Managing Restraints: A Refresher for CNAs

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Purpose and Objectives

The purpose of this course is to inform CNAs on how to prevent falls and how to use restraints safely.

After successful completion of this continuing education self-study CNA course, you will be able to:

1. Explain why use of restraints is controversial
2. State the reasons for using restraints

3. Describe people at risk of falling
4. Identify fall prevention measures that are tried before using restraints
5. State who is responsible for deciding to restrain a patient
6. Recognize the different types of restraints
7. Describe a CNA's responsibilities in caring for a restrained patient

Introduction

This course introduces an important topic. As a CNA, one of your goals is to keep your patients safe. Many patients injure themselves by falling. It may seem safer to keep them restrained and unable to move until you can assist them. However, studies show that in some situations restraint use can increase the patient's risk of injury.

Restraints don't always stop falls. In some instances, using restraints ***less*** may actually decrease the risk of falling. You will learn about all the pros and cons of this issue. You will also learn what your responsibility is to patients who are at risk for falling or in restraints.

Test Yourself

True or False?
The only way to prevent injuries from falls is to use restraints.

False!
Sometimes using restraints less can lower a patient's risk of falling.

Fall Statistics

Falls are a serious health risk, especially for the older patient. You must realize how common and serious falls truly are to your patients. The statistics related to falls are astounding!

- Among older adults, falls are the leading cause of death due to injury (National Council on Aging [NCOA], 2017).
- Falls are also the most common reason for non-fatal hospital admissions for older adults (NCOA, 2017)
- One in four people over the age 65 fall each year (Centers for Disease Control and Prevention [CDC], 2017).
- Every year, approximately 2.8 million elderly patients are treated for falls in the emergency department (CDC, 2017)
- It is estimated that an older adult is treated for a fall in the emergency room every 11 seconds, and an elderly person dies from a fall every 14 minutes (NCOA, 2017)
- One out of every five falls causes a serious injury, including broken bones and head injury (CDC, 2017)
- Falls are the third most common cause of traumatic brain injury in the United States (CDC, 2017).
- Over 95% of hip fractures are caused by falling (CDC, 2017)

Fall Prevention for Patient Safety

The prevention of falls standard focuses on important patient, nursing, and organizational activities that are essential to providing safe, high quality care.

In 2008, the Center for Medicare & Medicaid Services (CMS) implemented a policy that denies Medicare payment for treatment of specific hospital-acquired conditions (HACs). Patient death or serious disability associated with a fall while being cared for in a healthcare facility has been identified as a HAC (CMS, 2016; Sherrod et al., 2012).

The Role of the CNA in Fall Prevention

In the United States, unintentional falls are the most common cause of nonfatal injuries for people older than 65 years (NCOA, 2017). Fall-related injuries are the most common cause of accidental death in those over the age of 65 (NCOA, 2017).

Falls are a growing public health problem that needs to be addressed. Falls and related injuries have been associated with the quality of nursing care in the acute care setting. They are included as a nursing-quality indicator.

The definition of a fall is "***An unplanned descent to the floor with or without injury.***" (Nursing Improving Care for Healthsystem Elders, n.d.).

The CNA plays a very important role in preventing falls. Studies have shown that elderly patients are most likely to fall when trying to obtain a personal item or perform self-care. The CNA can prevent falls by promptly meeting the basic needs of patients. When basic needs are met regularly and frequently, patients will be less inclined to try to reach something themselves and risk falling.

Since falls are considered preventable, fatal fall-related injuries should never occur while a patient is under hospital care.

Fall Prevention

There are four basic steps you can take to prevent patient falls:

1. Discuss your patient's risk for falling with the Registered Nurse (RN) with whom you are working. RNs will complete a fall risk assessment on a patient who is at risk for falls.
2. Communicate this risk to your colleagues.
3. Check on high risk patients frequently.
4. Improve the safety of the patient’s environment.

All information and recommendations in this course are intended for use as guidelines only.

What Puts a Person at Risk of Falling?

Certain factors increase the likeliness of a fall. Some falls are related to genetics, aging, disease, medication or environmental hazards.

Here is a list of factors that may increase the risk of falls:

- Advanced age
- History of falling
- Lower body weakness
- Balance or gait problems
- Visual problems including wearing glasses
- Chronic conditions, such as arthritis, stroke, diabetes, Parkinson's disease, dementia
-
- Fear of falling

(CDC, n.d.)

