

Focus on... Safe Use of Restraints



This Focus On... section of *American Nurse Today* was funded by an unrestricted educational grant from Posey Co. Content was developed independently of the sponsor and all articles have undergone peer review according to *American Nurse Today* standards.

When and how to use restraints

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

By Gale Springer, RN, MSN, PMHCNS-BC

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

- American Psychiatric Nurses Association. APNA Position Statement on the Use of Seclusion and Restraint. Original 2000; revised 2007; revised 2014. www.apna.org/i4a/pages/index.cfm?pageid=3728. Accessed November 4, 2014.
- American Psychiatric Nurses Association. Seclusion & Restraint Standards of Practice. May 2000; Revised May 2007; revised April 2014. www.apna.org/i4a/pages/index.cfm?pageid=3730. Accessed November 4, 2014.
- Federal Register. Part II; Department of Health and Human Services, Centers for Medicare & Medicaid Services; Medicare and Medicaid Programs. 42 CFR Part 482; Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients' Rights; Final Rule. December 8, 2006. www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/downloads/finalpatientrightsrule.pdf. Accessed November 26, 2014.
- Joint Commission, The. Hospital Accreditation Standards. Provision of Care, Treatment and Services. Standards PC.03.05.01 through PC.03.05.19. 2010.
- Joint Commission, The. Sentinel Event Alert. Issue 8, November 18, 1998. Preventing Restraint Deaths. www.jointcommission.org/assets/1/18/SEA_8.pdf. Accessed November 4, 2014.
- Gale Springer is a mental health clinical nurse specialist at the Providence Regional Medical in Everett, Washington.**

Choosing the right restraint

Keeping patients and others safe is crucial, but restraints should be used only as a last resort.

By Christy Rose, MSN, RN, CCRN, CNRN

Nurses at the bedside are experts in driving the safest, most effective patient care. In some cases, nursing assessment and clinical judgment suggest the need to apply restraints. A patient who is violent or self-destructive or whose behavior jeopardizes the immediate physical safety of him- or herself or another person may meet the behavioral health requirements for restraints. Examples of such behaviors include:

- hitting, kicking, or pushing
- pulling on an I.V. line, tube, or other medical equipment or device needed to treat the patient's condition
- attempting to get out of a bed, chair, or hospital room before discharge, in patients who are confused or otherwise unable to follow safety directions.

Before using restraints, always explore alternatives for keeping the patient and others safe. When considering such options, discuss with the patient any conditions that may need to be addressed, such as pain, anxiety, fear, or depression. If distraction and other alternatives prove ineffective at calming the patient and he or she continues to pose a risk, consult with other healthcare team members. You may want to use an algorithm to help determine if your patient requires restraints. (To access the author's algorithm, visit www.AmericanNurseToday.com/Archives.aspx.)

Placing a patient in restraints requires a consult from the behavioral health team to consider behavioral restraint options—for instance, certain medications, distraction, seclusion, blanket wraps,

or manual locked restraints. If such options don't apply to your patient, proceed with restraints applicable for nonviolent, nonself-destructive patients, such as mitts, soft wrist restraints, or a chest vest. (See *Decision tree for nonviolent, nonself-destructive restraint*.)

Restraint options

Which type of restraint to use depends on the patient's behavior and condition.

Hand mitts and freedom sleeves

If the patient is confused and impulsive and doesn't follow directions but can be redirected, consider hand mitts to decrease grabbing ability. Or consider "freedom sleeves" (also called soft splints). These are a good deterrent for patients trying to remove a medical device from the face or head (such as a nasogastric tube or drain). With freedom sleeves, patients have difficulty bending their arms. Be aware, though, that the sleeves don't necessarily prevent them from removing I.V. lines.

Hand mitts and freedom sleeves let the patient move the arms up and down but limit the ability to bend and grab tubes or drains. They can be removed by unstrapping the hook-and-loop closures and sliding them off the arms. Be sure to monitor patients closely because they may try to remove these restraints themselves.

Enclosure bed

An enclosure bed helps prevent patient injury by stopping the patient from getting out of bed unassisted. It may be a good option for

patients who meet the criteria for this bed. (For more information, read "Enclosure bed: A protective and calming restraint" in this issue.)

