Reducing Restraint Use for Older Adults in Acute Care

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Abstract:

Although no evidence shows that restraints are effective for maintaining safety, preventing disruption of treatment, or controlling behavior, they're still commonly used in acute care facilities (especially in critical care) in the United States, where the reported prevalence of their use ranges from 7.4% to 17%.[1–3] They may be used to protect patients from falls or to prevent them from inadvertently removing tubes and other devices.[4] Older adults are three times more likely to be restrained during an acute hospital admission than younger patients, even though this practice is associated with poor outcomes.[1] (See *Adverse effects of physical restraints*.)

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Research over the past 20 years has repeatedly demonstrated that restraints don't protect patients from falling, wandering, or removing tubes and other devices; in fact, they can exacerbate many problems, causing serious physical, emotional, and psychological problems.[5]

This article briefly reviews the types and consequences of restraints, provides a list of evidence-based guidelines for restraint-free care, and offers strategies to reduce restraint use.[1,4,6–

[10] (See *Sorting out restraints*.) Use the information provided here to stimulate discussion on the unit to either reduce restraint use or continue to remain restraint-free.

Who's most at risk?

Research shows that older adults at higher risk of being restrained include those with these characteristics:

* were admitted to the hospital from a long-term-care facility

* have dementia or confusion

* exhibit wandering behavior

* are dependent in activities of daily living.[6]

Patients needing certain treatments are also at higher risk because restraints may be used to prevent patients from self-removing I.V. catheters, nasogastric tubes, and urinary catheters.[1]

Older adults with dementia are at highest risk of being restrained when hospitalized.[8] Impaired memory, judgment, and comprehension contribute to their difficulty adapting to the hospital. Brain damage associated with dementia also places these patients at risk for delirium, further increasing disorientation and confusion.[8]

Patients who feel lost and afraid may try to escape or resist care. Language deficits associated with dementia limit their ability to clearly express their concerns. The use of restraints for these patients may contribute to their depression, impaired social function, and a feeling of being imprisoned. Best practice supports avoiding physical or chemical restraints and communicating to the patient clearly, slowly, and calmly.[11]

Reduction strategies

The American Nurses Association [6] and other professional nursing and medical organizations representing gerontologic,[7,8] neurologic,[4] medical-surgical and intensive-care,[1] emergency,[9] and psychiatric [9,10] practitioners have all established evidence-based guidelines to show that being restraint-free is the standard of care. These guidelines provide alternatives to restraints that have proven effective.[1,6,10](See *Professional resources for restraint reduction;* use this list to check for updates regularly.) The strategies discussed in this article are supported by these guidelines.

The risk of using a restraint must be weighed against the risk of not using one when the patient's physical activity must be restricted to continue life-sustaining treatments, such as mechanical ventilation, artificial nutrition, or fluid resuscitation. Make every attempt to allow earlier weaning from these treatments so that restraints aren't necessary.

Obtain informed consent from proxy decision makers. The following is required:

* a comprehensive nursing assessment of problem behaviors

* a healthcare provider's prescription when instituting restraints, obtained either before the restraint is initiated or within an hour after the restraint is initiated

* documentation of the failure of alternatives to restraints.[6]

Take steps to reduce restraint use before the need for restraints arises. Administrators, nurses, families, and even patients may try to minimize the use of restraints. Implementing creative institutional strategies can help everyone understand that safe care can be provided without resorting to restraints.[1]

Creating precise protocols and specific laws may prevent arbitrary applications.[12] Educational programs have been found by some authors to reduce restraints; however, Möhler and colleagues concluded in their Cochrane review that insufficient evidence supports the effectiveness of educational interventions to reduce restraint use. They advocate for further research to determine which components should be included in educational programs to effectively reduce restraint use.[13]

Educational programs won't be effective in eliminating restraints if the underlying reason for restraints is inadequate staffing, inadequate staff training to manage problem behaviors, revolving staff assignments, or lack of resources.[6] Köpke and colleagues found that the combination of a group session for staff, additional education for key nurses, and educational materials for nurses, patients, relatives, and legal guardians reduced restraint use by 6.5% with no increases in falls or their complications, and no increase in psychotropic medication prescriptions.[14]

Nursing interventions

Even in cases where the indications for restraint use are relatively clear, the risks, benefits, and alternatives must be weighed. Analyze what may be precipitating the problem. Are environmental factors such as noise and lighting triggering the problematic behavior? Are patient factors such as pain, constipation, dysuria, or poor vision or hearing triggering the behavior? Does the patient have an acute medical illness? Is polypharmacy a contributing factor? Restraints never resolve the underlying problem; addressing the reason behind a patient's behavior is key to calming the patient.