Additional Risk Factors

Additional risk factors for falls may include:

- Neuromuscular disease
- Urinary or stool incontinence
- Postural hypotension (blood pressure that falls upon standing up)
- Cognitive impairment (difficulty thinking)
- Certain kinds of medications and taking more than four medications at one time
- Wearing shoes with thick soft soles
- Poor lighting
- Slick or irregular floor surfaces
- Beds or chairs that are too low or too high
- Unsafe stairways
- Bathroom fixtures that are too low, too high, or do not have arm supports
- Excessive clutter, tripping hazards, obstacles
- Unlocked wheelchairs
- Lack of safety equipment for holding or moving

(CDC, n.d.)

Test Yourself

True or False?

The risk of falling increases with chronic disease and taking more than four medications.

True!
These risk factors are common in the older population.

Alternatives to Restraints

Alternatives to restraints must be tried and deemed ineffective (by the RN and provider) before restraints can be used. You will see many strategies to avoid restraints. Some of these are:

- Reducing aggressive behavior by helping patients to talk out their frustrations
- Giving patients choices about their care
- Trying to find an acceptable alternative to intravenous lines (IVs), feeding tubes, and other devices
- Explaining why certain aspects of care are necessary
- Asking families and volunteers to comfort and watch patients
- Protecting devices from being tampered with
- Distracting patients from thinking about tubes and devices
- De-cluttering the patient environment, and removing safety hazards such as spills and wires
- Taking care of patient needs promptly, such as toileting, repositioning, and ensuring personal possessions are within reach during patient rounding
- Maintain routines, such as at bedtime, including toileting
- Provide items such as clocks and night-lights to help keep them oriented

(Registered Nurses' Association of Ontario [RNAO], 2012; Springer, 2015)

Initiation of Restraints

Restraints may only be used to uphold the safety of patients or others. Restraints are typically initiated for several reasons:

- To prevent falls
- To manage aggressive behavior
- To maintain medical therapy
- To give emergency treatment to out-of-control patients
- Some patients need to be stopped from pulling out an IV, feeding tube or urinary catheter
- Some patients who are intoxicated or psychotic may not be capable of cooperation

Test Yourself

True or False?

Asking families to spend time with patients is an acceptable alternative to protecting patients with restraints.

True!

Families can often calm and distract patients from interfering with their IVs and equipment.

Orders for Restraints

Restraints cannot be applied unless there is a written order for restraints. Patients are evaluated on an individual basis. Doctors and nurses rate them on how likely they are to fall. They figure out how best to prevent this from happening. Nurses use a variety of tools to measure the patient's strength,

balance and ability to move. When they identify a patient at high risk of falling, they take specific measures to protect the patient.

In an emergency, an RN may begin restraints and get a provider's order for it as soon as possible. Orders for restraints are renewed every 24 hours after evaluation by the provider. All patients with restraints require documentation at least every two hours, and require continuous monitoring. The patient's family is kept informed of any changes.
(CMS, 2015).

Test Yourself

True or False?
An RN may apply restraints in an emergency even before having a doctor's order.

True!
A nurse may do this to protect a patient and get a temporary order for it as soon as possible.

Types of Restraints

A physical restraint is anything that physically restricts a patient's freedom of movement, physical activity or normal access to his or her body. It can be human, mechanical, or a combination of both.

Examples of physical restraints are:

- Wrist, waist and leg restraints
- Jacket vest
- Hand mitts
- Lap buddies, belts, geriatric chairs or trays (if they are used to restrict a patient's movement)
- Protective or therapeutic holds
- Comfort or safety blankets (if they are used to restrict a patient's movement)
- Side rails (if they are used to restrict a patient's movement)
- Enclosure beds

(CMS, 2015; Rose, 2015)

Types of Restraints

A chemical restraint is a sedating drug to manage or control behavior. Medications used as restraints are used in addition to, or in replacement of, the patient's regular medication regimen. Chemical restraints are used only in severe emergencies. When caring for a patient who is receiving a chemical restraint, be sure to monitor the patient every 15 minutes during this time to ensure the patient's safety.

Seclusion is involuntary confinement of an individual in a locked room. Seclusion is physically less restrictive than physical restraints because the patient has the ability to move around. It is most often used in behavioral healthcare settings. Its main goal is to keep the patient away from others.

Therapeutic holds prevent individuals from self-injury or injuring others. The method may be a device

such as soft wrist restraint or it may be a human body. Medical devices, dressings, bandages, arm boards, or holding the patient during a procedure are not considered restraints.
(CMS, 2015; Rose, 2015)

Test Yourself

True or False?

