Baptist Health

A Nurse's Guide to Restraints

Purpose

To provide nurses the necessary knowledge and skills to determine when the use of restraints is clinically appropriate and justified, and to provide effective assessment, implementation and evaluation of the patient and their response when the use of restraints is indicated.

Learning Objectives

- Explore personal values, beliefs, and practices as related to the use of restraints.
- Discuss the historical background and the ethical issues surrounding the use of restraints.
- Learn the requirements regarding restraints necessary to continue participation in the Medicare and Medicaid programs to protect patient rights.
- Review the Joint Commission Standards regarding restraint use.
- Learn strategies for avoiding behavior restraints.
- Apply critical thinking skills to practice case scenarios.

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Self-Study Packet & Test Compiled by Clinical Learning

A Nurse's Guide to Restraints

Introduction

"We, as nurses, have routinely restrained the frail, the elderly, the cognitively impaired, the confused and disoriented, all the while telling ourselves it was for their own good. Now because of public outrage and the sanctions against this practice, we find that we don't know how to deal with these patients. It's nobody's fault but our own." Ellen S., Retired RN, Port St. Lucie, Florida

A very strong opinion, but is there any truth in it? There are no easy answers to the complicated and controversial issue of restraint use. When reviewing the research on the nurse's use of patient restraints, it is apparent that nurses have not been adequately prepared to deal with this ethical issue. Historically the justification for the use of restraining devices has been for patient safety; that is, to prevent falls or removal of medical devices such as IVs, endotracheal and nasogastric tubes, and Foley catheters. Additionally, from a hospital's point of view, there has been a fear that should an unrestrained patient fall and sustain an injury, the hospital and/or nurse would be liable for negligence. In the past, when restraints were used it was in the belief that it would promote patient safety and, without effective restraint practices, patients were considered to be in danger of injuring themselves or others.

At this point in history however, the evidence on the detrimental effects of restraint use is clear and compelling, which means restraints should be utilized *only* when no other viable option is available. Registered nurses need the necessary knowledge and skills to effectively determine if the use of restraints is clinically appropriate and adequately justified, and must be actively involved in the assessment, implementation and evaluation of the patient and their response to this intervention.

In addition, professional nurses are legally and ethically bound by the Nurse Practice Act and the American Nurses Association Code of Ethics to "promote, advocate for, and strive to protect the health, safety, and rights of the patient", which brings the practice of using restraints to the forefront.

The patient rights we are bound to protect include the right to:

- **Refuse** any treatment, except as otherwise provided by law.
- Be treated with courtesy and respect, with appreciation of individual **dignity** and protection of privacy.
- Expect reasonable **safety** in hospital practices and environment.
- Reasonable, **informed** participation in decisions about their care.
- Expression of grievances regarding any **violation** of rights, as stated in Florida law, through the grievance procedure of the healthcare provider and/or to the appropriate state licensing agency.

Personal Beliefs

In your particular context, what are some of the values, beliefs, and practices that you hold on this issue? Examples of these beliefs might be verbalized as:

- "I know it's important for a patient to be free, but I have to protect my patient's safety at all costs and stop them from pulling out their lines and tubes. I can't just sit there with them the whole shift!"
- "I know it is important to respect my patient's decisions, but the ones who are cognitively impaired don't really know what they want or need anyway, right?"
- "I know it is against the law to ignore legislative mandates about restraints, but won't I be sued if my patient gets injured?"

- "Some patients, especially the violent patients, have to be restrained for a while to avoid anyone getting hurt because of their crazy, disturbing behavior."
- "I know Mr. Smith wants to get up and walk around the unit, but he's a little confused and a little unsteady and I'm afraid that he'll hurt himself if he climbs out of bed without help."

Are you prepared? Is it possible that you have learning needs related to restraints?

Learning Needs

A learning need can best be defined as a discrepancy between performance and the level of competency required. A discrepancy exists when there is a deficiency in knowledge, skills, or attitudes. For example, in order to utilize restraints appropriately and effectively, the nurse must have knowledge and awareness of the risks involved, both bodily and in terms of violation of the patient's rights. They must also be competent to apply the restraints safely, as well as ascribe to the belief that the patient has the right to freedom from restraints unless every viable alternative has been considered. Here are some examples of learning needs related to restraints:

- *Knowledge* Deficiency: The nurse believes that restraints are harmless, beneficial, and serve to protect the patient.
- *Skill* Deficiency: The nurse rarely implements restraints for his or her patients, and when required to do so mistakenly secures the limb restraints to the moveable part of the bed.
- *Attitude* Deficiency: The nurse believes that restraints are often more harmful then beneficial, but believes he/she must apply them because of liability reasons.

