Position Statements

Reduction of Patient Restraint and Seclusion in Health Care Settings

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Adopted by: ANA Board of Directors

Related Past Actions: Action Report: Reduction of Patient Restraint and Seclusion in Health Care Settings, ANA HOD 2000

Position Statement: Reduction of Patient Restraint and Seclusion in Health Care Settings, ANA BOD 2001

Purpose: The purpose of this position statement is to address the role of registered nurses in reducing patient restraint and seclusion. Restraints have been employed with the belief that such actions promote patient safety. It was frequently thought that without effective restraint and seclusion practices, patients were in danger of injuring themselves or others, including nursing staff, patients, and visitors. The use of restraints has been demonstrated to be problematic. Additional research is needed to explore safe, appropriate, and effective nursing responses to patient behaviors that continue to place patients at risk, and to the safety factors related to restraint and seclusion.

Statement of ANA Position: The American Nurses Association (ANA) strongly supports registered nurse participation in reducing patient restraint and seclusion in health care settings. Restraining or secluding patients/residents either directly or indirectly is viewed as contrary to the fundamental goals and ethical traditions of the nursing profession, which upholds the autonomy and inherent dignity of each patient or resident.

ANA is concerned that lack of personnel to provide adequate monitoring of patients and less restrictive approaches to behavior management may increase the violation of patients' rights and place them at greater risk of harm caused by being placed in seclusion and/or restraints.

Dilemmas in patient care are an inevitable consequence of nursing accountability. Nurses struggle to balance their responsibility to protect patients' rights of freedom with their obligation to prevent harm to patients and staff. They may face pressure from family and peers to use restraints. ANA believes restraint should be employed only when no other viable option is available. An acute psychotic episode in which patient or staff safety is jeopardized by aggression or assault would justify temporary restraint. Restraint may also be justified in a case of dementia or delirium where an elderly person is likely to fall and fracture hips or other bones.

When restraint is necessary, documentation should be done by more than one witness. Once restrained, the patient should be treated with humane care that preserves human dignity. In those instances where restraint, seclusion, or therapeutic holding is determined to be clinically appropriate and adequately justified, registered nurses who possess the necessary knowledge and skills to effectively manage the situation must be actively involved in the assessment, implementation, and evaluation of the selected emergency measure, adhering to federal regulations and the standards of The Joint Commission (2009) regarding appropriate use of restraints and seclusion.

History: In 2000, the ANA House of Delegates (HOD) published an action report: Reduction of Patient Restraint and Seclusion in Health Care Settings, followed by a position statement in 2001: Reduction of Patient Restraint and Seclusion in Health Care Settings.

In the action report, the ANA HOD agreed to establish a position statement based on nine principles, including evidence-based practice, protection of human rights, patient/provider safety, and the authority of the registered nurse to exercise independent professional judgment in determining whether the emergent, temporary use of appropriate restraints and/or seclusion is necessary. Additionally, the HOD advocated for legislation and regulatory remedies, education, and research to address the issue.

The position statement in 2001 expanded on the action report and stressed that inadequate staffing is a contributing factor to the continued inappropriate use of restraints.

Supportive Material: Nursing has a history of involvement with attempts to reduce the use of restraint, going back well over 100 years. Frequently, when restraint was employed, it was with the belief that such action would promote patient safety. It was this belief, in part, which led to the increase in restraint use in the nursing home population. Concern about the quality of patient care in that setting increased, and the Nursing Home Reform Act, part of the Omnibus Reconciliation Act of 1987, was adopted into law. The results of this law greatly affected the quality of care received through increased assessment of and care planning for the patient, resulting in the reduction of both physical and chemical restraint. This law also has implications for individuals with mental illness. The patient populations affected are older adults, the elderly, psychiatric patients (adults and children), and disoriented or physically aggressive patients. The settings of restraint use include psychiatric facilities and residential sites for those with mental illness, developmental, or behavioral problems; general hospitals; emergency departments; and nursing homes (Dorfman & Mehta, 2006; American Psychiatric Nurses Association, 2007).