Putting patients alone in a locked room may be necessary for those with suicidal thoughts.

False!

Seclusion may be necessary for patients showing behavior that may harm others.

Physical Restraints: What Are the Risks?

There are many physical risks associated with the use of physical restraint on older people, including:

- Bruises
- Bedsores (decubitus ulcers)
- Breathing complications
- Urinary incontinence and constipation
- Deterioration of muscle strength and balance
- Increased agitation
- Poor nutrition
- Decreased cardiovascular endurance
- Increased dependence in activities of daily living
- Increased risk for injury if resisting the restraints

These risks are not always caused directly by the physical restraint itself, more commonly, the risk is to the older person's physical and mental condition. An older person with reduced physical and/or mental capacity will be more prone than a healthy person to exhibit harmful effects resulting from physical restraint.

Studies have shown that restraints can sometimes increase the risk of injury in the elderly, especially when the patient is confused or aggressive. The discomfort and anxiety caused by the restraints can worsen the patient's aggression.
(RNAO, 2012; Springer, 2015)

Restraints must be used sparingly, and only with an order for a limited time period.

Physical Restraints: Psychosocial Concerns

In some elderly patients, the use of physical restraints such as bedside rails and wheelchair bars are perceived positively, when the patient feels that the restraint is there for protection rather than punishment. Some elderly patients feel safer and more stable with these restraints. Dependence is not always experienced as something negative by older people. Many of them greatly appreciate the assistance being offered.

In general, however, physical restraint is not experienced as something positive. For many older people, the use of physical restraints is more traumatic than therapeutic. The use of physical restraints can cause psychological effects, including feelings of shame, loss of dignity and self-respect, loss of identity, anxiety, aggression and social isolation. Some elderly patients also worry about the possibility of injury in their attempts to escape from physical restraint.
(RNAO, 2012; Springer, 2015)

Physical Restraints: From the CNA's Perspective

Although physical restraints make care-giving easier, they are sometimes used for the wrong reasons. This can occur when a CNA or other healthcare team member uses restraints to:

- Provide structure and order to the care giving process. This can lead to a situation where the use of restraint becomes routine to meets caregivers' need for a fixed structure than older persons' therapeutic needs.
- Gain control over patients. Using restraints unnecessarily and talking down to the elderly, or using child-like language with elderly patients can make the elderly patient feel humiliated and disgraced.
- Escape legal proceedings.

(CMS, 2015; RNAO, 2012)

Restraints and Ethical Considerations

Ethics is about weighing up our moral values and norms that serve as guidelines for our clinical actions. When using restraints, it is important to remember the following ethical considerations, upholding patient rights:

- **Respect for the dignity of patients**

  Every patient should be treated with human dignity, respect and compassion.

- **Respect for autonomy**

  The ability of human beings to make choices must always be respected. The application of physical restraint to mentally competent older persons without their consent should be avoided whenever possible.

- **Promoting overall wellbeing**

  Caring for a patient is more than providing physical safety. Caregivers need to meet the emotional and psychosocial needs of patients as well. When considering the use of restraints, the social (possibility for contact), psychological (experience of themselves and their relatives), and moral (respect for autonomy, informed consent) dimensions of the patient’s wellbeing must be considered as well.

(CMS, 2015; RNAO, 2012)

Care that Reduces Risk of Falls

Standard fall prevention is used for low-risk patients. This is how you can prevent falls in this group:

- Check your patient's coordination and balance before getting the patient out of bed or transferring the patient to a chair
- Get patients up slowly, allowing them to sit for a few moments before standing
- Offer a bedpan, urinal, or assistance to bathroom before meal time, bedtime, and upon awakening
- Approach your stroke patient towards unaffected side and transfer your patient towards their stronger side – (maximizes patient participation in care)
- Obtain patient assistive device (cane, walker, or wheelchair) if patient used them prior to

hospitalization

- Describe fall prevention planning to your patient and their family
- Lock all wheelchairs, beds, and stretchers
- Advise appropriate footwear, including treaded socks

(AHRQ, 2013; Health Research & Educational Trust, 2016; RNAO, 2012)

Additional Measures to Reduce the Risk of Falls

Additional interventions you can perform to reduce the risk of falls include:

- Placing your patient's call bell and personal items within reach
- Ensuring that your patient has a physically safe environment (eliminate spills, clutter, electrical cords, and unnecessary equipment)
- Ensuring that the lighting is adequate
- Following the physical therapist's plan for exercising your patient
- Encouraging your patient to wear their glasses and hearing aids
- Reporting complaints and nonverbal signs of pain
- Orienting your patient to surroundings and environment as often as needed

(AHRQ, 2013; Health Research & Educational Trust, 2016; RNAO, 2012)

You must use high-risk precautions for high-risk patients and those that have previously fallen (VA National Center for Patient Safety, 2017). This usually means that you will be caring for patients in restraints. It could also involve use of special equipment such as special flooring, surveillance devices or alarms.

