

Safety Regarding Restraints

Justin, age 17, is admitted to the hospital with acute psychosis related to his diagnosis of schizophrenia. He also has uncontrolled diabetes. Justin has made a serious attempt to harm himself and has made gestures to harm others. In addition, he may be experiencing diabetic ketoacidosis. The only alternative to keep him and others safe is to medicate and restrain him until he can control his behavior. Although not the desired action, the nurse recognizes a need to intervene to protect the patient and others until his condition stabilizes.

Literature Review

Few current articles are available regarding restraints used in medical hospitals. A search of ProQuest with key words of *restraints* and *nursing* yielded 900 items. Few of these were specific to hospitals and even fewer were specific to the United States. A CINAHL search revealed 3,148 items regarding restraints but, again, not explicit to medical hospitals; 258 were in reference to chemical restraint. Medline had 1,539 articles regarding restraints and 51 articles addressing chemical restraints. Most of the information regarding restraints focused on older adults residing in nursing homes or psychiatric hospital use.

Types of Restraints

Three main types of restraint are used: physical, chemical, and seclusion (Springer, 2015). Physical restraint, which is used most commonly, involves use of an intervention or device that hinders the patient from moving or restricts the individual from contact with his or her body. According to Springer, physical restraint generally involves one or more of the following:

- A wrist, ankle, or abdomen restraint
- A sheet tucked in so tight it restricts movement
- The use of all side rails to prevent the patient from leaving the bed
- The use of an enclosure bed
- Tightly holding the patient so he or she cannot move limbs or head and cause further damage to self or others

The enclosure bed is an innovative restraint (Harris, 2015) recently introduced for use as part of a patient's plan of care to prevent falls and promote safety. The device consists of a mesh tent connected to a frame placed over a standard hospital bed; it limits the

patient's ability to leave the bed. This device is used most often as an alternative to vest or wrist restraints, and may be indicated for the patient who tries to leave the bed when it is unsafe to do so. Additionally, patients with dementia, traumatic brain injury, seizure disorder, Huntington's disease, or other developmental conditions (e.g., severe autism, intellectual/learning disabilities) may be well suited for use of the device. Harris indicated use of the enclosure bed has contributed to decreased sitter costs and patient falls. The bed is rented by the hospital per day from a vendor. Nurses should be trained before using the enclosure bed. As with all restraints, an order must be renewed every 24 hours for use of the enclosure bed and all other less-restrictive options must have been exhausted (Centers for Medicare & Medicaid Services [CMS], 2013).

Treatment in the Medical Setting

The nurse in the medical setting should be prepared for psychiatric emergencies. Additionally, it is the nurse who decides whether to use restraints (Lach, Leach, & Butcher, 2016). Birkeland and Gildberg (2016) noted the following about restraint use for a psychiatric emergency: "Mechanical restraints can be considered necessary to avert patients from either exposing themselves or others to imminent danger" (p. 10). However, little additional information is available regarding crisis in the medical setting. Nurses commonly address co-morbid conditions in hospitalized patients. The situation with Justin thus is not unique. However, if nurses are not prepared before an event occurs, the situation can escalate quickly. Staff may find it difficult to implement restraint; other patients also may find it difficult to witness restraint of a peer. However, the authors suggest there is no time for guessing or making novice mistakes. Staff should be prepared for crisis and know their organizational policy on use of restraint.

Patients may come from other areas of the hospital (e.g., emergency department), to the medical-surgical unit in four-point restraints. After patient transfer, chemical restraints may be used after physical restraints are removed (Springer, 2015). Although injections or oral medications (e.g., tranquilizers such as haloperidol [Haldol®]) may be used as restraints, they may not be documented as such. For example, a healthcare provider may order haloperidol for someone who experiences aggression and insomnia after a surgical treatment. If this medication was not considered a standard treatment for the patient's condition, it could be viewed as a chemical restraint (Springer, 2015). Alternatives to restraint use such as one-to-one care may be more successful but the use of additional staff adds further cost

Renee N. Bauer, PhD, MS, RN, is Assistant Professor, Program Director for Accelerated Track, Indiana State University, Terre Haute, IN.

