Restraints/Restrictive Practices

A Philosophy for Using Restraints

What are restraints?
A restraint can be any mechanical device (physical restraint) or drug (chemical restraint) used to limit the normal movements of a patient.

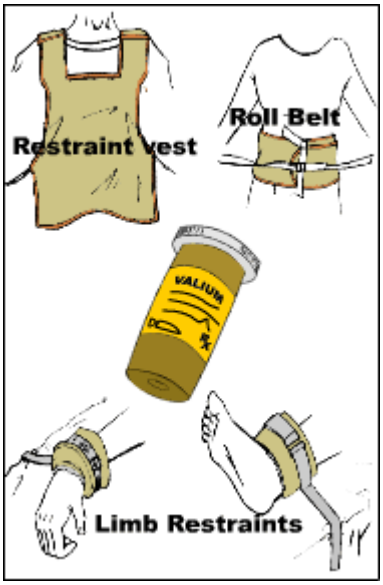
Physical restraints

Physical restraints include any device used for the purpose of restricting the movement of a patient or denying the patient access to parts of the body. Examples of physical restraints:

- Mittens
- Vests
- Limb restraints
- Chest restraints
- Roll belts

A siderail, when used for the SOLE PURPOSE of keeping a patient in bed, is also a restraint. However, half-rails that still allow a patient to get out of bed, or that are raised to assist a patient in turning or for some other purpose are NOT considered restraints. Similarly, supportive devices, such as a sling for a sprained wrist, are not restraints even though they may restrict movement.

Soft (cloth) restraints may have to be replaced by stronger restraints (4-point leather) for extremely agitated or combative patients. Leather restraints, used to secure ankles and/or wrists, are buckled into place and may be locked.



A restraint is a physical device or a drug used to restrict or limit the normal movements of a patient.

Chemical restraints

Chemical restraints include any drug given for the sole purpose of restricting the movements of a patient. Examples of chemical restraints:

- Sedatives
- Tranquilizers

Dangers of using restraints
There is always danger involved in restraining patients. In the US, approximately 100 deaths every year are blamed on the use of patient restraints.

The use of restraints has been shown to:

- Increase the number of falls (rails used to keep patients from falling sometimes cause more injury because of patients crawling **over** them and falling from a greater height)
- Increase the patient's length of stay in hospital (this can happen as a result of injuries acquired when patients try to free themselves from restraints)
- Increase mortality rates (patients are occasionally strangled by ties used to secure them to the bedrail, or they may die from cardiac arrest due to the increased agitation of being restrained).

The use of restraints increases the number of patient falls, the length of stays in hospital, and mortality rates.

Patients escaping physical injury from restraints may still suffer emotional injury. Patients have reported:

- Feeling humiliation and shame
- Being increasingly confused
- Not understanding why they were being restrained

Restraints are to be used ONLY as a last resort. They are used when other measures are not effective and the patient could injure himself or others if his movement is not restricted. At times, combative and confused patients who are potentially violent need to be restrained during an acute outburst. Patients who are simply confused, but not violent, should ONLY to

be restrained if they are endangering themselves or others AND other methods are not working. The least restrictive type of restraint must always be chosen.

Your facility may have policies that determine when restraints can be applied. Follow all policies of your facility. Before taking any action, you must document (in writing) the reasons why restraints are necessary (for example, "the patient is not able to understand the reason for having an IV line and persists in removing it") and the reasons for choosing the particular type(s) of restraints (for example, "a soft wrist restraint is being used to prevent the patient from pulling out the IV line").

In the above example, a patient, unable to understand the reason for using an IV line, may try to remove it. That patient would have to be placed in a soft wrist restraint for ONLY as long as he or she is still not able to understand the reason for the IV being in place. The restraint would be removed immediately once it has been determined that the patient is able to understand the necessity of having the IV line in place.

When not to use restraints
Traditionally, restraints have been used when there were concerns about patients falling. However, research has shown that although the use of restraints has decreased, the number of injuries from falls has NOT increased. That research would suggest that restraints **do not help** to prevent falls.

Sometimes restraints are applied for convenience, because of staff shortages. It may seem easier to put patients in restraints when staffing is "short," so that patients do not fall with fewer staff to watch them. However, studies have shown that dramatically decreasing restraint use actually **decreases** the number of falls and other injuries, even when staffing is "short."