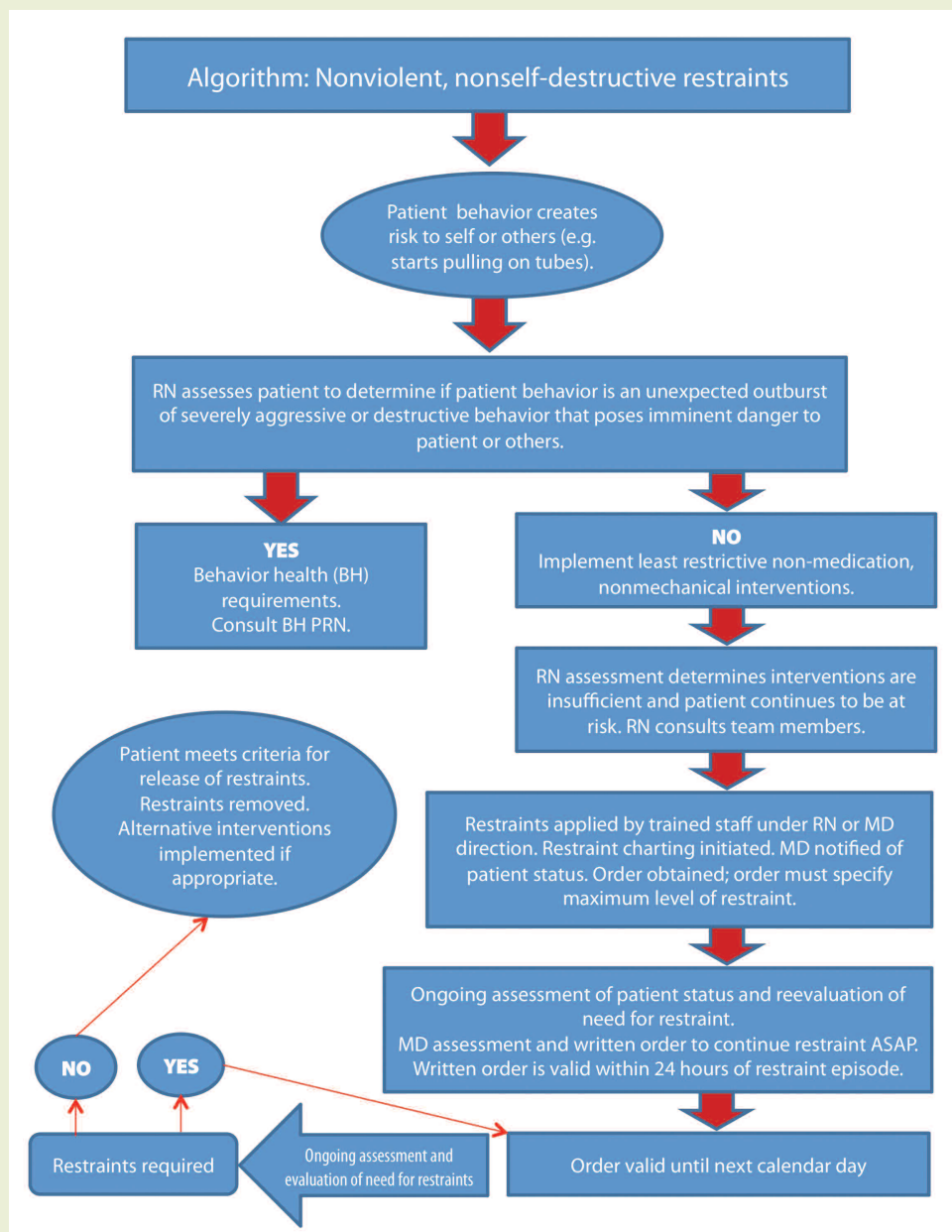
Chest vests and lap belts

Chest vests and lap belts (also called waist belts) may be warranted for confused or impulsive patients who are continually trying to get out of bed or a chair after repeated redirection, when it's unsafe for them to get up unaided. Apply the vest or belt according to the manufacturer's instructions. Fasten it securely to an immovable part of the bed or chair. Make sure you can easily slide your fingers underneath the vest or belt so it's not too tight. It shouldn't press uncomfortably against the skin, which could cause redness or impede expansion of the patient's midsection during respiration. Instruct the patient to call for assistance when he or she wants to get up.

