



Restraints

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Nursing standards are expectations that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses. Standards apply to all nurses regardless of their role, job description or area of practice.

— *College of Nurses of Ontario*

Introduction

The purpose of this document is to help nurses¹ understand their responsibilities and make decisions regarding the use of restraints. Restraints, whether physical, environmental or chemical, are a controversial measure used to restrict the movement or control the behaviour of a client.

Reasons for using restraints include protecting clients from injury, maintaining treatment and controlling disruptive behaviour. According to *Prevention of Falls and Fall Injuries in the Older Adult* (2002, Nursing Best Practice Guideline, Registered Nurses Association of Ontario), several studies have found that restraints actually increase the severity of falls and can increase confusion, muscle atrophy, chronic constipation, incontinence, loss of bone mass and decubitus ulcers. Restraint use is also linked to emotional distress, including loss of dignity and independence, dehumanization, increased agitation and depression. In severe cases, clients have been seriously injured or have died after becoming trapped in a restraint, such as a bed rail. Coroners' inquests in North America have cited the use of restraints as the cause of numerous deaths due to strangulation. There are no studies that demonstrate that the use of restraints results in increased client safety.

When and how restraints are used is also a legal issue. The *Patient Restraints Minimization Act, 2001* regulates when and how restraints may be used and addresses the principle of minimal restraint on clients. The Act is consistent with this document, the College of Nurses of Ontario's (CNO's) *Restraints* practice standard. It includes components

such as staff training, reassessment, record keeping, client consent, policy development relating to restraint use and alternative methods.

Many facilities in Ontario use a least restraint philosophy. This philosophy acknowledges that the quality of life for each client, with the preservation of dignity, is the value guiding the practice of health care practitioners, including nurses.² CNO supports this in all settings where nurses practise.

Nurses believe strongly in the right of clients to make their own decisions regarding care. When the client is not competent, the substitute decision-maker is expected to make the same decision the client would have made if he/she were competent. Nurses, as client advocates, are responsible for ensuring that the client has received information and has been a partner in planning and consenting to the proposed plan of care. Nurses respect client wishes even when those wishes carry risk.

Increasing numbers of facilities are reporting success in achieving the goal of restraint-free care. Changes in institutional policies have led to the development of educational programs and assessment tools that assist care providers in finding alternatives to restraints. The programs have offered nurses a process for identifying precipitating behaviour and have encouraged implementation of policies of least restraint.³ Quality practice settings effectively support nurses in achieving the goal of restraint reduction. The use of restraints is an intervention of last resort and is based on meeting the needs of the client.

What are Restraints?

Restraints are physical, chemical or environmental measures used to control the physical or behavioural activity of a person or a portion of his/her body. Physical restraints limit a client's movement. Physical restraints include a table fixed to a chair or a bed rail that cannot be opened by the client.

¹ In this document, *nurse* refers to a Registered Practical Nurse (RPN), Registered Nurse (RN) and Nurse Practitioner (NP).

² Ontario Hospital Association. *Position Paper on the Use of Restraints*. Toronto: Author, 1993.

³ England, W., Godkin, D., & Onyskiw, J. *Outcomes of Physical Restraint Reduction Programs for Elderly Residents in Long Term Care — A Systematic Overview*. Alberta Professional Council of Licensed Practical Nurses, 1997.

Environmental restraints control a client's mobility. Examples include a secure unit or garden, seclusion or a time-out room. Chemical restraints are any form of psychoactive medication used not to treat illness, but to intentionally inhibit a particular behaviour or movement.

What is considered a restraint may vary by practice setting. For example, a nurse working in a correctional facility cares for an entire population of clients who are restrained by the environment. In a paediatric setting, nurses typically do not view the use of cribs as a form of restraint. CNO acknowledges that nurses are in the best position to determine appropriate definitions of restraint for their specific practice settings.

Assumptions

Professional judgment is integral to decision-making and includes organizing data, giving it meaning and coming to a conclusion.

1. ***Nursing interventions promote well-being and prevent harm.*** Nurses respect the dignity of the individual and advocate for an environment that promotes a client's quality of life.
2. ***A least restraint policy does not mean that nurses are required to accept abuse.***
3. ***Nurses involve clients or substitute decision-makers in planning.*** It is important for the nurse to develop a plan of care with the client and the client's family. The health care team, which includes the client, discusses the proposed interventions to identify the client's therapeutic needs and to facilitate the client's short-term and long-term goals. To assist decision-making, nurses provide education for clients or their substitute decision-makers, including information about least restraint practices and the right to refuse proposed interventions.
4. ***Consent is essential to nursing interventions.*** Clients have the right to make decisions regarding their care and treatment. The nurse

informs the client or substitute decision-maker of any proposed intervention and alternative measures available. Nurses cannot use any form of restraint without client consent, except in an emergency situation in which there is a serious threat of harm to the individual or others, and all other measures have been unsuccessful. Emergency situations are time-limited. Once the situation is no longer critical, client consent is required. (For more information on these issues, see CNO's *Ethics* practice standard and *Consent* practice guideline.)