The nurse with a knowledge, skill, or attitude deficiency may or may not be aware of it. Bear in mind that sometimes the person that truly needs the education may not realize it, and that person could be you!

Background & Historical Highlights

Health Care Financing Administration (HCFA)

In 1999, the HCFA issued a new Condition of Participation for hospitals in the Medicare and Medicaid programs. Not to be confused with the Consumer Bill of Rights, the Patients' Rights Condition of Participation sets forth the following standard: The patient has the right to freedom from restraints used in the provision of acute medical and surgical care, unless clinically necessary; and the right to freedom from restraints and seclusion used for behavior management, unless clinically necessary.

As a Condition of Participation, hospitals must meet the requirements imposed by this regulation in order to be approved for, or to continue participation in, the Medicare and Medicaid programs. This means that hospitals must comply with the Joint Commission's standards regarding the use of restraints and develop the appropriate policies and procedures to be accredited.

The Joint Commission Restraint Standards
For Acute Medical and Surgical Hospitals

PC.03.05.01 The hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.
PC.03.05.03 The hospital uses restraint or seclusion safely.
PC.03.05.05 The hospital initiates restraint or seclusion based on an individual order.
PC.03.05.07 The hospital monitors patients who are restrained or secluded.
PC.03.05.09 The hospital has written policies and procedures that guide the use of restraint or seclusion.
PC.03.05.11 The hospital Evaluates and reevaluates the patient who is restrained or secluded.
PC.03.05.13 The hospital continually monitors patients who are simultaneously restrained and secluded.
PC.03.05.15 The hospital documents the use of restraint or seclusion.
PC.03.05.17 The hospital trains staff to safely implement the use of restraint or seclusion.
PC.03.05.19 The hospital reports deaths associated with the use of restraint and seclusion.

What the Joint Commission Says About Being 'Restraint-Free'

Today the ultimate goal for acute care hospitals is to become restraint free. The Joint Commission does concede however that "Because restraint may be necessary for certain patients, health care organizations and providers need to be able to use restraint when essential to protect patients from harming themselves, other patients, or staff. They also need to be aware of the associated risks of both its use and nonuse.

Restraint has the potential to produce serious consequences, such as physical or psychological harm, loss of dignity, violation of a patient's rights, and even death. Because of the associated risks and consequences of use, hospitals are increasingly exploring ways to decrease restraint use through effective preventive strategies or the use of alternatives. For some hospitals, a restraint-free environment is appropriate to their patient populations and clinical services and is achievable now or in the future. But for many hospitals, restraint use may continue to be necessary in clinically justified situations and in the foreseeable future, given the hospital's populations and clinical services, the current state of knowledge, and availability of effective alternatives." CAMH 2009

The American Nurses Association Position

Restraints have been in use for well over one hundred years. Unfortunately, there was widespread belief among nurses that the use of restraints promoted patient safety, and that *good alternatives to restraints did not exist*. Through the years it was this belief, in part, which led to the increase in restraint use in the nursing home population. As concerns about the widespread use of restraints and their impact on the quality of care in nursing homes generated national attention, the Nursing Home Reform Act (a part of the Omnibus Reconciliation Act of 1987) was adopted into law. These laws, which improved patient care by mandating increased assessment of and care planning for the patient as well as through reduction of both physical and chemical restraint, have had far reaching implications. The patient populations most affected are the elderly, the mentally ill, and the disoriented or physically aggressive patients.

