Patient Restraints and Seclusion

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Patient Restraints and Seclusion

INTRODUCTION

Restraints are any means used to restrict a patient’s movement, activity, or access to his or her body. Patients generally have a right to be free from restraints unless restraint is necessary to treat their medical symptoms or to prevent them from harming themselves or others.

In recent years, a move toward reducing and, if possible, eliminating the use of restraints within healthcare facilities has occurred. Restraining a patient raises serious concerns, such as infringement on patient autonomy, limits on freedom of movement, claims of battery, and risk of physical and/or psychological injury, and even death, resulting from restraints.

Therefore, before using restraints, healthcare professionals must carefully weigh the risks and benefits, and they always should consider whether alternatives to restraint or seclusion are available.

PURPOSE/OVERALL GOAL

This module focuses on physical restraint and seclusion. It outlines the types of restraints used in the healthcare setting, how and when they may be applied, standards for their use, and important considerations for providers to understand.

The goal of this module is to ensure that restraint and seclusion are used appropriately, correctly, and according to established standards for the patients in your care.

COURSE OBJECTIVES

After completing this module, the learner should be able to:

1. Define restraint and seclusion
2. Describe types of restraints used in healthcare
3. Explain conditions for which restraint and seclusion may be used
4. Explain standards regarding the use of physical restraints
5. Describe the benefits and complications associated with restraint use
DEFINING RESTRAINT AND SECLUSION

The U.S. Centers for Medicare & Medicaid Services provides the following definitions for restraints and seclusion.

Physical restraints:
- Are any manual methods, devices, materials, or equipment that immobilize or reduce the ability of a person to move his or her arms, legs, body or head freely
- Are any medications used as restrictions to manage a person’s behavior or restrict the person’s freedom of movement that are not part of a standard treatment or dosage for the person’s condition
- Do not include devices such as orthopedically prescribed equipment, surgical bandages, protective helmets, or other methods that involve the physical holding of a patient:
  - For the purpose of conducting routine physical examinations or tests
  - To protect the patient from falling out of bed
  - To permit the patient to participate in activities without the risk of physical harm

Seclusion:
- Is the involuntary confinement of a person alone in a room or an area where the person is physically prevented from leaving
- May only be used for the management of violent or self-destructive behavior
CATEGORIES OF RESTRAINT USE

There are two general categories of restraint use:
1. Medical/surgical
2. Behavioral management

Each category is defined based on the clinical justification for using the restraint and has its own set of requirements related to physician orders, monitoring, and documentation.

The **medical/surgical restraint designation** applies when it is needed to support medical care and healing. For example, the patient may be trying to pull out lines or tubes or has a fracture requiring restricted mobility and less-restrictive methods haven't worked.

The **behavioral management restraint designation** applies:
- When a patient is exhibiting violent, destructive, or aggressive behavior that presents an immediate, serious danger to the patient or to others, and
- When the patient has no lines or tubes that could be pulled out and does not have any other health problem requiring restricted mobility.
TYPES OF RESTRAINTS

It is important for you as a provider to become familiar with the various types of restraints used in the healthcare setting.

- Bed rails can provide assistance with bed mobility, repositioning, and getting out of bed. Raised bed rails, however, are considered a physical restraint when they restrict a patient from getting out of bed.
- Lap and wheelchair belts, which function similarly to seatbelts, can also be considered a restraint and are used for patients with neurologic disorders that affect balance and movement. If not easily removed, a lap tray is considered a physical restraint because it prevents the patient from standing up or getting out of the wheelchair.
- Lap trays support upper body positioning for patients who are in wheelchairs. If not easily removed, a lap tray is considered a physical restraint because it prevents the patient from standing up or getting out of the wheelchair.
- Belt restraints are used to prevent a patient from getting out of a chair or bed in order to reduce risk of falling.
  - Be sure there are no wrinkles in the patient’s gown under the belt, as this can increase the risk for pressure ulcers.
  - Do not position the belt over the patient’s chest, as this can interfere with breathing.
- Limb restraints are wrapped around a patient's wrists or ankles and are attached to the bed or chair to prevent limb movement. Limb restraints are used to keep patients from getting out of bed without supervision and from touching and interfering with medical equipment (such as IV needles and pumps, monitors, nasogastric tubes) that is necessary for treatment.
  - Be sure not to apply these restraints too tightly so that circulation is not impaired. A good strategy is to ensure that at least two fingers can be placed between the secured restraint and the arm or leg.
  - Do not apply them near an IV site, because occlusion or infiltration of the IV can occur.
- Elbow restraints prevent a patient’s arms from flexing and are commonly used to keep patients from pulling at an IV site. These restraints are made of fabric with slots for flat pieces of plastic or wood, which keep the restraint device from bending and immobilize the elbow.
- Mitt restraints can be placed on patients who try to use their hands to scratch themselves or to undo limb or elbow restraints.
INITIATING RESTRAINT OR SECLUSION

Restraint or seclusion should be initiated:
- Only when less restrictive measures are ineffective
- Only by staff members who have been trained in their use

Examples of patient conditions that might call for the use of restraints are:
- Poor mobility
- Impaired cognition
- High physical dependency
- High risk for falls
- Incidence of falls
- Psychoactive medication use