5. ***Restraint reduction is an interprofessional process.*** Nurses collaborate with other members of the health care team, including the client or substitute decision-maker, in assessing, planning and evaluating client care to eliminate restraint use. Nurses share knowledge about the risks of restraint use with the interprofessional team.

Policy Direction: Least Restraint

Least restraint means all possible alternative interventions are exhausted before deciding to use a restraint. This requires assessment and analysis of what is causing the behaviour. Most behaviour has meaning. When the reason for the behaviour is identified, interventions can be planned to resolve whatever difficulty the client is having that contributes to the consideration of restraint use. For example, if a client has poor balance or is frequently falling, an intervention, such as providing the client a walker, can be developed to help protect the client's safety while allowing freedom of mobility. A policy of least restraint indicates that other interventions have been considered and/or implemented to address the behaviour that is interfering with client safety.

CNO endorses the least restraint approach. Nurses need to assess and implement alternative measures before using any form of restraint. When restraint is required, the least restrictive form of restraint to meet the client's needs should be used.

Quality Practice Settings

Organizations that are committed to achieving quality practice settings create and maintain

supports for professional nursing practice. These supports include:

1. Fostering excellent nursing practice and safe client care. Practice settings that support a policy of least restraint provide a safe workplace for staff and clients.
2. Involving nurses in the development of a least restraint policy, including identifying specific resources to support nurses in achieving restraint-free environments.
3. Providing resources that include appropriate staffing levels, tools to identify clients at risk of restraint and an environment that's supportive of alternatives to the use of restraints.
4. Providing staff education about the assessment, planning, implementation, support and evaluation of least restraint practices and client rights.
5. Implementing mechanisms to evaluate the impact of staff education and the need for continued support or alternative strategies to assist staff in implementing a least restraint policy.

Nursing Responsibilities

There are a number of activities that should be carried out to provide quality care for clients. These activities are as follows:

- understanding the client's behaviour. This is essential for accurately determining the need for restraints. A thorough nursing assessment identifies factors that lead to difficult behaviour, for which a restraint may be considered. The assessment includes individual factors, such as the client's health status, strengths, abilities and medications, as well as environmental factors such as noise level;
- developing an individualized plan of care to meet client goals, such as increased safety or decreased agitation;
- collaborating with other members of the health care team in developing and implementing the plan of care. For example, physiotherapists can aid in assessing and treating gait disturbances to reduce the need for restraints. The confused client may benefit from occupational therapy to implement environmental interventions that aid in orientation. Problem-solving occurs, in part, through collaboration with other team members, including the client and the family;
- evaluating the plan of care and making changes if it is not effective. It may take several attempts to determine the best plan to avoid the use of a restraint;
- using least restrictive restraints. If attempts to modify or eliminate the risk factors have not been successful and a restraint is required, the nurse uses the least restrictive measure following consultation with the client or substitute decision-maker. Examples of least restrictive measures include using a secure ward for a wandering client rather than using a chair restraint, and using partial side rails rather than full side rails;
- discussing with the client or substitute decision-maker the options and associated risks of using a restraint to enable the client to make an informed decision. For example, a chemical restraint may be considered for a confused client who is pulling out her nasogastric tube. Given information about the options available, the family may choose to provide additional attendant care rather than a chemical restraint that could increase falls and confusion. The nurse needs to understand her/his values and be cautious of not interfering with decision-making. Clients will, at times, prefer to endure safety risks rather than be restrained;
- being aware of individual agency policies regarding the use of restraints. In some settings, a physician's order may be required prior to the use of restraints. In other settings, it is a nursing decision;
- regularly reviewing the continued use of restraints. When caring for a client who is restrained by physical, environmental or chemical means, the nurse is accountable for reviewing the continued use of restraints on an ongoing basis. The nurse is responsible for identifying any new client needs that may arise from the use of the restraints;
- being aware that restraint use, when required, is a short-term or temporary solution — never a

planned long-term intervention. The exception to this may be the use of an environmental restraint; and

- documenting the assessment of the client, interventions to eliminate the need for restraint, discussions with the client or substitute decision-maker, the results of ongoing evaluation and revisions to the plan of care.

Case Studies

Scenario

Mary has been a resident at a restraint-free long-term care facility for five years. When she first arrived, Mary experienced frequent falls due to difficulties with balance. Through assessment, the staff determined that Mary was likely to attempt to ambulate independently when she was bored or had to go to the bathroom. An interprofessional team developed a plan of care that included toileting Mary every two hours, providing her with a low bed with one side rail to assist her to balance when sitting, installing a special seat on her wheelchair and developing recreational activities that provided stimulation and prevented boredom.