The American Nurse's Association (ANA) response to the laws and increased regulation has been to fully support the rights of patients of all ages and in all settings to be treated with dignity, concern, and to receive safe, quality care. Developmentally appropriate methods of restraint must be used in the least restrictive manner. The family members, guardians or significant others of individuals placed in restraint must be informed immediately. In support of this position, the ANA has provided the following guidelines, with an emphasis on individual assessment, for determining restraint use:

- The decision to use a restraint or seclusion is not driven by diagnosis, but by a comprehensive individual patient assessment. For a given patient at a particular point in time, this comprehensive individualized patient assessment is used to determine whether the use of less restrictive measures poses a greater risk than the risk of using a restraint or seclusion.
- Include a physical assessment to identify medical problems that may be causing behavior changes in the patient. For example, temperature elevations, hypoxia, hypoglycemia, electrolyte imbalances, drug interactions, and drug side effects may cause confusion, agitation, and combative behaviors.
- Staff must assess and monitor a patient's condition on an ongoing basis to ensure that the patient is released from restraint or seclusion at the earliest possible time.

Ethical Considerations of Restraint Use

When the rights of the patient collide with what is best for the patient, the nurse is faced with an ethical dilemma. The underlying ethical issue related to use of restraints is the conflict between an individual patient's autonomy and the nurse's concern for patient safety. Traditionally, health care ethics have relied on the principles of respect, autonomy, beneficence, non-malfeasance, and justice. But now the evidence is not clear that restraint use protects patients from harm, or non-malfeasance. Thus, the use of restraints may not satisfy the ethical principle of acting in the patient's best interest. While the intention behind the use of restraints historically was for the benefit of the patient, there is ample evidence that indicates more risk of injury from the use of restraints than there are benefits. Physical complications associated with the use of restraints include physical de-conditioning, sensory deprivation, decreased muscle mass, tone and strength, increased osteoporosis, nosocomial infection, urinary and fecal incontinence, skin abrasions, and pressure ulcers. Psychological effects of restraint must also be considered.

"The issue is not whether to protect the patient; the issue is how to effectively protect the patient in a way that respects the patient's dignity."

In spite of a range of practice myths among nurses that the use of physical restraints can protect patients from any harm or injury, a range of serious adverse effects and consequences, such as physical problems and even accidental death by strangulation have been reported. There is no denying that some nurses have attempted to use physical restraint as an intervention to safeguard older patients from any harm, the fact remains that accidents, physical disability and emotional distress among patients do occur. In addition to the physical effects, there are psychosocial effects on patients who had one or more restraint experiences, such as low social functioning, increasing confusion and adverse emotional reactions.

Review of Restraint Standards of Care

What is a restraint?

Restraint in the acute care setting can be defined as "any involuntary method (chemical or physical) of restricting an individual's freedom of movement, physical activity, or normal access to the body". A drug or medication is a restraint 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.

What are the types of restraints?

1. **Chemical Restraint**: Medication is a restraint if 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. The guidelines to follow when using drugs as restraints is that the medication……….
   - Is used within the FDA approved pharmaceutical parameters including indications and dosage parameters;
   - The use follows national practice standards.
   - The use is to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and expected and actual response to the medication.
2. **Physical restraint** is when physical force is directly applied to a patient, without the patient's permission, to restrict his or her freedom of movement or normal access to the body. A physical restraint can be any manual (human) 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.
3. **Seclusion** refers to the involuntary confinement of a person in a locked room and is not utilized within Baptist Health.
4. **Forensic restraints** are used by correctional/police officers when a patient is under arrest.

List of available restraints in order of restrictiveness:

1. Side Rails up (see table below)
2. Roll belt/belt restraint
3. Soft limb holders – wrist
4. Soft vest restraint
5. Soft limb holders – wrist & ankle
6. Double security limb holders

Side Rails: Safety Device or Restraint?

Not A Restraint		Restraint
Patient ability to exit bed not restricted.	V E	Restricted ability to exit bed. Patient unable to self-release.
Patient able to raise or lower all/part of side rails.	R S	Purposeful limitation on patient mobility.
Prudent safety intervention in ED or for transport.	U S	Risk of increased injury as patient tries to circumvent.

What devices are not considered to be restraints?

1. Mechanisms usually and customarily employed during medical, diagnostic, or surgical procedures or treatment.
2. Devices used as adaptive support, such as orthopedic appliances or braces, or devices used to maintain body alignment.
3. Protective devices such as helmets.
4. Patients medicated with narcotics.
5. Forensic restrictions used by law enforcement officers.

What are the principles of safe restraint application?