There are important factors to consider before deciding to use restraints:

- The policies of your particular facility must be followed.
- There must be a **very good** reason for applying restraints of any kind.
- Except in an extreme emergency, other methods of handling the patient must be tried first.
- Restraints MUST NOT be used for the convenience of the staff.

Alternatives to Restraints

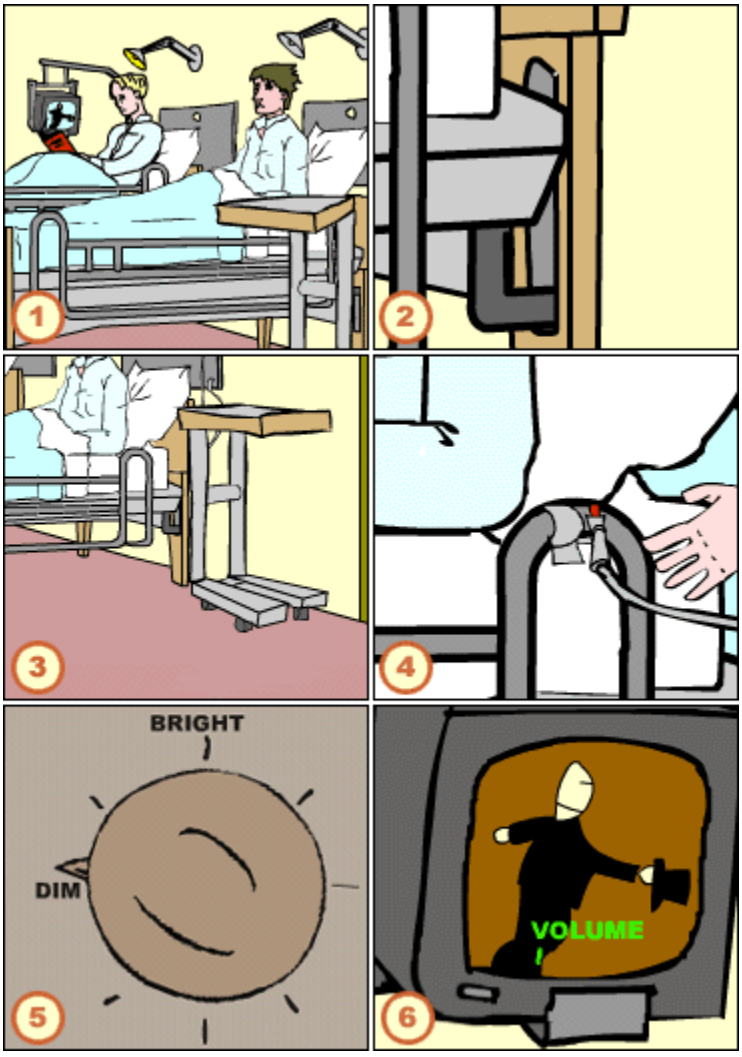
The confused patient and restraints
Confusion by itself is not a reason to use restraints. Restraints can further confuse patients and cause increased agitation. Alternatives to restraints should be used whenever possible with ALL patients, including confused patients.

Some measures to help minimize the use of restraints include:

- Analyzing medications that could be causing confusion or restlessness
- Analyzing treatments that may be particularly bothersome to the patient
- Avoiding the use of tubes, if at all possible (they can be a source of aggravation and give a confused patient something to pull at)
- Removing nasogastric tubes as soon as possible
- Offering assistance with oral intake
- Keeping IV lines and other solution bags out of sight
- Using adult diapers with foley catheters to prevent patients from pulling catheter out
- Offering opportunities for frequent toileting
- Using larger than needed dressings so patients can't pick at wounds.

Environmental interventions
A patient's environment can contribute to disorientation and falls. Some changes can often be made in the patient's room to decrease the chance of falls and to help him to stay oriented. These "environmental interventions," which reduce the need for restraints, include:

- Keeping the bed at the lowest level possible, or placing the mattress on the floor.
- Installing a bed alarm that detects patient movement and alerts staff.
- Keeping the path to the bathroom free of obstacles such as tables or chairs
- Using a nightlight or lamp so the patient is able to see where he or she is going
- Keeping lights lowered if they are too stimulating or disturb the patient
- Making sure the emergency call button or light is within reach of the patient and that the patient knows how to use it
- Placing a commode near the patient so trips to the bathroom won't be necessary
- Reducing noise level wherever possible so as not to disturb the patient (for example, by keeping voices down, turning down ringers on phones or lowering volumes on nearby TVs)
- Drawing the curtains (around the bed or on the windows) to eliminate distractions.