Psychiatric nurses have made considerable progress in restraint reduction (Delaney, 2006; Johnson, 2010). They have worked to institute trauma-informed care and a recovery framework for inpatient care (Cito, 2010). Their focus is on proactive measures to ensure restraint is used

only as an emergency measure, as well as reducing all coercive interventions by connecting with individuals from a patient-centered recovery framework (Chandler, 2008). Additionally, the Association of State Mental Health Program Directors' National Technical Assistance Center has developed eight core strategies to reduce restraints.

In December 2006, Centers for Medicare and Medicaid Services (CMS) published a rule requiring patients be evaluated face to face within an hour of being restrained or secluded for management of violent or self-destructive behavior. The evaluation is to be conducted by physicians, other licensed independent practitioners (LIPs), appropriately trained registered nurses (RNs), or physician assistants (PAs). When an RN or a PA performs the assessment, the attending physician or LIP responsible for the care of the patient must be consulted as soon as possible (Code of Federal Regulations, 2006).

The National Alliance for the Mentally Ill (NAMI) has affirmed its stand in 2003 that seclusion and restraints are justified only as a last resort in emergency situations, and that a qualified health provider make an assessment within the first hour of application. There is a critical need for mandated monitoring of the use (frequency, methods, etc.) of restraint and seclusion. The Joint Commission reported 202 restraint- and seclusion-related deaths in the United States over a five-year period, with the primary cause of death being asphyxiation (2010). Other sources list the following complications of restraint use: brachial plexus injury, delirium, incontinence, joint contractures, muscle weakness, pneumonia, pressure ulcers, and urinary tract infection (Collins, Haines, & Perkel, 2009). Restraint is currently defined as:

> "(A) any manual method or physical or mechanical device, material or equipment that immobilizes or reduces the ability of a person to move his or her arms, legs, body or head freely' or (B) a drug or medication when it is used as a restriction to manage the person's behavior or restrict the person's freedom of

movement and is not a standard treatment or dosage for the person's condition; (C) a restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort)" (Code of Federal Regulations, 2006, p. 71426).

ANA supports the rights of patients of all ages and in all settings to be treated with dignity and concern, and receive safe, quality care. (ANA, 2001). Developmentally appropriate methods of restraint must be used in the least restrictive manner with the ultimate goal of a safe, restraint-free environment. The family members, guardians, or significant others of individuals placed in restraint must be informed in accordance with HIPAA regulations.

When a patient's decision-making capacity is in question, autonomy and involvement should be protected whenever possible to protect the dignity and human rights of the person. When patient involvement is not possible, the choice to restrain or not must be carefully decided by nurses, and families, when available, after weighing benefits and burdens and considering the best interest of the patient. Should a patient's refusal of restraint endanger well-being, a medical determination should be made about the patient's decision-making capacity. If this is insufficient to resolve the issues, a competency determination will be needed from the judicial system. At times, situations call for immediate action to protect a patient, in which case time does not permit notice of a family member.

An increasingly vulnerable population for whom restraints might be considered is that of older adults whose numbers are predicted to surpass growth figures in previous generations (Institute of

Medicine, 2008). The increasing prevalence of age-related conditions such as Alzheimer's disease, wandering behavior, falls, and incontinence may lead to the application of physical restraints that are intended to protect the older adult. The application of such restraint poses difficult ethical questions as to when, how, and under what conditions the choice not to be restrained can be honored by nurses and the families of patients whose physical safety is at risk. A careful analysis of benefits and burdens for the patient must first be considered. Decisions to restrain are often conditioned by such concerns as inadequate staff to monitor unrestrained patients who may who may be perceived as at risk for falling or leaving the unit unaccompanied, and by concerns for legal liability should the patient or others be injured when not restrained. These concerns should not be the primary factors in decision-making regarding the use of physical or chemical restraints. Bed alarms and wander alarms may be used to alert staff to a patient's needs rather than physical or chemical restraints. Criminal restraints and custody arrangements are much more complex. When patients are involved with the criminal justice system, restraints are sometimes used for public safety rather than clinical purposes. In those circumstances, nurses should still work to promote dignity and physical well-being.