1. Restraint straps are never tied to side rails.
2. The working call signal is within reach or acceptable alternative.
3. Reasons for restraint use are explained to the patient.
4. Restraint education material is given to the family, which explains why and how restraints are used in the hospital.
5. When restraints are discontinued, they are discarded.
6. Restraints are never sent home with the patient or family.
7. Report the following conditions to the MD immediately:
    - ❑ Ineffectiveness of restraints in assuring patient safety
    - ❑ Increased patient agitation with restraint use
    - ❑ Extremity or respiratory complications from being restrained

What interventions might help reduce the use of restraints?

- ❑ Pain relief
- ❑ Comfort measures
- ❑ Investigating symptoms
- ❑ Relief from hypoxemia
- ❑ Fever reduction

- ❑ Talking with the patient
- ❑ Physical exercise/therapy
- ❑ Involvement in activities
- ❑ Meaningful distraction
- ❑ Contact with familiar persons or places, even by telephone
- ❑ Environmental adjustments
- ❑ Simple use of light to facilitate vision

What Are the Medical Reasons for Restraint Use?

- ❑ In furtherance of clinical care
- ❑ When cognitive or neurological status interferes with the provision of treatment or care (i.e. post-traumatic brain injury, acute withdrawal syndrome).
- ❑ Prevent removal of medical device
- ❑ Pulling at tubes, lines or dressings (i.e. intubated patients at high risk of extubation).

What are the order guidelines for Medical Use restraints?

A. Obtain an order for restraint from the physician /ARNP/PA for physical restraint.
    - If the physician can not be readily contacted to issue an order for restraints, but restraint use is indicated to keep the patient safe, the RN may initiate restraints after collaboration with the nursing supervisor. The physician is notified within 1 hour; and order is obtained and placed in the patient's medical record.
    - The original physician's order for restraints can be obtained by telephone. However the physician/ARNP/PA must make a face-to-face assessment of the patient within 24 hours and sign the initial order.
    - If restraint for non-behavioral health purposes is continued beyond 24 hours, its use is ordered once each calendar day by a physician/ARNP/PA, based on his or her examination of the patient. Must never be written as a "PRN" order

B. You must include reason with documentation in the MD progress note.

C. You must identify type to be used & criteria for removal.

D. Each episode of restraint requires a new order except during brief period to allow for activities of daily living (ADLs)

RN documentation for medical restraints must include:

- ❑ The least restrictive alternative strategies used that were unsuccessful.
- ❑ Clinical justification for use of restraints.
- ❑ Range of motion, comfort measures and repositioning are provided every two hours.
- ❑ Toileting is provided when awake, per patient request or need, or every two hours.
- ❑ Fluid and nutrition are offered when the patient is awake, when it is appropriate and not contraindicated by the treatment plan.
- ❑ Personal hygiene needs are met q 8 hrs or PRN.

Alternatives/Methods to avoid restraint use:

When some of the following symptoms are evident, the nurse can use the following questions in order to gather crucial information for the plan of care. It may also help to reflect back to the patient what you perceive, as in the following examples: "Mr. Jones, I see you holding your belly and moving toward the edge of the bed. Do you need to go to the bathroom?"

- ♣ "Ms. Lee, you have a worried look. It must be frightening not to be able to speak. You have a tube in your throat to help you breathe, and that's why you can't speak. Let me show you in this mirror what it looks like." (The caregiver shows the patient the tube in the mirror, then help the patient feel the tube with her hands.) "If it hurts, I can adjust it. We'll take it out when you're breathing better on your own, and then you'll be able to talk."
- ♣ "Ms. McIntyre, you're reaching toward the halo in your scalp. Is your head itching? I know your hair hasn't been shampooed for several days, and I see that the scalp areas around the metal prongs are crusty. I'm going to gently shampoo your hair, and we'll see if that makes you more comfortable."

Basic nursing care requires that the patient is kept warm, dry, and comfortable, and some creativity may be required to assess the source of discomfort. If the patient is able to verbalize his needs, listen and validate, then correct the problem as soon as possible. For many patients the source of agitation may be the presence of a tube somewhere on or in his or her body; and removal of the offending device may not be an acceptable option. If the patient pulls at an IV, you can wrap the site and arm with an elastic compression bandage, and consider use of a capped IV line.