Mary has had ongoing difficulty with a leg ulcer, and her physicians arranged for skin grafting at a local hospital. It was expected that Mary would be at the hospital for about seven days to receive post-operative intravenous therapy. The staff at the facility were concerned that Mary's poor balance would result in falls while in hospital and that the use of restraints might be considered. Adding to their concern was the knowledge that immobilization contributed to muscle wasting and that Mary's ability to ambulate on return to their facility might be impaired to the degree that she would require an alternative level of care.

Discussion

The concerns about Mary's hospitalization prompted staff to plan proactively. Before Mary was admitted to hospital, a care-planning meeting was held by telephone with key hospital nursing staff, the family and the nurse manager of the long-term

care facility. Mary's current plan of care was shared with the hospital nursing staff.

Because of the meeting, the hospital staff were able to follow the long-term care facility's plan of care, except for the recreational activity. To prevent falls related to boredom, and in anticipation that medication for pain might further increase Mary's difficulty with balance, the family devised a visiting schedule that allowed them to be with Mary and participate in her care. The hospital admitted Mary to a room close to the nurses' station and used an alarm that signalled when Mary attempted to get out of bed. The hospital physiotherapy department provided assisted exercises to maintain Mary's leg strength while she was less mobile.

A post-operative infection delayed Mary's discharge, but after two weeks she returned to the facility and to her pre-hospital admission routine. Despite post-operative confusion, Mary sustained no falls while in hospital, and due to the proactive planning of staff and family, the use of restraints was not included in her plan of care.

Scenario

A nurse in a long-term care facility is admitting a client who has been transferred from a local hospital. The facility has a least restraint policy and for the past year has used no restraints. It has a risk assessment protocol used on admission to help staff determine an appropriate plan of care that identifies behaviours that may lead to restraint use. Since implementing a least restraint policy, the facility has found that falls have not increased. The falls that have occurred have resulted in significantly less injury. Additionally, the incidents of skin breakdown declined by 50 per cent.

The family is insisting that their mother be restrained to protect her safety. They tell the nurse that if they do not restrain their mother and she falls, they will initiate legal action.

Discussion

This situation, like many involving the use of

restraints, is an ethical dilemma. While nurses respect client choice, limits do exist. As explained in CNO's *Ethics* practice standard, client choice might be limited by policies that promote health or by the resources available in a particular situation. When clients request nurses to perform an act that may cause serious harm, nurses need to inform clients in a nonjudgmental manner of the potential risks and harm associated with the practice.

The nurse in this scenario needs to explore the implications of the request. The family believes that if no restraint is used, their mother's safety will be jeopardized. The nurse is able to provide education about the risks of restraint use and the alternatives available. If the family continues to request that restraints be used, the nurse respects the family's choice but needs to explain that because the facility has a no restraint policy, it does not have restraints available or the resources to use restraints safely. Knowing this information, the family can then make an informed decision about where to place their mother. Client and family needs are best met when these discussions occur before the admission takes place.

Scenario

Nancy is working in the emergency department of a community hospital when a client from the local correctional facility arrives for treatment of a large leg wound. The client is handcuffed and accompanied by two correctional workers. The nurse asks the workers to remove the handcuffs and respect the client's privacy while he is in the emergency department. Although she is able to assess and treat his leg wound with the handcuffs in place, Nancy is uncomfortable with the client's restricted ability to move.

Discussion

In this scenario, the decision to use restraints is made by the correctional facility, not by the nurse. The correctional facility has a least restraint policy and has determined that there is risk of harm to others if the client is not restrained and accompanied by correctional workers. Should the

hand restraints interfere with the client receiving medical treatment, the nurse would need to discuss removing the restraints and alternative means of ensuring safety with the correctional workers. Nancy also needs to advocate within her facility for education on how to manage clients from correctional facilities and the types of restraints that may be used on these clients.

Scenario

Jody, a three-year-old, is intubated post-operatively on a ventilator following brain surgery. To prevent her from pulling out the endotracheal tube, her hands are restrained with mittens. Prior to the surgery, the need to use the mittens was explained to her parents and consent was obtained.

Discussion

This is an appropriate use of restraints that will be discontinued as soon as possible. To avoid frightening the child, the nurse arranged for the family to reassure Jody during the post-operative period. As well, using language Jody could understand, the nurse explained to her why she had to wear mittens. There are circumstances in which a nurse may need to restrain clients when they are not capable of understanding the necessity for the intervention. The nurse needs to consider these situations carefully and use the least restraint possible.

Resources

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