Limb restraints

Soft bilateral limb holders on both wrists may be appropriate for patients who are becoming increasingly agitated, can't be redirected with distraction, and keep trying to remove needed medical devices. When device removal would pose serious harm to the patient and cause a significant setback to recovery, or if the patient is a physical threat to him- or herself or others, limb restraints help protect the patient and staff and remind the patient not to pull on the device. Typically, these restraints are used for patients in intensive care units who have endotracheal tubes, intracranial pressure monitoring de-

Decision tree for nonviolent, nonself-destructive restraint



© Christy Rose, MSN, RN, CCRN, CNRN. 2014.

vices, chest tubes, external fixators, skeletal traction, or other devices whose removal would imperil the patient's health. In many cases, these patients are receiving sedatives or opioids to relieve pain and anxiety, impairing their safety awareness.

In more extreme cases, patients who are severely agitated or intoxicated, are undergoing alcohol or drug withdrawal, or can't follow safety directions may require arm and leg restraints, chemical re-

straint, or both. These methods should be used only for short periods. Monitoring requirements may call for one-to-one observation. Soft limb restraints are preferred, but locked cuff restraints can be used if soft restraints prove ineffective. Chemical restraints require a provider assessment and a one-time order with close patient monitoring.

Four-point restraints, which restrain both arms and both legs, usually are reserved for violent patients who pose a danger to them-

selves or others. Caregivers may use a combination of chemical sedation and four-point restraints to calm the patient as long as he or she poses a danger.

Monitor the patient in four-point restraints every 15 minutes. Know that these restraints must be reduced and removed as soon as safely possible. To reduce a four-point restraint, remove it slowly—usually one point at a time—as the patient becomes calmer. During removal, reorient the patient and contract with him or her for safe behavior.

A last resort

Keeping patients and others safe is extremely important, but restraints should be used only as a last resort. When they're needed, choose the least restrictive restraint possible. Reassess a restrained patient continually and remove restraints as soon as possible. During the restraint episode, educate patients and their families about the restraints and

keep them engaged in the care the patient's receiving. Be sure to document your assessment findings and progress toward restraint removal to help "tell the story" of the restraint incident.

Visit www.americannursetoday.com/?p=18948 for information on distraction techniques and on applying restraints and a list of selected references.

Christy Rose is a staff nurse in the surgical intensive care unit at Denver Health Medical Center in Denver, Colorado.

Enclosure bed: A protective and calming restraint

Learn about an alternative to more restrictive restraints.

By Jennifer L. Harris, RN, MS, NE-BC

An enclosure bed can be used as part of a patient's plan of care to prevent falls and provide a safer environment. This specialty bed has a mesh tent connected to a frame placed over a standard medical-surgical bed. Although it's considered a restraint because it limits the patient's ability to get out of bed, an enclosure bed is less restrictive than other types of restraints. It can be used as an alternative when a vest restraint would cause more agitation and wrist restraints aren't appropriate.

My 750-bed academic medical center became interested in the enclosure bed in 2007 as a way to decrease patient falls and patient-sitter costs. We've seen the enclosure bed have a calming effect on patients and give them more freedom than wrist and ankle restraints. Our hospital rents the bed; for a 24-hour period, the daily rental expense is much lower than the cost of a patient sitter. (See *A look at the enclosure bed*.)

Indications

Use of the enclosure bed hinges on the patient's behavior, so a patient-specific comprehensive assessment must be done. The bed may be indicated for patients who are at high risk for falls; are confused, impulsive, restless, or agitated; are unable to ask for assistance or respond to redirection; or who climb out of bed when it's unsafe to do so.

