QUALITY ASSURANCE MODULE #6: RESTRAINTS

RESTRAINTS (2009) – SAFE NURSING PRACTICE!

The Ministry of Health and Long-Term Care passed the Patient Restraints Minimization Act in 2001. The Act sets out when to use restraints on clients and emphasizes the minimal use of restraints. The College’s Restraints practice standard is consistent with the Act and encourages documentation, nurse education, policy development, client consent and regularly reviewing the need for a restraint.

Types of Restraints

Restraints can be chemical, physical, or environmental measures used to control the physical or behavioral activities of a client or part of the client’s body. An example of a chemical restraint is a psychoactive medication. A physical restraint could be a fixed table or bed rail. A locked unit is an example of an environmental restraint.

Common Myths about Restraints

There are several common myths about the use of restraints. Some nurses and other healthcare providers believe that the use of restraints can protect clients from injuries and falls; control abusive or disruptive behaviors; and reduce negative outcomes. In fact, research has shown that the use of restraints can increase the incidence of falls and skin tears, increase agitation, and disruptive behavior, and increase incontinence and muscle atrophy. The use of restraints can also decrease the dignity of the client.

When to Use a Restraint

The decision to use a restraint on a client, and a nurse’s accountability in that decision, is often complex.

By applying the decision process for deciding to use a restraint, nurses can provide the best possible client-centered care. The process can help you decide whether to use a restraint or try alternative interventions. Nurses must assess the client’s needs first and then the need for a restraint. If it’s determined that a restraint is necessary, nurses need to develop a plan for the client’s care, implement the use of a restraint, and evaluate the restraint’s effectiveness.

The first step is to assess whether restraining a client is the most appropriate intervention. A thorough assessment may identify factors that are contributing to the client’s behavior; for example, consider the client’s health status and medications. As well, environmental factors, such as a high level of noise, can cause stress and agitation in some clients.
Selecting a Restraint

After exhausting alternative interventions and determining that a restraint is required, choose the least restrictive form of restraint. The less restrictive the restraint, the less invasive it is for the client. For example, it’s less invasive to allow a client to walk around in a secure unit than it is to restrain the client to a chair. Before using a restraint, discuss with the healthcare team the options and risks associated with different types of restraints. Nurses should obtain client consent to use a restraint, except in emergency situations in which there is a serious threat of harm to the client or others.

Evaluation and Accountability

After you have obtained consent, develop an individualized plan of care with the client, the client’s family, and the multidisciplinary healthcare team. Once the restraint is applied, evaluate its effectiveness and whether there’s a continued need for the restraint. One must follow their practice settings policies and procedures related to ongoing assessments and the frequency of such assessments.

Documentation is key in terms of your discussions with the client and family and your nursing assessments.
Restraints

Table of Contents

Introduction 3
What are Restraints? 3
Assumptions 4
Policy Direction: Least Restraint 4
Quality Practice Settings 5
Nursing Responsibilities 5
Case Studies 6
Resources 9
OUR MISSION is to protect the public’s right to quality nursing services by providing leadership to the nursing profession in self-regulation.

OUR VISION is excellence in nursing practice everywhere in Ontario.
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 nurses 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. In 2001, the Ontario government passed Bill 85, the Patient Restraints Minimization Act. The Act 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. 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. 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.

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


PRACTICE STANDARD

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. 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:

- 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.
REFLECTION


1. Accountability. One of the most important components of client care is safe, effective, and ethical nursing practice. As with any nursing intervention, a nurse must be able to use their nursing knowledge and judgement in their decision making in the use of restraints. Nurses are accountable to have knowledge, technical skills, and good nursing judgment in the utilization of restraints. Nurses must continuously reflect on their practice and maintain their competence to assess the appropriateness of the use of restraints for their patients.

Accountability Check:

Do I possess the knowledge, technical skills, and good nursing judgment required to assess the appropriateness of the use of restraints for my patients?

2. Continuing Competence. Improve your knowledge: by reviewing the Restraints practice standard (2009) available on the CNO website: www.cno.org. Review as needed and annually review your practice settings policies & procedures. Stay abreast with updates from CNO by searching the CNO Website and reading the quarterly CNO Standard; attend in services when offered and be involved in nursing practice meetings to advocate for policy changes reflecting the use of restraints. Keep current with legislation to ensure the use of least restraints.

Continuing Competence Check:

Do I ensure that my competence with regards to the use of restraints stays up-to-date?

3. Ethics. Protect yourself and your client by ensuring you continuously make effective ethical decisions about client care as it relates to the use of restraints in your nursing practice. It is an imperative for nurses to ensure ethical decisions are made in the best interest of safe, quality, and effective client care.