Test Yourself

True or False?
Getting patients out of bed carefully and slowly is a key time for fall prevention.

True!
Some patients may collapse or feel dizzy upon standing up.

Monitoring of Restraints

The patient's provider will do an evaluation within hours after restraints are first applied. Daily medical re-evaluations will follow.

Nurses monitor patients who are restrained for behavioral management every fifteen minutes. They look for signs of restraint-related injuries, check circulation, and do range of motion. They take vital signs, attend to hygiene and elimination needs, give physical and psychological comfort, and evaluate readiness for discontinuing restraints.

Nurses monitor patients restrained for medical reasons at least every two hours. This is to safeguard against physical or emotional distress. The nurse checks to make sure the restraint is correctly applied. It protects the patient's rights and dignity. During this check, the nurse may think of a less

restrictive way to protect the patient.

Sometimes there is a change in the patient's behavior or physical status. This may warrant the removal of the restraint.
(CMS, 2015; RNAO, 2012)

Care of Patients in Restraints

As a CNA, you may be assigned a patient in restraints. Patients in restraints require ongoing monitoring, and you will check on this patient based on the type of restraint used and per your organization's policy.

Look for signs of restraint injury such as bruises, welts or skin tears. Remove and reapply restraints in order to do range-of-motion exercises with the restrained body part. This is a time to take care of toileting, check skin, and check to make sure the bed is dry. Report any changes in your patient's condition, including the response to being in restraints.

Putting on restraints correctly is crucial. Incorrect use of restraints can cause serious harm to your patient. Staff must be trained and show competency for application of restraints, implementation of seclusion, monitoring, assessing, and providing care for a patient with restraints or seclusion. If you don't know or remember how to put on a particular restraint, ask the supervising nurse to show you.

Never put a restraint on an arm with an arterial line, a burn, a fracture, or on a restricted extremity. Never tie a restraint to something that can be moved.
(CMS, 2015; Rose, 2015)

Test Yourself

True or False?

Patients in restraints are safe from injuries and therefore require less frequent monitoring.

False!
Restraints can cause injuries and distress due to restriction. These patients need to be checked on at least every two hours.

Documenting Falls

Despite our best efforts, sometimes a patient still falls.

In these cases, this is what you need to do:

- Immediately following a fall, signal for help. Your patient may need CPR or some other type of emergency response
- DO NOT MOVE THE PATIENT on your own.
- Even if the patient does not appear to have any traumatic injury, the incident must be documented. Where, when and how you found the patient should be recorded.
- Also, document anything the patient says about the fall, using the patient's words in quotes.
- Record anything you did in response to the fall or injury.
- Watch for and report any changes in the patient in the hours after the incident
- Follow your organization's guidelines for documentation of any fall.

(AHRQ, 2013; VA National Center for Patient Safety, 2017)

Test Yourself

True or False?
When you find a patient who has fallen, your first action is to move the patient off the floor.

False!

Never move the patient on your own.
Signal for help.

Conclusion

Ensuring patients are safe is a large responsibility of your job.

How best to do this is different for each patient. Noticing and reporting changes in patients is crucial to keeping up with their needs.

Also, you have the best opportunity to maintaining patient safety by attending to their environments and using restraints correctly.

Test Yourself

True or False?
Using restraints properly is the only way to keep your patients safe.

False!
Two other ways to promote safety are noticing and reporting changes in patients and keeping the environment free from hazards.

Resources

Here are a few resources you can use to learn more about falls and fall prevention:

- Centers for Disease Control and Prevention. Injury Prevention and Control: Older Adult Falls. http://www.cdc.gov/HomeandRecreationalSafety/Falls/index.html

- Institute for Healthcare Improvement. Falls Preventions. http://www.ihi.org/Topics/Falls/Pages/default.aspx

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