Other patients who might benefit from an enclosure bed include those with Alzheimer's disease or other types of dementia, traumatic brain injury, seizure disorder, Huntington's disease, or developmental

A look at the enclosure bed

The enclosure bed shown here (manufactured by Posey Co.) is for adults and children. A casing over the mattress is attached to the sides, preventing the patient from slipping underneath. The procedures used to elevate the head of the bed and change bed height are the same as those for a standard med-surg bed.



delays. The bed also may be indicated for patients recovering from stroke, as well as for patients with delirium associated with alcohol withdrawal who have completed treatment for acute withdrawal.

Inclusion criteria

To be considered for the enclosure bed, the patient must be at high risk for falling and must demonstrate one or more of the following:

- impulsiveness
- agitation
- inability or unwillingness to ask for assistance or respond to redirection
- unsteady gait
- wandering behavior.

A history of falling alone isn't enough to warrant use of the enclosure bed or other restraints.

Exclusion criteria

Patients shouldn't be placed in an

enclosure bed if they are violent, combative, self-destructive, suicidal, or claustrophobic. Although the bed has small holes for one or two I.V. lines and an indwelling urinary catheter, patients with multiple lines generally are excluded. If the patient becomes increasingly agitated, terrified, or distraught after being placed in the bed, clinicians must reassess the situation and try a different intervention.

Evaluation period

Before our hospital decided to add the enclosure bed to our approved specialty rental inventory, staff nurses and other providers conducted an evaluation to identify patient risk behaviors that could be managed in this bed. The hospital conducted a 6-month trial of the enclosure bed, during which staff used the bed and completed an evaluation tool. The tool asked specific questions about staff com-

fort level with the bed, ease of use, family response to the bed, and whether the bed met the patient's needs.

Education and implementation

Based on staff feedback and positive patient outcomes during the evaluation, the enclosure bed was added to potential interventions to prevent falls and to provide a safer environment for patients. Our facility has developed processes to request or order the bed, monitor the patient while in the bed, and discontinue the bed.

The enclosure bed was introduced as a type of restraint to providers who have the authority to order restraints. Staff nurses received education on indications for the bed, how to operate it, and documentation requirements. Nursing staff at the unit level worked with provider teams to implement the enclosure bed.

Education consisted of reviewing the procedural checklist, watching an instructional video and completing a self-learning module on restraint use. During the demonstration on how to zip the panels and use the locks on the zippers, nurses had the chance to get into the bed to see what it's like.

Required processes

Before an enclosure bed is requested, nursing staff must review with the provider team the behavior that puts the patient at risk for falls and injury, as well as for impulsive behavior that harm the patient or staff. One example is an impulsive patient with early-onset dementia who is hitting and kicking at staff.

As with all restraints, an enclosure bed requires a provider restraint order that must be renewed every 24 hours. Before a patient is placed in the bed, staff try less restrictive options, such as distraction, bed and chair alarms, reducing stimuli, and moving the patient to a room closer to the nursing sta-

tion. Once the decision to use an enclosure bed is made, clinicians must educate the family about the bed, its function, the reason for using it, how the panels are zipped and unzipped, and how the bed contributes to a cocoon-like environment. If family members aren't available in the hospital, the charge nurse contacts a family member by phone to explain the change in the patient's care.

Using a restraint flowsheet, nursing staff document the patient's response to the enclosure bed and the frequency with which they met the patient's care needs during bed use.

When the patient's behavior improves, the enclosure bed is discontinued. The specialty bed coordinator is notified and the vendor picks up the bed.

Placing the patient in the bed

Before using the bed, inspect it for proper assembly. Then unzip the bed and adjust the head of the bed. Once the patient has been placed in the bed, sit in a chair next to the bed for a few minutes with the sides unzipped to help him or her get acclimated. Adjust the head of the bed so the patient can sit in it comfortably. Then zip the sides and see how the patient reacts to the enclosure. If the patient will be left alone, place a call button within reach.

The patient's activity schedule should include getting him or her out of the bed multiple times a day. Staff should assist the patient to ambulate at least three times daily. The patient should sit in a bedside chair for all meals, if able to tolerate ambulation and activity. According to the Centers for Medicare & Medicaid Services' Interpretive Guideline §482.13(e) (6), "a temporary, directly supervised release...for the purposes of caring for a patient's needs (e.g. toileting, feeding, or range-of-motion exercises) is not considered

a discontinuation of the restraint. As long as the patient remains under direct staff supervision, the restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the restraint."