Jan Weust, DNP, RN, is Assistant Professor of Nursing, School of Nursing, Indiana State University, Terre Haute, IN.

for the organization. Unlike the psychiatric unit where each patient in restraints is watched by a single staff member, hospitals are not mandated to provide one-to-one supervision (Staggs, Olds, Cramer, & Shorr, 2017).

The American Nurses Association (ANA, 2012) strongly recommended registered nurses practice in a setting focused on active reduction of restraint and seclusion. Restraints have been associated with strangulation, agitation, complications from immobilization, increases in nosocomial infections, pressure sores, incontinence, and increases in stay and mortality (Hevener, Rickabaugh, & Marsh, 2016). However, dilemmas in patient care are an inevitable consequence when nurses struggle with patients' freedom while having an obligation to avert harm to other patients and staff. In addition, ANA (2012) noted some healthcare workers feel pressured into using restraints by family members or other members of the healthcare team.

Despite efforts to prevent the use of seclusion and restraint, the American Psychiatric Nurses Association (APNA, 2014) acknowledged these measures may be appropriate at specific times. In its position statement on the use of seclusion and restraint, the association recommended implementation of professional standards and quality care in all patient groups and settings with potential behavioral emergencies. The APNA also encouraged evidence-based practice based on research into factors related to prevention and management of behavioral emergencies. Healthcare providers must ensure all other options have been exhausted and consider restraint use the best possible decision in current circumstances (The Joint Commission, 2016).

Studies have demonstrated nurses and doctors do not always feel adequately trained to apply restraints (Barton-Gooden, Dawkins, & Bennett, 2015). One pilot study in the West Indies reported various practitioners in regions of the world express sadness, guilt, and fear when restraints are used. Although restraint use is declining in the United States, Jamaica continues to promote use, especially in nurses lacking evidence-based practice knowledge. Although restraint use is high in some global areas, healthcare providers report moral dilemma and institutional lack of support regarding restraints.

Generally, nurses must recognize antipsychotic medications have a therapeutic use; not simply chemical restraints, they provide treatment resulting in a decreased need for therapeutic holding or physical restraint (Springer, 2015). Implementation of a safe environment consists of sufficient nurse-to-patient staffing ratios that provide early intervention. Additionally, crisis prevention intervention is a lengthy training in many hospitals that can address escalation before initiating restraint.

Proper Training with Devices

Even though The Joint Commission (2016) and other regulators such as the CMS (2013) have indicated preference for a milieu without restraints, this may not be possible due to the emotional/cognitive lability of the psychiatric patient such as Justin in the medical setting

(Knox & Holloman, 2012). Staff in medical units must be prepared for crisis at all times. Proper training for the healthcare team is essential. Facilities receiving Medicare and Medicaid funds must follow The Joint Commission (2017) Standard EC.01.01.01, which requires the organization to develop a site-specific security management plan and staff training on the use of restraints. For example, a forensic behavioral health environment may have different restraint use and training criteria than a geriatric health environment. Once the required skill set and type/level of training are established, The Joint Commission also indicated the organization must create and implement their policies.

A medical-surgical unit should have properly trained staff, with enough personnel to prevent harm to an affected patient and others. The patient then could be transferred to a guarded area or room without unnecessary stimuli to promote calm, with one staff member responsible for giving directions. Even though the patient's behavior may be escalating, staff should be calm while giving simple directions and informing the patient of what is happening. The patient should be given as much privacy as possible. Additionally, the patient will be told of what needs to occur to end the restraint. Usually, this is completed by the patient voicing safe expectations (Lanthen, Rask, & Sunnqvist, 2015).

Alternatives are available to restraints. In some areas of the hospital, such as the medical-surgical intensive care unit, nurses have revisited the idea of patients using mitts rather than have them risk pulling out endotracheal tubes. One quasi-experimental study suggested using a tool called a restraint decision wheel (RDW). While this device was intended to decrease restraint use, the conclusion of the study supported nurses using mitts rather than following an RDW. Nurses previously had considered mitts a form of restraint; however, mitts were considered an alternative, can be used if not applied with any other physical restraint, and can be easily removed by the patient (Hevener et al., 2016). More research is needed in support of an RDW.

