

Don't Statement:

Don't use physical restraints with an older hospitalized patient.

Statement of Rationale:

Restraints cause more problems than they solve, including serious complications and even death. Physical restraints are most often applied when behavioral expressions of distress and/or a change in medical status occur. These situations require immediate assessment and attention, not restraint. Safe, quality care without restraints can be achieved when multidisciplinary teams and/or geriatric nurse experts help staff anticipate, identify, and address problems; family members or other caregivers are consulted about the patient's usual routine, behavior and care; systematic observation and assessment measures and early discontinuation of invasive treatment devices are implemented; staff are educated about restraints; and the organizational culture and structure supports restraint-free care.

Despite federal guidelines to the contrary, older patients—especially those with impairments in memory and cognition (whether acute from delirium or longer standing from dementia, or both) – are regularly restrained in hospitals at much higher rates than other adults. One recent study across 40 hospitals in 6 U.S. metropolitan areas reported an average rate of restraint as 50 per 1000 patient days, with Intensive Care Units having the highest use (56%) (Minnick, Mion, Johnson et.al. 2007). The rate varied widely across the individual hospitals. Restraint of hospitalized older adults contributes to serious medical and psychological problems, requires additional staff time, poses serious ethical challenges and results in longer hospital stays which are costly. Recent emphasis on improving quality in hospitals includes tracking restraint use as an important indicator, signifying national awareness of the problematic outcomes of restraint use, especially with frail elders. Patients and families can help bring about change in practice by questioning the use of restraints and providing information about the patient's usual patterns. This information assists staff in development of individualized care plans which avoid use of control measures.

Background:

For centuries, shackles and restraints were used to manage violent behavior in severe mental illness. Over the past 100 years, this practice has come to be seen as ineffective and dangerous as well as a violation of human rights. The increased use of physical restraints with medically ill elders is increasingly documented post-WWII, perhaps in relation to several changes occurring in health care: greater numbers of hospitalized elders (especially those with cognitive impairments), concerns about 'protecting' elders from falls and injuries, reducing patients' interference with invasive medical devices (e.g., urinary catheters, IV lines, ventilators), growing scarcity of nursing staff, and fears concerning malpractice. By the 1960s health care journals and texts warned against the use of restraints with frail elders, citing numerous poor physiological, psychological, physical and ethical outcomes, yet many myths prevailed. These myths, now refuted, included deeply held beliefs about frail, often 'confused,' older patients: that older patients were 'more likely to fall and sustain serious injuries'; that restraint

was supported by an ethical duty to ‘protect patients from harm’; that older confused people were really ‘not bothered by being restrained’; that ‘inadequate staffing necessitated’ use of restraint; that there were ‘no other interventions available’ meeting underlying patient needs, and that failure to restrain put individuals and hospitals ‘at risk for legal liability’ (Evans & Strumpf, 1990). Pressure on hospitals, and most especially on the nursing staff, regarding legal responsibility for patient-related accidents and injuries countered professional judgment, and no doubt contributed to use of physical restraints. Research in the 1980s-2000s supported assessment and intervention, NOT the use of physical restraints, and gradually led to a revision in national guidelines and a re-interpretation of the standard of practice (Evans & Strumpf, 2011). Patient behavior that may be interpreted by some as ‘unsafe’ now should trigger multidisciplinary assessment to uncover any change in medical condition or explore the meaning in behavioral expressions of distress (pain, need to urinate, hunger, fear)(Talerico, Evans, Crandall, 2013). It should never be the reason to apply a physical restraint.

Evidence:

Hospitalized elders are at the greatest risk for being restrained when suffering from impairments in memory and cognition which compromise their judgment and full participation in care. Instructions to ‘use the call bell when you need to get to the bathroom’ or even to recall where the bell is located and how to use it, are quickly forgotten. Such older adults have difficulty recognizing where they are and why, can’t make sense of the environment, and may try to ‘go home’ or protect themselves from staff who perform any procedures, including something as simple as a bath. Full length bedrails are an impediment, but not a deterrent, to getting out of bed. Finally, patients with existing brain damage from dementia are unable to communicate needs and symptoms in an understandable way and are, thus, at the highest risk for additional acute impairments such as delirium and other complications. Signs of changes in memory, cognitive function or behavior represent a change in medical condition and require immediate investigation.

Restrained patients are at risk for functional decline, serious injury or death from falls or strangulation, poor circulation, heart stress, incontinence, muscle weakness, infections, skin breakdown (pressure ulcers), reduced appetite, behavioral changes, social isolation and depression among other adverse events (Evans & Cotter, 2008). Interviews with hospitalized, restrained older patients revealed considerable physical and psychological distress as well as social discomfort and pain (Strumpf & Evans, 1988). Research in several hospital settings has demonstrated that restraint use can, indeed, be safely diminished. For example, frail older patients receiving consultation from an advanced practice registered geriatric nurse were nearly 7 times less likely to be restrained (Sullivan-Marx, Strumpf, Evans et.al. 2003). Others demonstrated success in medical but not intensive care units (Mion, Fogel, Sandhu, et.al., 2001) and another team reduced the rate to 2.3% following institution of a systematic plan to address restraint (Cospers, Morelock & Provine, 2014), and a special environment was successful in providing restraint free care to patients with delirium (Flaherty, Little, 2011). These studies of restraint reduction in hospitals support measures that are effective in providing safe, humane care for frail elders, particularly those with impairments in memory and cognition. The findings have in common several features: multidisciplinary rounds on restrained or at-risk patients to identify and address problems; use of unit-based champions, advanced practice nurse experts, or leaders to help change the practice; better communication with previous care providers (including family members) about the patient’s

usual routine, behavior and care; institution of systematic observation and assessment measures attuned to the population; discontinuation, if possible, of invasive treatments; increased availability of alternate safety measures on the unit; staff and provider education about restraints, and development of an organizational culture and structure to support restraint-free care (Bourbonniere, Strumpf, Evans Maislin, 2003).

Advocacy by families of hospitalized elders can play a significant role in prevention of physical restraints with loved ones. First, families bring a wealth of knowledge about daily routines, communication patterns, things that bring pleasure and enjoyment, and usual behavioral expressions of pain and discomfort, hunger, need to toilet, boredom, loneliness, fear, and so on. Staff have no prior knowledge of this information unless it is given verbally or in writing. Families are, thus, critical in bridging this information gap and helping to bring about a more individualized and successful care plan. Second, if possible, arrange for a family member stay around the clock or at least at night for the first 1-3 nights after hospitalization to help the elder orient to where s/he is and why, and that they are safe. Third, have a discussion with the primary nurse about the care and the ways that safety and comfort will be assured and voice concern if restraint is under consideration, using the evidence provided here. Be aware that restraint devices are not limited to vests or wrist/ankle ties, but also include full length bedrails, net beds, waist belts, hand mitts, and so on. Speaking with the primary or supervisory nurse when you have a concern is important. Together, you can develop a plan for excellent, humane care for your elder.

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Rev 10/14