Psychosocial interventions
Patients' fears, as well as other feelings, play a large part in determining how they behave.

The psychosocial aspect involved in providing patient care cannot be overlooked when trying to avoid the use of restraints.

Psychosocial elements for avoiding the use of restraints include:

- Assigning consistent caregivers to promote feelings of familiarity and security
- Incorporating a schedule similar to the patient's normal home schedule for eating, sleeping, toileting, and relaxing
- Providing reassurance to the patient by keeping all personal aids, such as eyeglasses, hearing aid, cane, walker, dentures, prosthesis, etc., close at hand
- Asking family members to bring in favorite pillows, photos, blankets, etc.
- Having a family member (or sitter) stay with the patient, if necessary
- Reminding the patient of where he or she is and why
- Reminding the patient of the date, day, and time
- Keeping a clock in view of the patient for awareness of the time
- Explaining actions or treatments and reinforcing them (over and over, if necessary)
- Providing favorite TV or radio programs and newspapers
- **Talking to** the patient
- **Listening to** to the patient.

When behavior is disruptive or inappropriate, try to determine why the patient is behaving in that manner. Reasons could include:

- Type or strength of medication
- Lack of exercise throughout the day (which makes sleep difficult at night)
- Worry about issues at home
- Fear of medical procedures to be faced.

Types of Restraints

Side rails
A side rail on a bed is a restraint if it is intended to restrict movement of the patient. Currently, the emphasis is on restraint reduction and the traditional use of side rails as restraints should be avoided whenever possible. An effective alternative in many cases is to install a bed alarm that detects patient movement and alerts staff.

If there is no alternative to using side rails as a restraint, observe the following guidelines.

<u>DO:</u>

- Check the patient frequently.
- Remember that patients sometimes try to climb over a side rail.
- Place the call button within easy reach of the patient.
- Make sure the patient knows how to use the call button.
- Tell the patient and family members why the restraint is being used and when it can be removed.
- Follow the policies of your facility.
- Document the use of the restraint.

NEVER restrain an agitated patient by raising the side rail.

A side rail may be an appropriate device for a patient who is sedated because it will help to remind the patient that help is required before getting out of bed. If the patient can use the side rail as a turning aid or to access bed controls, it is not considered a restraining device.

Limb restraints
Limb restraints are usually made from cloth and have padding to protect the skin at contact points. Examples include wrist restraints, mittens and ankle restraints. One end of a limb restraint is wrapped around the patient's limb and the other end is secured (usually to the bed frame). Limb restraints and mittens may be secured with ties, buckles, or Velcro straps.

- Wrist restrains are used to keep patients from pulling out tubes or disturbing dressings or wounds.
- Mittens are sometimes used instead of wrist restraints because they are less restrictive and allow for more patient movement.
- Ankle restraints are used to prevent disturbing dressings or wounds and may also be necessary for patients who are kicking or trying to get out of bed.

Currently, with the emphasis on restraint reduction, traditional types of limb restraints are being replaced by positioning devices.

The guidelines listed below may be helpful when using limb restraints.

<u>DO:</u>

- Follow the directions of the manufacturer
- Use restraints of the appropriate size
- Attach limb restraints to the bed frame (so they move with the bed when raised or lowered)
- Use quick-release knots that can be untied easily in case of an emergency
- Check circulation and ensure that restraint is tight enough to limit movement WITHOUT impairing circulation
- Offer food and fluids frequently, and provide assistance
- Offer a bedpan frequently, and provide assistance
- Tell patients and their families why restraints are used and when they can be removed
- Document the use of all restraints, including times the patient was offered food, fluids, and opportunities for toileting
- Follow the policies of your facility
- Check the patient frequently.

<u>DO NOT:</u>

- Attach limb restraints to the bedrail
- Tie restraints tight enough to impair circulation.

<u>Every two hours:</u>

- Remove the restraints
- Check the patient's circulation
- Inspect the skin for signs of injury
- Provide range-of-motion exercises to limbs released.

Belt restraints
A belt restraint is sometimes used to keep patients in a chair or wheelchair. Their use should

be avoided if at all possible. With the current emphasis on restraint reduction, wheelchairs are now being manufactured with self-release belts installed.

The guidelines listed below may be helpful when using belt restraints.