Ask family, friends, or staff from the previous care setting about the patient's history; usual communication style and cues to indicate pain, fatigue, hunger, or a need to urinate or defecate; abilities in activities of daily living; and daily routines ("Is he often awake at night or an early riser?" "Does she prefer breakfast before dressing? Take an afternoon nap? Have a routine for dressing?"). Discuss with the patient's family the options and help the family make an informed decision. For example, a chemical (medication) restraint may be considered for a confused client who is pulling out her nasogastric tube. Given information about the options available, the family may choose to provide an attendant rather than a chemical restraint that could increase falls and confusion. The nurse needs to understand her/ his values and be cautious of not interfering with decision-making. Patient family members will, at times, prefer to endure safety risks rather than have their family member restrained.

What Are the Violent/Self-Destructive Reasons for Behavioral Restraint Use?

- The patient displays an unanticipated outburst of severely aggressive, violent or destructive behavior that poses an imminent danger to the patient or others.
- The patient may only be restrained or secluded while the unsafe situation continues. Once the unsafe situation ends, the use of restraint or seclusion must be discontinued regardless of the length of time identified in the order.

What are the order guidelines for restraints used to manage violent or self-destructive behavior?

Physician Order-Restraint forms are used & signed by an MD within 1 hr of implementation after a face-to-face assessment.

1. Orders must be time-specific as per age.
   - 4 hours for adults 18 years of age or older
   - 2 hours for children and adolescents 9 to 17 years of age
   - 1 hour for children under 9 years of age
2. May be renewed for a maximum of 24 consecutive hours
3. Must never be written as a "PRN" order
4. Must include reason with documentation in the MD progress note.
5. Must identify type to be used & criteria for removal.
6. Each episode of restraint requires a new order except during brief period to allow for activities of daily living (ADLs)

RN documentation for behavioral management restraints must include:

- The least restrictive alternative strategies used that were unsuccessful.
- Clinical justification for use of restraints.
- Range of motion, comfort measures and repositioning are provided every two hours.
- Toileting is provided when awake, per patient request or need, or every two hours.
- Fluid and nutrition are offered when the patient is awake, when it is appropriate and not contraindicated by the treatment plan.
- Personal hygiene needs are met q 8 hrs or PRN.
- Monitor the restrained patient at regular intervals (vital signs, circulation, level of agitation, mental status, cognitive functioning, skin integrity) based on the individual needs of the patient but no less than every 15 minutes.

What principles should we follow if the "Code Green" results in restraints?

- De-escalation of the situation is the goal.
- Patient dignity and privacy is maintained.
- Restraints are discontinued as soon as possible.
- The RN must follow hospital policy for use of restraints to manage behavior.

Behavioral Restraints: Proceed with Caution

In an emergent situation, the RN may apply restraints or instruct an LPN, PCT, EMT or Paramedic, and/or security personnel under the direct supervision of the physician or RN, who must be present. Safety is priority for both the patient and staff, and strict guidelines accompany this emergency intervention.

The RN must notify the MD immediately of the emergent behavior change and review possible physiological reasons. If restraints have been applied, the patient's MD, or designee, must respond and assess the patient face-to-face within 1 hr of notification, & document the assessment.

What Alternative Approaches Can Nurses Use to Avoid Behavioral Restraints?