Documentation should be detailed, occur at the time of the crisis, and include all persons involved in the situation (Birkeland & Gildberg, 2016). This not only ensures accuracy of the record, but also provides protection should a question arise about correct application of the restraint. Training should occur yearly and for every new employee. It is easy to forget policy in a time of a crisis which does not allow time for one to reflect on proper procedure/technique. Documentation should include the following:

- Measures taken to prevent restraint use
- Date and time of restraint application
- Type of restraint used (e.g., leather, soft)
- Padding of bony prominences
- Restraint rationale
- Duration of restraint application
- Detailed patient assessment (e.g., mental status, activity level, condition of restrained extremity/extremities, rationale for continuing or discontinuing restraint)
- Nutrition offered (e.g., drink of water)

- Assessment of and meeting the need for elimination (toileting)
- Patient response, including any apparent emotional or physical pain during and following the activity
- Unexpected events or patient outcomes, with notification of the authorizing provider
- Patient and family education, the introduction of triggers that could precipitate escalation (Halter, 2014)

Additionally, the documentation should include any barriers to communication (The Joint Commission, 2016). This may be compounded by a medical diagnosis such as the one demonstrated by Justin.

Adolescent Restraint Use

Restraint in the adolescent includes any device applied to the patient with the intent to immobilize the patient's extremities (The Joint Commission, 2016). Restraints largely are intended to prevent patient interference with medical procedures. Manual restraint may involve the use of varying levels of force to hold an adolescent such as Justin during a necessary procedure while preventing harm to staff and patient. Following a written order from the treating clinician, staff who complete this procedure also must follow facility policy and manufacturer's guidelines. While parents and family members can be allowed to be present during the restraint, it may be emotionally distressing for them to witness. Family never should be asked to assist in restraint application. In Justin's case, although the family may have brought him to the facility, they were not required to assist in de-escalation. Education on how and why restraints were necessary is paramount and should be documented in the patient's record (Halter, 2014; Lanthen et al., 2015).

As with adults, restraint use never can be written as a standing order for adolescents (The Joint Commission, 2016). Recommendations determine the restraint order renewal and other specifications, such as order directives and time limitations. Time for renewal is contingent on patient age. For example, an order must be renewed every 2 hours for children ages 9-17; orders are renewed every hour for children under age 9. Also, according to The Joint Commission, restraints must be removed every 2 hours for a minimum of 15 minutes to allow inspection of skin, promotion of circulation, completion of range of motion exercises, and repositioning; in addition, patient elimination needs should be addressed. Additionally, hospitals now are mandated to report a patient death that occurs within 24 hours of restraint use.

Follow Institutional Policy

Nurses should follow institutional policy and accrediting agency's standards. Employees should have easy access to forms or electronic documentation to verify provision of safe care to the patient in restraints (Lanthen et al., 2015). Healthcare providers should ensure the restraint is used for the least amount of time; patients should have circulation checks of a restrained

extremity completed frequently, and they should remain in a safe supine or lateral position. Nursing measures include administering ordered medications as needed, and providing soothing, safe care at the time of crisis. Because nurses play a pivotal role in restraint application, they need proper training and knowledge to identify those at risk for restraint (Lach et al., 2016).

Debriefing

Debriefing after initiation of restraints is also important (Lanthen et al., 2015). Many restraint situations may have proceeded smoothly but persons involved should have the opportunity to state concerns and identify what went according to plan with each incident. This allows the healthcare team involved in the episode to decide collectively what needs to be modified when a crisis happens again. These situations may be emotionally charged, but being properly trained and debriefing both patient and staff will make the event less painful and promote collegiality in the workplace. It is also vital to debrief with the patient. When the patient can tolerate the conversation, Lanthen and colleagues recommended staff provide a rationale for restraint application and discuss how restraint use can be prevented for future episodes. Debriefing may prevent future episodes of restraint use (Azeem et al., 2015).