Ethics Check:

Do I take an ethics-based approach to decisions about client care as it relates to the use of restraints in my nursing practice?


Knowledge Check:

Have I acquired the knowledge necessary to make decisions about client care as it relates to the use of restraints in my nursing practice?

5. Knowledge Application. Apply the knowledge: identify opportunities for improvement in the use of restraints supporting clients and substitute decision makers. Continuously seek opportunities to learn about new strategies to minimize the utilization of restraints to ensure quality, ethical, and safe client care.

Knowledge Application Check:

Am I seeking opportunities to apply my knowledge to decisions about client care as it relates to the use of restraints in my nursing practice?
6. Leadership. Demonstrate nursing leadership: role model critical thinking and problem-solving skills to minimize the use of restraints for clients. Share knowledge with other healthcare providers, coach, and mentor colleagues if one identifies gaps in understanding the intent behind the least restraint philosophy. Be active in committees to ensure restraints reflect CNO standards, become a champion within your practice setting related to the use of least restraints.

**Leadership Check:**

Do I demonstrate leadership (e.g. share and demonstrate knowledge, critical thinking, problem-solving) to minimize the use of restraints for clients?

7. Relationships. Maintain professional and/or therapeutic relationships with colleagues to promote the philosophy of least restraints. Share your nursing knowledge, skill, and judgment required by CNO’s professional standards to avoid inappropriate use of restraints. Share your knowledge with colleagues including novice nurses, foster a supportive environment in applying the restraint standard.

**Relationships Check:**

Do I maintain professional and/or therapeutic relationships with colleagues to promote the philosophy of least restraints?

**WITHOUT STANDARD WORK, IMPROVEMENT IS IMPOSSIBLE!!!**

I am knowledgeable and aware of how my seven Professional Nursing Standards apply to the CNO Documentation Standards.

Signature: ______________________________

Date: ______________________________

______________________________
PRACTICE REFLECTION WORKSHEET ON RESTRAINTS

Collection of Personal Information

The College of Nurses of Ontario (the College) collects the information in the Learning Plan for Practice Assessment under the general authority of the Regulated Health Professions Act, 1991, S. O. 1991, c. 18, the Nursing Act, 1991, S. O. 1991, c. 32, and its regulations, and the College’s bylaws. The College collects the information for the purpose of assessing your continuing competence through its Quality Assurance Program. Appropriate measures are taken to safeguard the confidentiality of the personal information you provide, and all documents become the property of the College.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Registration Number:</th>
<th>QA Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Class</th>
<th>Current Practice Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client Population:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Learning Needs

What learning needs did I identify through Practice Reflection?

1. To complete the Documentation Standard Learning module from CNO to ensure I practice safely and competently.

2. To complete the Restraints Learning module from CNO to develop a comprehensive understanding of restraints to develop a teaching tool for clients and families within my practice setting.

Learning Goal #1

What do I want to learn?

To complete the Documentation Standard Learning module from CNO to ensure I practice safely and competently.

Which practice document does my goal relate to?

Goal #1: Activities and Timeframes

How am I going to achieve my goal?

1. By June 30, I will complete the Documentation Learning Module online.
2. I will read three (3) articles related to effective nursing documentation.
3. I will ask my manager to review my documentation of client care I provided and ask for feedback.
4. By September 30, I will ask my manager and educator to provide us with education on the importance of nursing documentation. I would like to recommend we have a legal expert come and present the legal aspects of documentation.
5. I will read the Standard from the College of Nurses of Ontario to ensure I am aware of changes to practice.

Learning Goal #2

What do I want to learn?

I will review current literature on the use of restraints in the elderly patient population and review the learning module on Restraints from CNO.

Which practice document does my goal relate to?

Goal #2: Activities and Timeframes

Goal #2 Activities and Timeframes

How am I going to achieve my goal?

1. By June 30, I will have researched two (2) articles on the use of restraints.
2. Discuss the new policy and procedure that the organization has developed at a staff meeting in September.
3. By July 15, I will complete the CNO Learning Module on Restraints.
4. Ask our educator to provide education on the use of restraints by October 30.
How do my learning goals support my commitment to continuing competency? How does my learning relate to the competencies of my practice?

I am able to keep up to date and competent on effective documentation practice and develop strategies on how to teach clients and family members the risks and benefits associated with restraints.

Evaluation of changes/outcomes to my practice - What did I learn? What impact has my Learning Plan had on my practice?

I have learned the importance through my error of ensuring I am aware of standard changes. The learning module helped me enhance my practice. I am much more confident with approaching colleagues when there is a practice issue.

References:
College of Nurses of Ontario (2009). Restraints. Toronto: Author