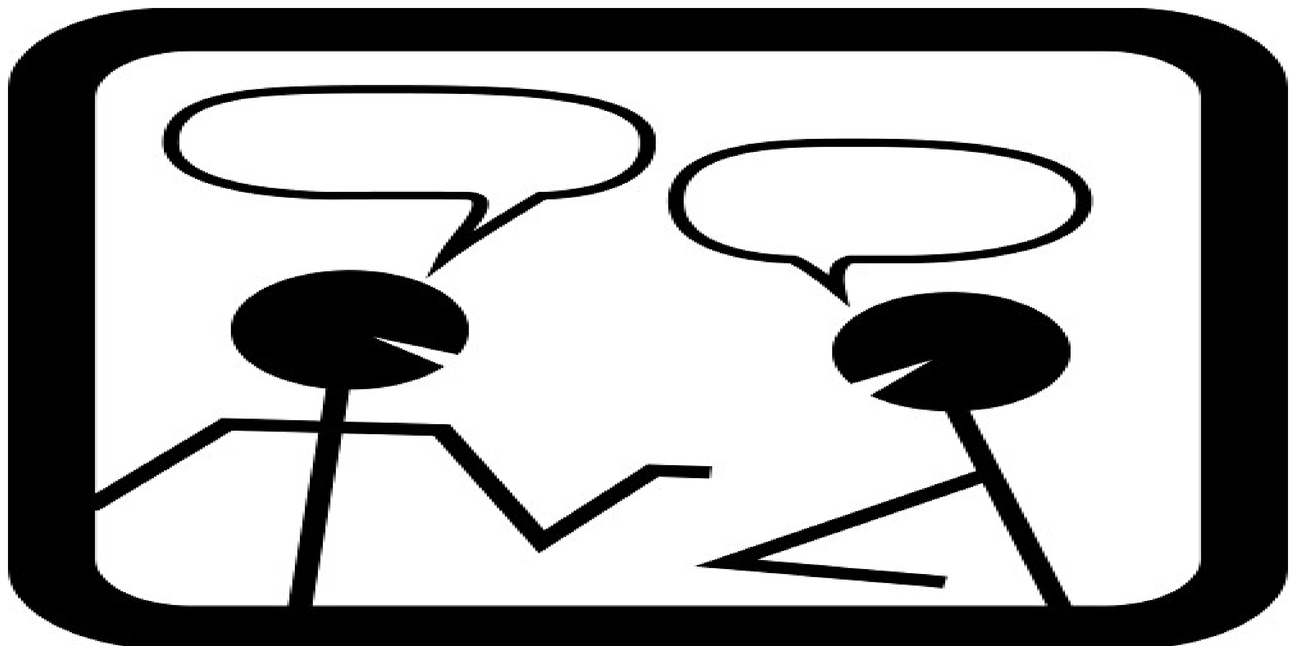
De-escalation is a valuable therapeutic intervention that can be used by nurses to help counter the problems of aggression and violence in healthcare settings. The immediate priorities of the nurse faced with an angry and potentially violent individual are to maintain safety while preventing the behavior from escalating into violence. The approach recommended by the American Psychiatric Nurses Association is to maintain caring and concern in a non-authoritarian, therapeutic manner that helps to defuse anger, while at the same time setting limits.

What do you do when a 220-pound violent, mentally ill or otherwise impaired patient is throwing furniture or has already assaulted a staff member? The first thing you should do is clear the area of others, and then remain quietly available at a safe distance until the peak of the crisis has passed. The risk of injury to both patients and staff is high when a direct verbal or physical intervention is attempted at the peak of a crisis. If a staff member has been assaulted, the staff member should be removed from the area and other staff must take the lead in intervening. A patient should not automatically be secluded or restrained following a staff assault, a response often born of fear or the conviction that the person needs "consequences." Seclusion or restraint should never be used to introduce consequences; instead, other approaches to supporting behavior change may be instituted once the crisis has passed.

Early identification of the problem and appropriate assessment of the situation are essential. Anger, fear, and frustration can all lead to violent behavior, and each calls for a specific approach. "Meet the patient where they are" is a phrase commonly used to convey the need to match the approach to the patient's emotional state and to the events that triggered that state.

An often overlooked but very simple crisis communication technique is to ask the patient "What would help you right now, at this moment?"

It is surprising that this is a question we don't think of asking, yet it often yields a very specific and helpful response. A patient might just need clarification of a misunderstanding, some personal space, or might need to walk. Engaging the patient in the decision of how best to intervene can help them get through the situation without resorting to seclusion or restraint.



"What would help you right now, at this moment?"

De-Escalation techniques experienced mental health nurses find helpful in a crisis:

- Assess the situation promptly and intervene early.
- Use problem solving with the individual - ask "What will help now?"
- Reassure individual that no harm will come to him or to others.
- Decrease the tension with relaxation techniques.
- Don't crowd the individual; give him or her space.
- Ignore challenges; redirect challenging questions.
- Don't say "you must". Avoid power struggles.
- Set limits and tell them what the expectation is.
- Be aware of the individual's and <u>your</u> nonverbal behaviors.
- No more than 5 words in sentence, 5 letters in a word.
- Use reflective technique -- "Am I hearing you correctly?"
- Agree to disagree. Avoid an argumentative stance.
- Be willing to break the rules.
- Offer choices and offer to help.
- Use open-ended questions. Allow venting and/or pacing.
- Give the individual time to think. Use simple language.
- Maintain a calm demeanor and voice.
- Tell them what you can do to help them.
- Be aware of your expression, your tone.
- Engage the individual and be empathetic.

Restraint Related Complications:

Restraint-Related Positional Asphyxia

Every staff member who is taught to apply physical restraints needs to be aware of the dangers of restraint-related positional asphyxia, a deadly condition which can occur when a person being restrained cannot breathe properly. Risk factors which may increase the chance of death include obesity, prior cardiac or respiratory problems, and the use of illicit drugs such as cocaine. Almost all persons who have died while being restrained in police custody or in a psychiatric facility have engaged in extreme levels of physical resistance against the restraint for a prolonged period of time. Risk factors include:

1. **Cocaine-induced bizarre or frenzied behavior**. When occurring while confined by restraints, cocaine induced excited delirium (an acute mental disorder characterized by impaired thinking, disorientation, visual hallucinations, and illusions) may increase a person's susceptibility to sudden death by increasing the heart rate to a critical level.
2. **Drugs and/or alcohol intoxication**. Drug and acute alcohol intoxication is a major risk factor because respiratory drive is reduced, and the individual may not realize they are suffocating.
3. **Violent struggle** extreme enough to require officers or health care workers to employ some type of restraint technique may cause the individual to be more vulnerable to subsequent respiratory muscle failure.
4. **Unresponsiveness** during or immediately after a struggle. Such unresponsive behavior may indicate cardiopulmonary arrest and the need for immediate resuscitation.
5. **Restrained in a face-down position**. A cycle of increasingly labored breathing is made worse by weight being applied to the person's back-the more weight, the more severe the degree of compression. The individual experiences increased difficulty breathing, and the natural reaction to the ensuing hypoxemia is to struggle more violently. The police officer applies more compression to subdue the individual, and the person suffocates.

It is important to understand how preexisting risk factors, combined with the individual's body position when restrained or in transit, can compound the risk of sudden death. Police officers and health care workers alike must be alert to those factors resulting in deaths involving positional asphyxia.

Restraint-Related Emotional Effects

People who have been restrained typically experience a sense of punishment even in the care of healthcare workers. Patients characterize the experience as dehumanizing, humiliating, and report no beneficial results. Following are two first hand accounts retrieved from the world wide web on June 27th, 2009:

Dianna (Nov 16, 2006):

> *"Others who have lived 'on the outside' all their lives, never locked up, never overmedicated, never at the mercy of doctors, nurses and orderlies, can not possibly understand what many of us have gone through. It does help to share my story and relieve some of the pain of the past. Moreover, it helps to know that I am not alone and others have experienced the same things."*

Melissa (Dec 7, 2008)

> *"What does it feel like to be in restraints? Everybody asks me. It only happened once, and I probably deserved it. I threw a hardcover book and it hit the wall with a resounding boom right over the head of the mental health worker who was supposed to be watching me on one to one. She was reading a cheap romance, and, for some reason, that annoyed me greatly. There is no sound in the world like the snap of rubber gloves. It brings to mind visions of hulking orderlies and nurses with hypodermics. I sat on my bed with my back against the wall and my knees pulled up to my chest, planning to fight to the death, as the room filled with people, apparently the largest ones on duty.*
>
> *Arms all around, hands all over, picking me up, turning me over, hands on holding my arms and legs tight against the bed, my body, my neck, my head, so that I couldn't move a single muscle in my body."*

Special Populations: The Elderly & Patients with Dementia

Frail elderly patients or those with dementia may have limited opportunity to make their views, needs and dislikes known before being restrained. Agitation is often seen in this group of patients and, more often than not, is a response of fear of the unknown or an expression of physical or emotional pain and discomfort. In a patient with dementia, behavioral symptoms should not be dismissed but rather viewed as a clue to unmet needs (such as for food or water, comfort, or interaction) or as a sign of a change in health status (such as infection, myocardial infarction, or pain). Regular assessment is crucial, as is nurses' ability to address problems, on a patient-by-patient basis, with input from the patient, family, and home caregivers.