DO:

- Use a restraint of the correct size
- Follow the manufacturers directions for proper application
- Tell patients and their families why restraints are used and when they can be removed
- Check the belt, and the patient, frequently
- Follow the policies of your facility
- Document the use of all restraints.

DO NOT:

- Secure restraint too tightly
- Leave the patient unsupervised for any length of time.

Chest and vest restraints
There are times when patients must be immobilized in a bed or chair. However, chest and vest restraints should ONLY be used as a last resort. They not only restrict patient movement, but they also pose a safety hazard to the patient.

The guidelines listed below may be helpful when using chest and vest restraints.

DO:

- Use a restraint of the correct size
- Follow the manufacturers directions for proper application
- Tell patients and their families why restraints are used and when they can be removed
- Attach chest/vest restraint to the bed frame (that will move as the bed is raised or lowered)
- Reposition the patient **at least** every 2 hours and adjust pillows for comfort
- Check the patient, frequently
- Follow the policies of your facility
- Document the use of all restraints.

DO NOT:

- Attach a chest/vest restraint to the bedrail
- Use a chest/vest restraint if a less restricting device would be adequate.

Restraint Orders

What are restraint orders?
An order to restrain a patient MUST come through the proper authorities. It is usually issued by a licensed independent practitioner (LIP) such as a medical doctor (MD), a doctor of osteopathy (DO), or nurse practitioner (NP). Some hospitals might allow a physician assistant (PA) to give a restraint order, but this is not common and depends on privileges granted by the hospital.

A restraint order must contain:

- The type of restraint ordered
- The reason for the restraint (based on the behavior of the patient - NOT on a diagnosis)
- The time limit or duration of the restraint (NOT more than 24 hours)
- The signature of the practitioner who issued the restraint order.

Important Note about JCAHO Standards
As of April of 2005, the Joint Commission on Accreditation has clarified their standards relating to restraints used in behavioral health settings. The intent of that clarification was to address some confusion regarding whether the Acute Care Standards or the Behavioral Health Standards should apply when caring for a behavioral health patient in an acute care, rather than a behavioral health, setting.

Most importantly, the **Behavioral Health Standards should be employed ANY TIME restraint and seclusion is used for behavioral health reasons,** regardless of the setting, even when that setting is acute care.

For more information, on Joint Commission standards on this topic, click the following link: http://www.jointcommission.org/AccreditationPrograms/BehavioralHealthCare/Standards/09_FAQs/PC/Restraint+_Seclusion.htm

Duration and frequency of restraint orders
A time limit must be written into every restraint order and the length of time is based on the age of the patient, the reason for restraint, and hospital policy. A restraint may be applied for **no more** than 24 hours.

Patient behavior must be monitored and documented at least once every hour. As soon as the patient does not meet the criteria for the restraint, it must be removed. If a restraint has to be continued beyond the 24-hour time limit, a new order must be obtained.

Written restraint orders and protocol restraint orders
Written Restraint Orders
A restraint order is normally written by a licensed independent practitioner. In serious psychiatric cases, a restraint may be ordered verbally, but the licensed independent practitioner must then assess the patient within 1 hour of the restraint being applied and sign the order within 24 hours.

Protocol Restraint Orders
Some facilities have specific protocols for applying restraints. Criteria for restraints are clearly defined and relate to specific conditions and patient behavior. To use protocol procedures, a licensed independent practitioner must have issued a Standing Order in advance, indicating that protocol procedures are to be followed. In this case, a nurse may follow protocol instead of needing an individual order for each instance of restraint.

Protocol Restraint Orders are similar to Standing Orders for patient treatment. Nurses can use Standard Orders to administer treatment when certain conditions apply, without calling the doctor for a specific order.

Documentation
When restraints are applied, all monitoring activities must be thoroughly documented. Most facilities have specific forms on which to document the monitoring of the patient in restraints.

Monitoring activities that must be documented include:

- Releasing the restraints at least every two hours

- Repositioning the patient
- Checking circulation and performing range-of-motion exercises
- Checking the patient's skin condition and noting skin care procedures
- Offering nutrition/fluids at least hourly, unless sleeping (note times and patient's responses)
- Providing toileting opportunities at least hourly, unless sleeping (note times and patient's responses)
- Assessing patient behavior at least hourly (to clarify the reason for continuing the restraint)
- Assessing patient response to being restrained
- Removing the restraints (when the criteria for the restraints no longer exist).

End of Restraints/Restrictive Practices Lesson