Section 6

Physical Restraints CAP

Problem

This CAP identifies persons who are physically restrained. A restraint is any device (for example, a physical or mechanical device, material, or equipment attached or adjacent to the person's body) that the person cannot easily remove and that restricts freedom of movement or normal access to his or her body. What is important is the effect the device has on the person, not the purpose for which the device was placed on the person. This also includes the use of passive restraints such as chairs that prevent rising. The goal of this CAP is to eliminate the use of restraints by employing appropriate measures as necessary according to the person's physical and/or cognitive abilities.

Physical restraints are associated with negative physical and psychosocial outcomes. They are almost never indicated, and at most should be used only as a short-term temporary intervention. If used for any significant period of time, the physical consequences may include loss of muscle mass, contractures, lessened mobility and stamina, impaired balance, skin breakdown, constipation, and incontinence. Further, persons who try to free themselves from restraints may fall and be injured. There is even a high risk of strangulation when certain types of restraints are used.

The psychosocial effects of restraint use may include a feeling of shame, hopelessness, and stigmatization as well as agitation. Behavior disturbances that are sometimes the excuse for restraint use may even be aggravated. It is sometimes suggested that restraints be used because of staffing shortages. However, there is considerable evidence that the use of restraints increases demands on staff because it is necessary to check the person's status more often than usual throughout the day, and there may be a decline in physical and mental health as well.

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Overall Goals of Care

- Identify and treat symptoms related to use of physical restraints.
- Identify and carry out alternative care approaches (for example, restorative care, alternative seating/positioning, individualized activities, or constant monitoring by staff/volunteer).
- Evaluate the use of alternative methods and outcomes in an ongoing manner.

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Physical Restraints CAP Trigger

This CAP applies to persons in long-term care facilities and post acute care settings. This CAP does not apply to persons in home care or other community settings.

The Physical Restraints CAP identifies two types of persons for follow-up, using interRAI's ADL Self-Performance Hierarchy Scale. Both groups will be restrained in their movement at the time of assessment by devices such as trunk restraints or chairs that prevent rising. The groups differ in their ADL self-performance status: One group is more self-engaged in ADLs, while the other group has little independence in these activities.

TRIGGERED TO REMOVE RESTRAINTS FOR PERSONS WITH THE ABILITY TO PERFORM SOME MIDDLE- OR EARLY-LOSS ADL ACTIVITIES (for example, personal hygiene, dressing, and walking)

Persons in this subgroup tend to be restrained because of concerns about falling, wandering, and behavioral problems (for example, resisting care, physical abuse, or socially inappropriate behavior). About one in five restrained persons will fall into this group. Organizations with effective restraint reduction programs have been able to eliminate restraints in caring for such persons.

This group includes 1% of persons in long-term care facilities and 2% of persons receiving home care.

TRIGGERED TO REMOVE RESTRAINTS FOR PERSONS WITH LITTLE OR NO ABILITY TO PERFORM MIDDLE- OR EARLY-LOSS ADLs

Persons in this subgroup are more likely to have a history of falls and behavioral problems than the subgroup not triggered. About 70% of these persons have severe cognitive loss and a like number are unable to walk or use a wheelchair. About 40% will be unable to sit upright on their own, over one-quarter will have severe problems in seeing or understanding others, and about 15% will be tube fed. With effective restraint reduction programs, few, if any, such persons will require restraints.

This group includes 1 to 6% of persons in long-term care facilities and less than 1% of persons receiving home care.

NOT TRIGGERED — This group includes persons who do not use physical restraints or a chair that prevents rising. In addition, persons with quadriplegia and those who are comatose are not triggered. Their plan of care would call for the use of proper chairs and support apparatuses.

Physical Restraints CAP Guidelines

Initial Considerations Prior to Temporary Use of a Physical Restraint

There are a limited number of situations where a physical restraint may need to be applied on an emergency basis. An example would be to prevent violence to others, harm to self, or a suicide attempt (consult facility psychiatric practice standards for such emergency use), or to allow an essential medical treatment to proceed. As soon as the immediate concern passes, the person must be evaluated for removal of the restraint and referred for care as described below.

When consideration is being given to the use of a physical restraint at other times, first complete a thorough assessment to consider care approaches that do not involve restraint use. The following are examples of issues to consider:

- **Seating** — Does the person need a different type of seat? Often, restraints are misused as positioning devices.
  - Consider an assessment by a therapist to determine the most suitable seating apparatus given the person's physical condition.