Older patients will be receiving care increasingly in their homes (IOM, 2008). Family members, especially those who have observed restraint use by nurses in the acute care setting, may consider restraints for cognitively impaired clients in the home, when the "safety" of patients is compromised by impaired judgment. Family members and other non-nurse care providers will need to understand ethical aspects of decisions to use physical or chemical restraints. Educating non-nurse caregivers about the use of restraints should be undertaken by nurses. Similarly, nurse educators should explore the ethical implications of restraining patients with students and discuss the need for institutional policies that clarify when, where, and how clients are to be restrained and monitored while restrained. The ANA Code of Ethics for Nurses (2001) should be used as a guideline for these educational sessions. There are regulatory requirements for training in facilities

as a condition of participation in Medicare and Medicaid. Nurses should be involved in their implementation at the facility level.

Nurse administrators should be aware of all implications of allowing the application of restraints in health care settings. A clear institutional policy should be available to nurses to guide decision-making regarding restraints. Accepted national standards such as those of the The Joint Commission should guide policy development. The nurse administrator should make consultation available to nurses, including ethics consults about decisions to restrain.

While many institutions have decreased the use of physical restraint, critical care or intensive care units (ICUs) have had limited success in decreasing restraint use with intubated and mechanically ventilated patients. Early extubation and non-invasive ventilatory methods have had a positive impact on limiting restraint use. However, the sustained use of restraints to prevent extubation is not substantiated by actual data; yet a substantial number—more than one-third of patients—were restrained while self-extubation occurred (Mion, Minnick, Leipzig, Catrambone, & Johnson, 2007). In addition, avoidance of self-displacement by patients of central intravenous lines, nasogastric tubes, and indwelling bladder catheters are also justified as reasons for placing ICU patients in restraints (Mion et al., 2007; Minnick, et al., 2007b). Changes in bedside nurses' critical thinking and decision-making related to restraint will occur only with education and continuous discussions supported by administration. The current use of restraints needs to be replaced with an individual case-by-case discussion and ethical and moral considerations. In addition, better restraint alternatives need to be developed to secure endotracheal tubes and other equipment to help support better care outcomes (Mion, Halliday, & Sandhu, 2008).

"Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior" (Code of Federal Regulations, p. 71427). Seclusion and/or

restraint may be more likely to be employed inappropriately—that is, for non-emergency situations or circumstances where no significant risk of harm exists—when hospital unit staffing is inadequate or the staff is inappropriately trained to provide less restrictive interventions (The Joint Commission, 2009). Where the hospital cannot provide for an assessment by a licensed independent practitioner or appropriately trained nurse within an hour, ANA supports that all the following requirements should apply:

1. A registered nurse shall confer by telephone with a physician or other health care professional permitted by the state and hospital to order restraint or seclusion within an hour after the restraint or seclusion is initiated. This requirement is consistent with obtaining telephone orders within an hour after instituting the procedure if an order cannot be obtained beforehand.
2. The reasons for a patient's not being seen within the hour shall be documented in the patient record.
3. The patient must be physically assessed by a registered nurse hourly until a licensed independent practitioner arrives to see the patient.
4. To ensure safety in case of delay, the patient must be seen by an LIP or appropriately trained RN to order restraint or seclusion within one hour after its application. Adding such language to the current requirements assures that patient safety is not compromised by delay in assessment.

To achieve a culture of non-use of restraints, facilities should adopt formal procedures and policies that clearly state the intent to promote a reduced restraint environment for patients. Such statements must include a focus on:

1. intention to comply with policy standards;
2. environmental designs to facilitate restraint reduction;

3. sufficient registered nursing staff to monitor and intervene as needed; and
4. implementation of an individualized approach grounded in the following principles:
    a. All behavior has meaning.
    b. Patient needs are best met when behavior is understood.
    c. A systematic approach of assessment, intervention, and evaluation is the best means to respond to behavior.

