



Complete Summary

GUIDELINE TITLE

Use of physical restraints in the acute care setting.

BIBLIOGRAPHIC SOURCE(S)

O'Connell AM, Mion LC. Use of physical restraints in the acute care setting. In: Mezey M, Fulmer T, Abraham I, Zwicker DA, editor(s). Geriatric nursing protocols for best practice. 2nd ed. New York (NY): Springer Publishing Company, Inc.; 2003. p. 251-64. [21 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Use of physical restraints in the hospital setting. In Mezey et al. (Eds.). Geriatric nursing protocols for best practice. Springer Publishing Company: New York.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Patient injury, including disruption of therapy and falls

GUIDELINE CATEGORY

Management
Prevention
Risk Assessment
Treatment

CLINICAL SPECIALTY

Geriatrics
Nursing

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Hospitals
Nurses
Pharmacists
Physician Assistants
Physicians
Social Workers
Utilization Management

GUIDELINE OBJECTIVE(S)

- To describe the current use of physical restraint in acute care
- To describe the perceived benefits of physical restraint
- To discuss the potential harm as a direct or indirect result of physical restraint
- To identify the most common reasons nurses cite for use of physical restraint
- To provide nonrestraint strategies for dealing with common patient problems: disruption of therapy, agitation and confusion, and falls

TARGET POPULATION

Older adults in acute care settings with risk factors for physical restraint use including:

- Severe cognitive impairment and/or physical impairment
- Presence of medical devices in cognitively impaired patients
- Fall-injury risk
- Diagnosis or presence of psychiatric disorder (such as alcohol withdrawal)

INTERVENTIONS AND PRACTICES CONSIDERED

Risk Assessment/Prognosis

Identify risk factors for falls and disruption of therapy

Prevention

1. Develop a nursing care plan with alternatives to physical restraints
2. Refer to occupational and physical therapy as appropriate

Treatment/Management

1. Implement physical restraints only as needed

2. Modify the care plan to compensate for use
3. Provide caregiver/staff education regarding restraint use
4. Refer to geriatric nurse specialist/psychiatric specialist as needed

MAJOR OUTCOMES CONSIDERED

- Incidence of physical restraint use in acute care
- Rates of therapy disruption as a result of patient self termination
- Number of serious injuries related to falls
- Adverse effects/harms of physical restraints

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Medline and CINAHL were the electronic databases used.

NUMBER OF SOURCE DOCUMENTS

35

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Subjective Review

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Parameters of Assessment

- Baseline and current cognitive state, determine if new-onset delirium.
- Physical function: ability to transfer and walk (refer to the National Guideline Clearinghouse [NGC] summary of the protocol [Assessment of Function: Of Critical Importance to Acute Care of Older Adults](#))
- Therapeutic devices: alternative modes of therapy?
- Identify risk factors for falls and disruption of therapy (e.g., for fall risk, assess memory, balance, orthostatic blood pressure, vision and hearing, use of sedative-hypnotic drugs or narcotic agents).

Nursing Care Strategies

Prevention

- Develop a nursing plan tailored to the patient's presenting problem(s) and risk factors.
- Consider alternative interventions.
- Refer to occupational and physical therapy for self-care deficits or mobility impairment; use adaptive equipment as appropriate.
- Document use and effect of alternatives to restraints.

Treatment

- Use restraints only after exhausting all reasonable alternatives.
- When using restraints:

- Choose the least restrictive device.
- Reassess the patient's response every hour.
- Remove the restraint every two hours.
- Renew orders every 24 hours after evaluation by licensed independent practitioner.
- Modify the care plan to compensate for restrictions imposed by physical restraint use:
 - Change position frequently and provide skin care.
 - Provide adequate range of motion.
 - Assist with activities of daily living, such as eating and use of toilet.
- Continue to address underlying condition(s) that prompted restraint use (e.g., delirium). Refer to geriatric nurse specialist, occupational therapist, and so on, as appropriate.

Follow-up Monitoring of Condition

- Document incidence and/or prevalence of physical restraint, both house-wide and unit-specific, on an ongoing basis.
- Educate caregivers to continue assessment and prevention.
- Identify patient characteristics and care problems that continue to be refractory and involve consultants (e.g., geriatric specialists, psychiatric-liaison specialists) in devising an expanded range of alternative approaches.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Patient Benefit

Physical restraints will be used only under well-documented exceptional circumstances, after all reasonable alternatives have been tried.

Health Care Provider Benefit

Providers will use a range of interventions other than restraints in the care of patients.

Institutional Benefits

- Incidence and/or prevalence of restraint use will decrease.
- Use of chemical restraints will not increase.
- The number of serious injuries related to falls, agitated behavior, and premature disruption of medical devices will not increase.
- Referrals to occupational therapists, physical therapists, psychiatric-liaison services, and so on, will increase, as will availability of adaptive equipment.
- Staff will receive ongoing education on the prevention of restraints.

POTENTIAL HARMS

- Several studies revealed the harmful consequences that occur, either directly or indirectly, as a result of the use of physical restraints. Short-term complications include hyperthermia, new onset of bladder and bowel incontinence, new pressure ulcers, and increased rate of nosocomial infections. Severe or permanent injuries include brachial plexus nerve injuries from wrist restraints, joint contractures, and hypoxic encephalopathy. The most serious injury is death from strangulation.
- Obviously physical damage may occur from physical restraints; less appreciated are the psychosocial complications. Strumpf and Evans interviewed elderly patients discharged from the hospital and found significant psychological distress with recollections of the restraint experience up to 6 months after discharge. Approximately one-third of physically restrained medical patients exhibited psychological distress manifested as anger, agitation, or depression. Case reports of sudden death have been linked to severe psychological stress from the physical restraint.
- Additional adverse events are associated with the use of physical restraints, although these are not necessarily a direct cause of the restraint. For example, studies have shown that restrained patients are significantly more likely to die than are non-restrained patients.

Legal Concerns

Hospitals have been found liable for both the use of physical restraints and for not using restraints.

QUALIFYING STATEMENTS

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The fact that hospitalized older patients who are restrained are more severely ill and have greater mortality rates calls into question the goals of care and therapy. Clinicians need to weigh the benefits and risks not only of providing therapy, but also of administering that therapy in the context of quality care at the end of life.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003

GUIDELINE DEVELOPER(S)

Hartford Institute for Geriatric Nursing - Academic Institution

GUIDELINE DEVELOPER COMMENT

The guidelines were developed by a group of nursing experts from across the country as part of the Nurses Improving Care for Health System Elders (NICHE) project, under sponsorship of The John A. Hartford Foundation Institute for Geriatric Nursing.

SOURCE(S) OF FUNDING

Supported by a grant from The John A. Hartford Foundation.

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Authors: Anne M. O'Connell, MSN, RN; Lorraine C. Mion, PhD, RN

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

Copies of the book *Geriatric Nursing Protocols for Best Practice*, 2nd edition: Available from Springer Publishing Company, 536 Broadway, New York, NY 10012; Phone: (212) 431-4370; Fax: (212) 941-7842; Web: www.springerpub.com.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on February 2, 2004. The information was verified by the guideline developer on June 14, 2004.

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