- When a wheelchair is used for transport only, encourage the person to move to other chairs for more permanent seating during the day. This would not necessarily apply to a wheelchair that has been customized for that person (for example, having tilt/recline, custom back). Such a wheelchair is often the most appropriate seating as compared to standard furniture. Provide access to as many types of seating as reasonable for that person to allow for a change in posture and perhaps a different environment.

- **Ambulation, transfers, and positioning** — What is the person's daily routine? This review may point to ways to individualize the current living environment to reduce the risk of falling by providing the person with the necessary help for transfers, ambulation, or position changes before the person would try such moves unassisted. Consider the times of both day and night when interventions other than restraints can reduce the risk of adverse outcomes.
  - Consider the usual time the person gets out of bed, uses the toilet, is involved in activities, eats meals, rests in bed, and sleeps.
  - Are there opportunities for the person to be repositioned without restraints during meals, activities, and at other times?
  - Does the person use suitable adaptive equipment, including canes and walkers, for mobility? Has the person been trained (if appropriate) and monitored on the proper use of the adaptive equipment?
  - Does the person have suitable nonskid, well-fitting footwear?

For persons already in restraints, determine the reason for their use. If, after this review, the decision is made to temporarily continue using a physical restraint, the person's plan of care must identify the following:

- A detailed rationale for use of the restraint.
- The specific time(s) the restraint(s) is (are) to be used and a detailed schedule for checking the status of the person when it is. Such a schedule will specify the frequency of checking by hour and day. For example, one such plan would call for the person to be checked every 15 minutes for the first 2 days and every hour for the following 5 days.
- Monitor the person's physical and emotional response to the restraint (for example, assess for agitation, calling out, pulling at the restraint, tearfulness).
- Determine the presence of the person's consent (or proxy consent if the person is not capable to provide consent) for the restraint use.
- Design a plan outlining steps to eliminate the use of the restraint as soon as possible.
- Establish a target date by which the restraint will be removed. If this date has passed, re-evaluate in detail the need for restraint use and document the reasons it was not removed by the target date.

Considerations Following Application of a Physical Restraint

Is the person restrained because of a history of falling? [Consult the Falls CAP for a more detailed discussion of falls.] If this is the case, there are two main actions:

(1) develop a list of the conditions that may place the person at an increased risk of falling; and (2) develop alternative care strategies for each of the applicable conditions identified in the following section. Restraints are never a correct strategy to address these conditions. The following is a list of common conditions that call for nonrestraint solutions.

- High-risk clinical factors suggesting that severe injury might result should a fall occur. Examples include osteoporosis; severe visual impairment; anticoagulation therapy including wafarin, heparin, or aspirin; recent hip fracture; and a recent episode of syncope.
- Functional limitations that suggest a fall would have a higher likelihood of a serious consequence—for example, the presence of a significant limitation in locomotion or transferring. [See the ADL CAP.]
- Would the person benefit from an exercise or rehabilitation program to improve underlying conditions? Examples include strength training to improve muscle tone, aerobic exercise to increase cardiovascular stamina, and gait and balance training to increase steadiness.

Is the person restrained because of a history of wandering behavior? Restraints are rarely indicated for such behavior and even then only for a matter of a few minutes under most circumstances. Many techniques and devices are now available to address this issue. Alert devices can be placed on the person so that a door automatically locks when the person approaches. Identification bracelets, such as Medical Alert, can be placed on the person for prompt identification. Circular paths that do not have an exit outside may allow the person to walk without being able to leave the building. [See the Behavior CAP for more details on how to address the care of such persons.]

- Does the person wander because of an abnormal cognitive state (for example, short-term memory impairment, impaired cognitive skills for decision making, variations in mental function over the course of the day)? Assess and treat reversible cognitive problems. [See Delirium CAP, Cognitive CAP.]
- Is the person able to make him- or herself understood and can he or she understand others? Note clarity of speech and the person's ability to give and to understand directions and conversation. Provide different forms of communication/directions as needed (for example, wall signs that redirect the person). [See Communication CAP.]
- Determine if the person's need to move could be satisfied through purposeful activity, such as participation in a walking program.
- Determine if there are patterns to wandering or behavior disturbances. Consider what is motivating the person. Consider the time of day and build a routine around the need to wander. Consider the person's prior routine to identify possible activities the person might want to pursue.
- Determine if wandering or behavior disturbances may be a side effect of a medication. [See Behavior CAP.]
- Has the person recently moved into the facility? Is the person trying to deal with loss or fear of the unknown? The care approach should include strategies to make the person feel safe, comfortable, and secure in the care environment.

