Restraint Reduction

Moving Towards
Restraint Free Care
RESTRAINTS: Defined

- Any manual method, physical or mechanical device, material or equipment, that immobilizes or reduces the ability of the patient to move his or her arms, legs, body, or head freely;
- A drug or medication which is used as a restriction to manage the patient’s behavior or to restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.
- Verbal language that will impose upon decision making abilities, actively persuade, encourage, or discourage a patient’s actions, threaten, or instill fear.
RESTRAINTS: Do Not Include

- Handcuffs or other restrictive devices applied by law enforcement officials for custody/detention purposes
- Devices used to limit mobility in relation to medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes.
- Protective helmets
- Surgical dressings or bandages.
- Side rails:
  - Raised for seizure precautions
  - Raised on stretchers
  - Four (4) side rails raised on specialty beds up in rotating modes used for pulmonary toileting in the critical care units.
RESTRAINT: Non-Violent Behavior

- Used for the following:
  - To improve the patient’s well-being and safety.
  - To directly support medical healing.
  - When behavior is irrational or uncooperative, attempting to seriously interfere with physical medical treatment or device: IV, ventilator, dressings, tubes, drains, etc.
  - When less restrictive measures have proven ineffective.
RN Responsibilities

- Assess the patient
- Attempt alternatives
- Obtain physician order
- Monitor patient per Patient Monitoring Criteria
- Coordinate patient care based on monitoring criteria.
- Reassess patient’s need for restraint (reorder required q24h)
- Notification of nursing leadership when patient is in restraints for ≥ 3 days.
Before Applying Restraints, Ask Yourself If You Have.....

- Used creative strategies such as:
  - Concealing the g-tube with an abdominal binder?
  - Concealing the IV tubing with long clothing or a gown?
  - Concealing catheter tubing with pajama bottoms?

- Increased staff or family supervision
- Moved the patient to a room closer to nurses’ station
- Sat the patient in a chair near the nurses’ station
- Scheduled frequent patient rounds
- Suggested a physical therapy consult
- Tried an ambulation and toileting schedule
Assessment and Management of Underlying Physical Problems

- Incontinence, fecal impaction, constipation, UTI, full bladder
- Pain
- Hunger or thirst
- Sensory impairment (vision, hearing)
- Dementia, delirium, psychosis
- Cognitive defects
- Muscle weakness
- Alcohol withdrawal
- Electrolyte Imbalance

Assessing the patient thoroughly is the first step in limiting the use of restraints.
Review of Medication Regime

- Side effects of medication
- Complications of polypharmacy
- Dosing with awareness of patient’s age or compromised physical status
- Scheduling of medications
- Encourage initiation of oral medications, as opposed to IV, when possible
- Are PRN meds available and are they being used?
- Have meds from Long Term Care Facility been continued?
Interventions

- **Environmental**
  - Lower beds of patients’ at risk
  - Improve lighting
  - Keep a clear path to the bathroom and door
  - Keep call bell and personal items within reach
  - Answer call bells promptly

- **Behavior Management**
  - Structured routine
  - Relaxation techniques (therapeutic touch, massage, warm baths, music therapy)
  - Psychiatric consult

- **Verbal**
  - Use distraction and diversion to change the focus of the behavior
  - Reorient as necessary
  - Use simple language when giving directions
Patient and Family Education

Educating patients and families can help reduce, or eliminate, the need for restraints. Whenever possible or appropriate:

- Explain why a restraint may be necessary
- Explain the possible benefits and risks of restraints
- Discuss available alternatives
- Ask for suggestions or help
Remember...

- Early identification of potential behavioral and environmental risk factors, as well as useful alternatives, are part of routine assessment and allow for planning for, rather than reacting to, these patient situations.
- When Restraints Must Be Used: the patient’s rights, dignity and well-being must be protected and maintained.

Preventive strategies must be tried AND DOCUMENTED before using restraints.
Restraint for Violent/Self Destructive Behavior

- Behavioral restraints are used to protect the patient from:
  - Injury or harm to self
  - Injury or harm to others
  - Destruction of the environment
RN Responsibilities

- Assess the patient
- Attempt alternatives
- Emergency situations: the RN can restrain the patient but must:
  - Obtain order within one (1) hour of applying restraint
  - Face to face evaluation by MD within one (1) hour of initiating restraint
- Reassessment of the need and monitoring/care of the patient as outlined in Monitoring Criteria table.
Reordering Restraints (Violent/Self Destructive Behavior)

- **Adults (18 years and older)**
  - Reorder every 4 hours
  - Reevaluation by MD in person every 8 hours

- **Adolescents (age 9-17 years)**
  - Reorder every 2 hours
  - Reevaluation by MD in person every 4 hours

- **Children (Under age 9)**
  - Reorder every hour
  - Reevaluation by MD in person every 4 hours