The desired outcome of applying physical restraints is:
- To protect patients and/or healthcare providers from harm when other interventions have proven ineffective or insufficient
- To prevent patients from performing certain activities – such as getting out of bed unattended or trying to remove an endotracheal tube – that could impact their recovery

Before initiating restraint or seclusion, consider:
- Whether other less restrictive options are possible
- All potential physical and psychological risks of their use

Give special consideration to vulnerable persons such as:
- Those who are obese or frail
- Those who have medical comorbidities
- Those with intellectual or developmental disabilities
- Those whose repeatedly challenging behaviors put them at risk for incomplete assessments
APPLYING A PHYSICAL RESTRAINT

A physical restraint:
- Is a device applied to a patient in order to immobilize or prevent the patient from freely moving his or her arms, legs, head, and/or body
- Is intended to prevent patient interference with medical procedures, reduce risk for falls and injury, and/or prevent a potentially violent or aggressive patient from causing harm to self or others

The Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC) have developed guidelines regarding the use of physical restraints. They include:
- Physical restraints must have a written order from the treating clinician.
- Restraints are to be used in accordance with facility policy on restraint use, facility/unit protocol, and manufacturer instructions.
- Special consideration should be given to preserve patient dignity.
- Special consideration should be given to protect the patient from physical harm (such as skin breakdown or respiratory impairment) during restraint use.
- Restraints must be removed as soon as it is considered safe to do so.
- Patients who are at increased risk for intentionally harming others might be placed in seclusion instead of having physical restraints applied.

Guidelines regarding the application of a restraint include:
- Nurses and other healthcare personnel who have received specialized training regarding physical restraint application can apply them.
- Trained staff can be assisted by other personnel, but monitoring and assessing patients who are being restrained cannot be delegated to assistive personnel.
- Family members can be present during physical restraint use and, in some cases when it is appropriate to the situation, can be encouraged to sit with the patient to alleviate the need for restraint.

The guidelines for physical restraints do not apply to immobilization procedures or devices that are:
- Used during or immediately following surgical or other procedures (such as the use of IV arm boards)
- Used as protective equipment (such as helmets)
- Used as adaptive devices
COMPLICATIONS OF RESTRAINTS

Physical restraints can cause injury and even death if applied inappropriately or if the patient is not correctly monitored after restraints are applied. The majority of deaths that have occurred were associated with the use of a vest restraint, frequently called a “Posey vest,” which is now banned in many healthcare facilities.

Potential complications associated with the use of mechanical devices for patient restraint include:

- Asphyxiation
- Strangulation
- Death due to aspiration after vomiting and being unable to clear the airway
- Death due to inability to escape from the building in the event of fire or other disaster
- Occlusion of blood circulation
- Nerve damage
- Blood loss from blood vessels injured by the patient when struggling against the restraints
- Falls
- Loss of muscle tone
- Development and/or worsening of pressure ulcers
- Decreased mobility
- Agitation, frustration
- Reduced bone mass
- Stiffness
- Loss of dignity
- Incontinence, constipation
IMPORTANT CONSIDERATIONS

The use of physical restraints carries legal and ethical implications. A careful evaluation is required when deciding whether to initiate restraint or seclusion.

- There is growing emphasis on the need for providers to seek alternatives to the use of physical restraints.
- At the same time, studies have shown that the risks associated with failure to take immediate action can outweigh the risks of harm associated with the use of restraint or seclusion.

Some important considerations include:

- Your facility must have a written policy for use of restraint devices that is in accordance with federal and state laws as well as guidelines issued by the Centers for Medicare and Medicaid Services and The Joint Commission.
- Restraint should not be used as a punishment or to reduce behaviors (aside from behaviors that can cause self-injury or injure others) that are disturbing to staff.
- Clinical care facilities cannot legally use restraint devices unless device use is determined to be essential in preventing disruption of necessary care and treatment.
- Failure to use restraints can lead to legal liability if preventable injuries occur.

Physical restraint can only be used under the orders of a physician or other treating clinician and according to unit or healthcare facility protocol.

- Orders for physical restraint cannot be written as a standing order.
- If physical restraints are applied to a patient because of violent or aggressive behavior in an emergency situation when a written order does not exist, the treating clinician must be contacted within a reasonable amount of time to produce a written order. In general, a physician or other prescribing clinician must make a face-to-face assessment of the patient and his or her condition within 1 hour of application of the restraint.
- The assessment of the physician or other prescribing clinician should include evaluating:
  - The patient’s need for physical restraint
  - The patient’s reaction to physical restraint
  - The patient’s behavioral and medical condition
  - The need to continue or discontinue physical restraint
- If the assessment is performed by a nurse or physician assistant, the nurse or physician assistant must consult with the physician or other treating clinician as soon as possible following the assessment.
- The Joint Commission states (unless state law is more restrictive) that each order for physical restraint is to be renewed within the following limits:
  - Every 4 hours for adult patients ages 18 and older
  - Every 2 hours for children and adolescents ages 9 to 17
  - Every hour for children under age 9
  - For a maximum of 24 consecutive hours
CONCLUSION

Appropriate use of restraints in the healthcare setting promotes patient and staff safety. Documentation should clearly reflect the need for restraints for medical or safety reasons.

Hospitals and healthcare professionals can incur liability from inappropriate use of restraints or seclusion and for failure to use restraints or seclusion to protect a patient. Therefore, you must carefully evaluate each situation in which use of restraints or seclusion is considered.

REFERENCES: