Remember—restraint use is an exceptional event and shouldn't be a part of a routine protocol.

Selected references

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