Case Studies

Scenario A

Mary has been a resident at a restraint-free long-term care facility for five years. When she first arrived in the hospital, Mary experienced frequent falls due to difficulties with balance. Through assessment, the staff determined that Mary was likely to attempt to ambulate independently when she was bored or had to go to the bathroom. An interdisciplinary team developed a plan of care that included toileting Mary every two hours, providing her with a low bed with one side rail to assist her to balance when sitting, installing a special seat on her wheelchair and developing recreational activities that provided stimulation and prevented boredom.

Mary has had ongoing difficulty with a leg ulcer, and her physicians arranged for skin grafting at a local hospital. It was expected that Mary would be at the hospital for about seven days to receive post-operative intravenous therapy. The staff at the long-term facility were concerned that Mary's poor balance would result in falls while in hospital and that the use of restraints might be considered. Adding to their concern was the knowledge that immobilization contributed to muscle wasting and that Mary's ability to ambulate on return to their facility might be impaired to the degree that she would require an alternative level of care.

Discussion: How might the hospital staff follow the long-term care facility's restraint-free plan of care as closely as possible?

1. Set up a visiting schedule with family that allows them to be with Mary and participate in her care.
2. Ensure rounding every two hours for toileting and other needs.
3. Keep the bed in a low position with one side rail up.
4. Encourage family or hospital volunteers to provide activities to prevent boredom.

Scenario B

A nurse is admitting a patient who has been transferred from a local nursing home. The nursing home has a minimal restraint policy and for the past year has not used restraints on this patient. The hospital risk assessment protocol used on admission to help staff determine an appropriate plan of care has determined that restraint use is not indicated.

The family is insisting that their mother be restrained to protect her safety. They tell the nurse that if they do not restrain their mother and she falls, they will initiate legal action.

Discussion: What is the ethical dilemma? How would you deal with it?
While nurses respect the patient and their family's choices, limits do exist. The demands of the patient's family might be limited by policies that promote health or by the resources available in a particular situation, such as employing a sitter. When a patient or their family is requesting that nurses perform an act that may cause serious harm, nurses need to inform them in a nonjudgmental manner of the potential risks and harm associated with the practice.

The nurse in this scenario needs to explore the implications of the request. The family believes that if no restraint is used, their mother's safety will be jeopardized. The nurse is able to provide education about the risks of restraint use and the alternatives available. If the family continues to request that restraints be used, the nurse respects the family's choice but needs to explain that because the facility has a minimal restraint policy; it does not have restraints available or the resources to use restraints safely. Knowing this information, the family can then make an informed decision about where to hospitalize their mother, presently or in the future.

Scenario C

A nurse is working in the emergency department of a community hospital when a patient from the local correctional facility arrives for treatment of large leg wound. The client is handcuffed and accompanied by two correctional workers. The nurse asks the workers to remove the handcuffs and respect the client's privacy while he is in the emergency department. Although she is able to assess and treat his leg wound with the handcuffs in place, the nurse is uncomfortable with the client's restricted ability to move.

Discussion: What measures can the nurse take in this situation?

In this scenario, the decision to use restraints is made by the correctional facility, not by the nurse. The correctional facility has determined that there is risk of harm to others if the client is not restrained and accompanied by correctional workers. Should the hand restraints interfere with the client receiving medical treatment, the nurse would need to discuss removing the restraints and alternative means of ensuring safety with the correctional workers. The nurse should also advocate within her facility for education on how to manage patients from correctional facilities as well as what to expect in these special populations.

Scenario D

You are caring for a patient in the E.D. who was brought in for a Tylenol w/ codeine overdose. She is uncooperative and obviously angry. The ED MD is assessing her when he asks you if you were able to contact any family. You respond, "I talked to her mother, but she says that at this point, she wants nothing to do with her." Upon hearing this, the young woman kicks the nurse closest to the stretcher and screams (among obscenities) "She did not say that! I'm getting out of here!" She then pulls her IV out and tries to leave.

Discussion: What do you do?

1. Call a Code Green and use force to detain her if necessary.
2. Attempt to calm and reassure the patient.
3. Apply restraints if necessary, explaining the need to treat her for the Tylenol overdose.
4. Ask if someone came to the hospital with her or if there is anyone you could call to be here with her.
5. Use a firm, caring tone of voice.
6. Apologize for upsetting her, as that was not your intention.
7. Place on suicide precautions and assign a sitter. (Or two sitters!)

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