Programs to prevent delirium, falls in high-risk patients, and polypharmacy may prevent the need for restraints in the first place. Attention to adequate pain control, bowel and bladder function, sleep, noise reduction, and lighting can also contribute to a restraint-free facility.

Educating patients, families, and the healthcare team can increase the use of less restrictive alternatives.[5] Additional creative strategies to reduce restraint use on specific units include constructing a “comfort” room to reduce unsettled patients' level of stress, providing continuing

education on alternatives to restraints for novice nurses in ICUs, and empowering staff to create a restraint-free culture of safety.[15–17]

A multipronged strategy that was effective in reducing restraints in a behavioral health facility will likely work in acute care units as well. (Restraints and seclusion may be used in such facilities to manage patients' aggression toward self or others.) The strategy included notification of executive staff of all seclusion and restraint events, formal debriefings after each restraint event, and staff mentoring.[18] This report shows the importance of involving hospital administrators in monitoring restraint use and educating staff, patients, and families in “real time” to reduce restraint use that day.

Another creative strategy is to expose staff to appropriate research. Hofso and Coyer have compiled research about patients who'd been restrained while mechanically ventilated.[19] Choosing their article for a journal club assignment may help nurses understand the detrimental aspects of restraints. Combining this article with one of the professional resources listed in this article will show staff that effective alternatives can become the standard of practice.

The least restrictive alternative should always be implemented. Here are some examples from the Hartford evidence-based practice guideline:

* For a patient at risk for falling out of bed, lower the bed and put padding on the floor rather than using bed rails.

* Use a lap belt with a hook-and-loop release rather than a vest restraint without a release.

* A deck of cards or a lump of modeling clay can help to keep the patient involved in an activity other than the target behavior that may be endangering the patient or staff.[6]

Literature from the mental health field provides guidance for those attempting to use the least intrusive interventions for older adults whose behaviors endanger themselves or others. A combination of system wide intervention plus targeted education to reduce the use of restraints has been effective in multiple studies.[11]

Changing the culture

A restraint-free culture needs to become standard practice when providing care for hospitalized older adults, and the standard by which licensure and accreditation agencies evaluate providers. Staff motivation to use nonrestraining interventions for older adults at risk for falls and related injuries requires more than individual enthusiasm. In addition, nursing staff must implement creative evidence-based strategies to effectively reduce restraints. Factors such as legislative or regulatory incentives to reduce restraints, consumer endorsement of nonrestraint care practices, administrative support to minimize restraint usage, dissemination of the restraint reduction resources developed by professional organizations to staff and administrators, and an

organizational culture that encourages individualized care may all help to eliminate restraint use.[1,5–10,15,17] Consider becoming a champion for restraint-free care on your unit.

Adverse effects of physical restraints[1,4]

Damaging consequences of using physical restraints include the following:

* functional decline

* decreased peripheral circulation

* cardiovascular stress

* incontinence

* muscle atrophy

* pressure ulcers

*infection

*agitation

*social isolation

* confusion, depression, and fear

* serious injuries, including fractures from falls

* death from aspiration, restriction of breathing, and strangulation.

Sorting out restraints

Restraints may be physical or chemical.

Physical restraints are any appliances or equipment used to prevent physical activity.

* *Direct physical restraints* refer to restraint with equipment, such as bed side rails, chairs with trays, restraint belts, locked room doors, restraint vests, bed linens, and wrist and leg restraints.

* *Indirect physical restraints* include strategies that promote passivity—for example, preventing the patient from walking except in situations related to care procedures and placing mobility aids out of the patient's reach.

Chemical restraint is the use of medication, particularly psychotropic medication, without specific indications, in excessive doses, or as sole treatment without behavioral interventions, and administered for the staff's convenience.[20]

Professional resources for restraint reduction

Each of these guidelines reviews the risks of using restraints, evidence-based alternatives to restraints, best practices for care, and organizational strategies to reduce the use of restraints.

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