Restraints and Alternatives

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The use of physical restraints in older adults is associated with poor outcomes: functional decline, cardiovascular stress, decreased peripheral circulation, incontinence, muscle atrophy, pressure ulcers, infections, agitation, social isolation, loss of self-esteem, serious injuries, and even death. However, physical and chemical restraints are sometimes necessary to protect the patient, staff, and others from harm.

To address concerns about the improper use of restraints (and seclusion) the Centers for Medicare & Medicaid Services (CMS) published their final rule regulations for hospitals effective January 8, 2007. The regulations included additional expectations for staff education, face-to-face evaluations, formal notice—given upon admission—of patients' rights and freedom from inappropriate use of restraint and seclusion, and reporting of death due to restraint and seclusion.

According to CMS regulations, "a restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes the ability of a patient to move his or her arms, legs, body, or head freely...or a drug or medication when it is used as a restriction to manage the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition" (Department of Health and Human Services, CMS, 2006). Although CMS agrees that restraining may be an appropriate part of a patient's plan of care, they strongly advocate that restraints only be used when absolutely necessary and when other measures have been unsuccessful.

Hospitals have responded by attempting to reduce restraint use and increase alternatives. Rehabilitations nurses who care for the elderly have the opportunity to creative devise creative care plans that manage patient behaviors without using restraints.

Older patients with dementia have the highest risk for being restrained when hospitalized. Elderly patients with impaired memory, judgement, and comprehension often have difficulty adapting to the hospital setting. At particular risk for restraint use are patients whose behavior (i.e., confusion, agitation, impulsivity) is judged to be "unsafe" (i.e., contributing to falls or interfering with treatment or medical devices). Other hospitalized elderly at risk are those who have experienced stroke or brain injury with cognitive deficits resulting in impulsivity, wandering, confusion, impaired judgement, agitation, and aggression.

Many rehabilitation facilities have significantly reduced the number of restraint episodes or become restraint free by relying on various alternative measures for preventing and managing problematic behaviors.

Confusion

The rehabilitation nurse's comprehensive assessment addressing the cause of confusion must include any physiologic, pharmacologic, emotional, and environmental factors that may be responsible for an individual's unsafe behavior. This data can provide information about safety risk and also can help define strategies for restraint-free management and care. Knowing the older adult's premorbid behavior and function is essential for personalizing care. Any behavior that precipitates a decision to restrain a patient should first trigger an investigation aimed at recognizing and eliminating the cause of the behavior (e.g., recognize that a common reason for bed exit is the need to toilet; anticipate the need by putting the patient on a toileting schedule).

A medication review of the side effects and medication effects on cognition is also important. Avoid medications that can aggravate acute confusion in the elderly (e.g., hypnotics, sedatives, antianxiety agents, tricyclic antidepressants, other medications with anticholinergic side effects). Look for other medical conditions that could cause confusion such as infection, dehydration, and pain. Potential restraint-free interventions for managing patients with confusion include maximizing structure and consistency (e.g., memory book, calendar, consistent routines), frequent reorientation, a room near the nursing station, opportunities for exercise and ambulation, toileting schedules, lower bedrails (or use of half rails if ambulatory), implementation of wheelchair and bed exit alarms, discontinuation of lines and tubes if possible, low bed, if appropriate, abdominal binder, long sleeve clothing (or knit sleeve to limit access to lines and tubes), environmental exit alarms that alert an attempted elopement, and continuous observation or family staying with patient, if appropriate.

Impulsivity

Restraint-free interventions for impulsivity include cuing the patient to stop, think, and act, verbally reviewing steps before beginning an activity, having the patient rehearse the steps to complete a task, identifying and intervening immediately with impulsive behaviors, reviewing and rehearsing how to appropriately engage in a behavior, completing frequent checks, activating and explaining the bed and wheelchair exit alarms, initiating low bed, if appropriate, placing patient in a common area where staff can frequently visualize patient and behaviors, arranging for constant observation, or asking family to stay with patient, if appropriate.

Agitation and Aggression

It is important to be aware of staff behaviors that may trigger agitation and aggression. Modify behavior by moving and speaking quietly, slowly, and directly, staying relaxed, safely positioning self, redirecting patient to a less stimulating or frustrating activity, discontinuing an activity, not arguing with a patient about behavior, being flexible, and modifying treatment interventions. The environment should be modified by minimizing stimulation (e.g., lights, noise, visitors), maximizing consistency, providing safe motion, activity, and verbalization, providing clear expectations of interactions and treatment, scheduling rest periods, facilitating safety by removing items that could cause injury, arranging for constant observation, or involving family (if calming and reassuring to patient).

In today's healthcare climate, rehabilitation nurses are asked to make critical clinical decisions, predicting and anticipating patient behaviors that put both patients and staff at risk for injury. As clinicians and educators, we have a responsibility to be advocates for our elderly patients. Temporary restraints may be an appropriate part of a patient's personalized plan of care, but we must strongly advocate that restraints should be used only when absolutely necessary and when other alternatives to avoid restraint have been unsuccessful.

Reference

Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2006). Federal Register, 42 CFR Part 482, Medicare and Medicaid Programs; Hospitals Conditions of Participation: Patient's Rights; Final Rule retrieved August 11, 2007 from http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/CMS3018N.pdf.

Suggested Resources

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