Conclusion

Collectively, healthcare workers can continue to work on measures concentrating on the reduction of restraints and continue to properly train staff. They must remember restraints are to be used as a last resort and continue to work as an interprofessional team. Traditionally, restraints have been used in the hospital to prevent patients from injuring themselves and maintain the use of therapeutic devices. Proper care and safety are paramount for patients such as Justin. Culture change requires nurses to receive comprehensive education on patients' rights, the indication for restraints, and appropriate alternatives (Hevener et al., 2016). Collaborative efforts are essential in creating a safe environment, and being cognizant of the risks for both patient and staff will lead the profession in the right direction. **MSN**

REFERENCES

- American Nurses Association (ANA). (2012). *Reduction of patient restraint and seclusion in health care settings*. Position statements. Retrieved from <http://www.nursingworld.org/restraintposition>
- American Psychiatric Nurses Association (APNA). (2014). *APNA position on the use of seclusion and restraint*. Retrieved from <http://www.apna.org/14a/pages/index.cfm?pageid=3728>
- Azeem, M.W., Reddy, B., Wudarsky, M., Carbeta, L., Gregory, F., & Sarofin, M. (2015). Restraint reduction at a pediatric psychiatric hospital; A ten-year journey. *Journal of Child and Adolescent Psychiatric Nursing, 28*(4), 180-184. doi:10.1111/jcap.12127
- Barton-Gooden, M., Dawkins, P.E., & Bennett, J. (2015). Physical restraint usage at a teaching hospital: A pilot study. *Clinical Nursing Research, 24*(1), 73-90. doi:10.1177/1054773813493112
- Birkeland, S., & Gildberg, F. (2016). Mental health nursing, Mechanical restraint measures and patients' legal rights. *The Open Nursing Journal, 10*, 8-14 doi: 10.2174/1874434601610010008

continued on page 355

Safety Regarding Restraints

continued from page 354

- Centers for Medicare & Medicaid Services (CMS). (2013). *Guidance for hospitals, critical access hospitals (CAHs) and ambulatory surgical centers (ASCs) related to various rules reducing provider/supplier burden*. Retrieved from <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-20.pdf>
- Halter, M.J. (2014). *Varcarolis' foundations of psychiatric mental health nursing: A clinical approach* (7th ed.). St. Louis, MO: Saunders.
- Harris, J. (2015). Enclosure bed: A protective and calming restraint. *American Nurse Today*, 10(1). Retrieved from <https://www.americannursetoday.com/use-enclosure-beds/>
- Hevener, S., Rickabaugh, B., & Marsh, T. (2016). Using a decision wheel to reduce use of restraints in a medical-surgical intensive care unit. *American Journal of Critical Care*, 25(6), 479-486. doi:10.4037/ajcc2016929
- Knox, D., & Holloman, G. (2012). Use and avoidance of seclusion and restraint: Consensus statement of the American Association of Emergency Psychiatry project BETA seclusion and restraint workgroup. *Western Journal of Emergency Medicine*, 13(1), 35-40. doi:10.5811/westjem.2011.9.6867
- Lach, H.W., Leach, K.M., & Butcher, H.K. (2016). Changing the practice of physical restraint use. *Journal of Gerontological Nursing*, 42(2), 17-26. doi:10.3928/00989134-20160114-04
- Lanthen, K., Rask, M., & Sunnqvist, C. (2015). Psychiatric patients experiences with mechanical restraints: An interview study. *Psychiatry Journal*, Article ID 748392. doi:10.1155/2015/748392
- Springer, G. (2015). When and how to use restraints. *American Nurse Today*, 10(1). Retrieved from <http://www.americannursetoday.com/use/use-restraints>
- Staggs, V.S., Olds, D.M., Cramer, E., & Shorr, R.I. (2017). Nursing skill mix, nurse staffing level, and physical restraint use in U.S. hospitals: A longitudinal study. *Journal of General Internal Medicine*, 32(1), 35-41. doi:10.1007/s11606-016-3830-z
- The Joint Commission. (2016). *Comprehensive accreditation manual for hospitals*. Oakbrook Terrace, IL: Author.
- The Joint Commission. (2017). *Standards FAQ details: Plans – Security management risk assessment Standard EC.01.01.01*. Retrieved from https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFaqlId=1182&ProgramId=46

Copyright of MEDSURG Nursing is the property of Jannetti Publications, Inc. and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.