Is the person restrained because of agitated or abusive behaviors? [Consult the Behavior CAP for a more detailed discussion of behavior management.]

- Does the person have a history of a psychiatric diagnosis? Review the person's medication regimen to ensure that correct medications are being used.
- Determine whether the behavior is the result of an unmet need in a nonbehavioral area (for example, pain/discomfort, fatigue, hunger, thirst, fear, bowel/bladder need, boredom or overstimulation, need to move around), and design alternative strategies to meet such needs.
- Is the abusive behavior new? Because an acute medical condition can result in delirium or an acute psychotic episode associated with striking behavioral change, immediate referral to a physician is required if this is a consideration. [See Delirium CAP.]
- Identify any precipitating factor(s), remove them from the environment if possible, and adjust care schedules to reflect the person's unique needs. Examples of treatment strategies include
  - Allow the person to decide to get up in the morning or be bathed.
  - Redirect the person with calm, simple, clear, and reassuring directions and remove environmental hazards and other persons from the immediate vicinity. Allow the person to safely express his or her emotions.
  - Provide one-on-one intervention/supervision, as tolerated by the person. Many persons who are agitated and pacing may be willing to be accompanied by a staff member while verbally releasing their anger and frustration.
  - Avoid speaking in loud, forceful, or urgent tones that may further irritate the person. If the person is being physically abusive, move away and allow the person to have space. This will decrease the person's sense of feeling trapped. Remove others from the situation. When it seems safe, approach the person in a calm, reassuring manner.
- Was abusive behavior toward another person provoked or unprovoked? Identification of provoking factors will aid in determining a suitable plan to prevent future abusive behavior toward others. Examples of treatment strategies include the following:
  - If the person wandered into another's room, a harsh response by the occupant may make the wanderer strike out (behavior provoked).
  - If the abuse was not a result of provocation, consider an immediate referral to a physician while beginning immediate steps to maintain safety of staff and other persons.
  - Approach the person in a calm, quiet, soothing manner. A person often mirrors the behavior of those around him or her.
  - Consider the physical environment and decide if overstimulation or understimulation may be factors that affect abusive outbursts. Proper interventions may include, but are not limited to, adjusting awakening and retiring schedules, adapting meal times, providing one-on-one activities and variations in current activity schedules, adjustment of

medications, and referral for medical or psychiatric evaluation and intervention.

- Take steps to improve the continuity of care (for example, use a primary nursing care approach). Is one staff member assigned to the same person over long periods of time to build up an understanding of his or her individual strengths, preferences, needs, and idiosyncrasies? A sense of familiarity with a consistent caregiver may reduce and even eliminate periods of abusive behavior.

Is the person restrained to prevent the removal of an essential medical device (for example, IV tube or tracheostomy tube)?

- What is the person communicating by trying to remove a medical device? Could it be localized pain at a tube insertion site that could be corrected? Did the person express wishes to not have a tube before it was inserted? Is the person trying to convey his or her wishes? Consider discussions with the person, family, and health care team to review the goals of care and the person's wishes about health care treatments.
- Is a family member able to spend time with the person to calm and reassure him or her?
- If a device is considered necessary, interventions to distract the person from pulling at it include the following:
  - Dress the person in a long-sleeved shirt to cover tubing in the arm.
  - Dress the person in long pants with a leg bag to discourage pulling at an indwelling catheter.
  - Dress the person in a turtleneck shirt to keep him or her from reaching for a subclavian line.
  - Offer the person something to hold to occupy his or her hands (for example, putty, a foam ball, rosary beads, a clean piece of tubing, or a personal possession small enough to hold).
  - Invite the person to attend activities that keep the person actively involved.
  - Arrange for a sitter or a video monitor.
- If treatment is temporary (for example, IV antibiotics) and the above alternatives do not work, consider the least restrictive form of restraint, closely monitor the person, and devise a plan to remove the restraint as soon as possible.

Additional Resources

"Everyone wins! Quality care without restraints." 1995. The Independent Production Fund, in association with Toby Levine Communications, Inc., New York, NY.

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