Outcomes

In our hospital, the enclosure bed was incorporated quickly into the safety plan for med-surg patients. The adult med-surg nursing staff has used the bed with more than 200 patients. On average, patients stay in the bed about 6 days; no patient falls or injuries have occurred. In some facilities, using the bed decreases overall sitter expenses. Our experience has shown a slight reduction in sitter hours when the bed is used.

Based on our positive experiences and patient outcomes, we will continue to use the enclosure bed as an option for fall prevention and patient safety.

Several patients have been discharged from our hospital with a plan of care that included an enclosure bed. In the home, the bed can be used for patients with agitation secondary to dementia or for pediatric patients with significant chronic neurologic or behavioral problems. The experience the families gained with the enclosure bed in the hospital helped provide a safe discharge plan for several patients.

Involving staff with an initial trial of the bed, identifying appropriate patient criteria, and educating staff, patients, and families about the bed's benefits have contributed to successful implementation of this specialty bed.

Visit www.americannursetoday.com/?p=18950 for information on caring for a patient in an enclosure bed, using the enclosure bed with pediatric patients, and a list of selected references.

Jennifer L. Harris is a senior advanced practice nurse at the University of Rochester Medical Center-Strong Memorial Hospital in Rochester, New York.

Assessing and documenting patient restraint incidents

Accurate information can promote restraint-free care.

By Jim Woodard, RN, MBA

Restraining a patient is considered a high-risk intervention by the Centers for Medicare & Medicaid Services, The Joint Commission (TJC), and various state regulatory agencies, so healthcare providers must carefully assess and document the patient's condition.

baseline, assess his or her mental status, mood, and behavioral control. This allows clinicians to later determine how the patient is tolerating restraint and helps ensure restraint will be discontinued as soon as clinically indicated.

Medications can be an important part of a restraint intervention. Appropriate use of as-needed medications can shorten the restraint time. Assess the patient's response to medications.

Assessment during the restraint period

A restrained patient is susceptible to injuries caused by restricted breathing, circulatory problems, and mechanical injuries. Once restraints have been applied, take steps to ensure a safe, injury-free outcome. Perform a quick head-to-toe assessment to help identify areas of concern or conditions

that require further monitoring.

Being restrained is a traumatic experience for the patient, so continually assess how he or she is dealing with the stress.

Documentation

Accurate documentation of the restraint episode is vital to safe, effective patient care and provides information that can improve the quality of care. Document the reason for restraint and that you explained the reason to the patient and family.

You can use a flowsheet to doc-

ument assessments. The flowsheet should include the following:

- patient behavior that indicates the continued need for restraints
- patient's mental status, including orientation
- number and type of restraints used and where they're placed
- condition of extremities, including circulation and sensation
- extremity range of motion
- patient's vital signs
- skin care provided
- food, fluid, and toileting offered.

Also, include the education you provide to the patient and family. Remember—the goal is to remove the restraints as soon as possible.

Post-restraint debriefing

When the restraint episode ends, a nurse or other qualified caregiver should debrief the patient. Reviewing the restraint episode with the patient yields important information that can help lead to restraint-free treatment. Information gained from debriefing helps the treatment team design therapeutic interventions that may help prevent the need for restraints. Be sure to document the debriefing.

Toward restraint-free care

Accurate assessment and documentation of restraint episodes provide valuable information to improve treatment processes, ultimately helping nurses create an environment where restraint-free care is possible.

Visit www.americannursetoday.com/?p=18952 for a list of selected references.

Jim Woodard is the associate chief nursing officer at Porter Adventist Hospital in Denver, Colorado.

Assessing the patient's medical condition

Review the patient's medical record for preexisting conditions that can cause behavioral changes—for instance, delirium, intoxication, and adverse drug reactions. If the behavior results from an underlying medical problem, accurate assessment allows timely medical intervention and may reduce the restraint period required or even eliminate the need for restraint.

Assessing the patient's behavior

To establish the patient's behavioral