When instituting change toward reduced use of restraint, initial educational efforts must address fundamental components of such care. Open communication and dialogue at the highest administrative levels, including registered nurses and staff from all disciplines as well as community representatives, is essential to implementing change. This is consistent with the ANA Code of Ethics for Nurses (2001), interpretive statement 2.3, Collaboration and Provision 6, Improving Health Care Environments. Early success with less complex problems, such as eliminating restraints for positional support with substitution of wedge or roll cushions, fosters confidence for handling more difficult situations. If systems lack internal resources to provide education and specialist intervention, independent nursing consultation services can be contracted. Each of these steps should be documented in facility records.

Targeting specific units or groups of patients, such as all new admissions, and then identifying who is restrained and why, lays the groundwork for interventions aimed at eliminating or minimizing use of restraints. Interventions may take the form of actions categorized as *physiologic*, *psychosocial*, *activity*, or *environment*.

Physiologic approaches include such efforts as pain relief or investigating symptoms indicative of developing complications such as hypoxia, delirium, or fever. Psychosocial interventions focus on the meaning of patient behavior and address that need; for example, is the agitation communicated by a patient due to fear of impending surgery or the onset of delirium? Activities

can include talking with the patient, physical exercise, therapy (massage and therapeutic touch, music therapy, pet therapy, reminiscence therapy), involvement in activities, meaningful distraction (meditation or prayer), or contact with familiar people or places, even by telephone. Environmental adjustments may range from the simple use of light to facilitate vision or relocation of the patient to another bed or room, to specifically designed units that reduce the hazards of falling. To foster transition to reduced restraint care and sustain lasting change, nursing and institutional practice patterns must be altered and knowledgeable practice enhanced through education, intensive clinical evaluation, and consistent reinforcement of standards and policies (Park, Tang, Adams, & Titler, 2007).

Finally, it must be recognized that psychotropic medications do have a therapeutic use are not merely “chemical restraints” but treatment strategies which can result in a decreased need for therapeutic holding or physical restraint. However, an adequate number of registered nurses must be available to provide the necessary care. Adequate staffing can reduce need for restraints and seclusion. Staff must be educated in the use of alternatives to restraint, and such alternatives must be made available to them through both organizational policy and in fact. Only then can patient safety and quality care be assured.

Recommendations: To ensure safe, quality care for all patients in the least restrictive environment, ANA supports nursing efforts to:

1. Educate nurses, nursing students, unlicensed personnel, other members of the interdisciplinary team, and family caregivers on the appropriate use of restraint and seclusion, and on the alternatives to these restrictive interventions;
2. Ensure sufficient nursing staff to monitor and individualize care with the goal of only using restraint when no other viable option is available;
3. Ensure policies and environmental support services are in place to provide feasible alternatives to physical and chemical restraints;

4. Move progressively toward a restraint-free environment while providing a therapeutic sanctuary for all;
5. Enforce documentation requirements and education about what should be documented;
6. Explore the ethical implications of restraining patients with nursing students and discuss the need for institutional policy that clarifies when, where, and how clients are to be restrained and monitored while restrained;
7. Be aware of all implications of allowing the application of restraints in health care settings. The nurse administrator should make consultation available to nurses, including ethical consultation about decisions to restrain; and
8. Develop clear policies based on accepted national standards to guide decision-making regarding restraints.

Summary: There is a critical need to provide educational opportunities to assist nurses in developing the necessary assessment and intervention skills to reduce the use of restraint and seclusion. ANA is concerned that lack of personnel to provide adequate monitoring of patients and less restrictive approaches to behavior management may increase the violation of patients' rights and place them at greater risk of harm caused by being placed in seclusion and/or restraints.

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Additional Resource List

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