Actionable Patient Safety Solutions™ (APSS™):

Restraint Safety

How to use this guide

This APSS provides evidence-based actions and resources for restraint safety for executives, leaders, clinicians, and performance improvement specialists. This document is intended to be used as a guide for healthcare organizations to examine their own workflows, identify practice gaps, and implement improvements. In it, you'll find:

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Executive Summary

The Problem

The use of restraints can increase the likelihood of physical and psychological harm to both patients and healthcare workers as well as fatalities, therefore; it is crucial to establish a universal protocol to protect patient rights and ensure safety for all (Ye et al., 2017). Looking at a sample of child and adolescent psychiatric inpatients (N=2,411), 29% experienced restraint or seclusion, with higher frequency for children (53%) than adolescents (19%) (Pogge, et al, 2013). While national data tracking is limited in this area, other studies have suggested that upwards of 37% of patients experience restraint (Leidy, et al, 2006). Increased transparency, reliability and consistency of seclusion and restraint data across the nation is imperative to promote awareness, benchmarking ability, and quality improvement initiatives. Due to limited national data and standards, organizations have varying restraint policies and procedures which can result in inconsistent and unsafe clinical care & practices.

The Cost

A 91% reduction in restraint use has been shown to mirror a 92% reduction in cost associated (LeBel & Goldstein, 2005), due to the 23% share of staff time claimed directly by restraint use alone (Goldstein, 2005). Overall, restraint use is estimated to claim an average of 23% of nursing time and $1.4 million in staff costs, which equates to 40% of the inpatient operating budget (LeBel & Goldstein, 2005).

By reducing reliance on restraint use, organizations can save time, money, resources, and lives without compromising quality of care.

- University of Massachusetts reduced their mechanical restraint use by 98% and saw an 86% decrease in the amount of sick time used by staff members (Commonwealth of Massachusetts, 2020).
- Florida State Hospital reduced restraint use by 54% and saved nearly $2.9 million from reduced workers' compensation, staff and consumer injuries, and length-of-stay costs (SAMHSA, 2010).
- The Massachusetts statewide child/adolescent seclusion and restraint prevention initiative reduced seclusion and restraint use by 89%, avoiding 34,037 restraints and saving an average of $1.33 million per year (SAMHSA, 2010).

The Solution

Many healthcare organizations have successfully implemented and sustained improvements while reducing death from restraint misuse. This includes the following actionable steps:

- Standardize the organization's restraint policy in accordance with state and federal regulations and make it easily accessible to everyone who provides care
- Allocate appropriate staffing and education resources for de-escalation and crisis prevention trainings
- Engage the frontline in restraint safety improvement activities
- Sustain safety initiatives through ongoing review and follow up of all incidents of restraint
- Avoid restraint use altogether by implementing safety alternatives earlier.

This document provides a blueprint that outlines the actionable steps organizations should take to successfully improve restraint safety and summarizes the available evidence-based practice protocols. This document is revised annually and is always available free of charge on our website. Hospitals who make a formal commitment to improve restraint safety and share their successes on the PSMF's Shared Learning Network have access to an additional level of consulting services.

Leadership Checklist

On a monthly basis, or more frequently if a problem exists, the executive team should review all restraint use trends. Use this checklist as a guide to determine whether current evidence-based guidelines are being followed in your organization:

Implement measures to prevent restraint use through early intervention.

- ☐ Hire those with mental health experience in the emergency room and inpatient units.
- ☐ Develop an assessment system to identify signs that may be indicative of escalating behavior, and ensure documentation and communication to all members of the care team.
- ☐ Involve those with a mental health background in preventative rounding on at-risk patients.
- ☐ Include relationship building with the patient in the job description for all patient-facing employees. Educate all patient-facing employees, including security personnel, on therapeutic relationships for safety.
- ☐ Incorporate post-restraint use debriefs for staff members to consider the patient's escalation and their responses retrospectively. Take this time to focus on a positive intervention that was successful or specific staff who were successful in their approach.
- ☐ Stock emergency departments and units with items that may assist in de-escalation, including but not limited to: snacks, drinks, music options, sensory items, books/magazines, journals, coloring options, playdoh, stress balls, etc.
- ☐ Implement Trauma-Informed Care education to leaders & staff (Azeem, et al, 2011; AAP, 2021).

Allocate appropriate resources.

- ☐ Ensure there are enough staff to effectively manage necessary preventive care.
- ☐ Align de-escalation and restraint training with workplace safety training.
- ☐ Include de-escalation procedures, trauma informed care, and crisis prevention in initial and ongoing education.
- ☐ Ensure staff sitter availability.

Engage the frontline in restraint safety improvement.

- ☐ Ensure frontline involvement in restraint safety improvement activities. Maintain their engagement and remove barriers to progress.
- ☐ Align all policies, protocols, workflows, and patient education material for consistency. Make sure the restraint use policy is readily accessible to all.
- ☐ Ensure that restraint protocols are embedded into clinical workflows, whether electronic or paper.
- ☐ Debrief on a regular basis to solicit team feedback about barriers to sustained compliance. Adjust the plan as often as needed.

- [ ] Set a standard of accountability to ensure consistency in all approaches.

Sustain restraint safety initiatives.

- [ ] Use restraints only when it can be clinically justified by patient behavior that imminently threatens the physical safety of the patient, staff, or others.
- [ ] Initiate restraints based on an individual order.
- [ ] Continuously monitor patients who are restrained.
- [ ] Discontinue restraints at the earliest possible time.
- [ ] Develop and maintain written policies and procedures that guide the use of restraint.
- [ ] Evaluate and re-evaluate the patient who is restrained.
- [ ] Document the use of restraint.
- [ ] Train staff to safely implement the use of restraints.
- [ ] Hold staff accountable for providing the standard of care and reward success.
- [ ] Involve Patient and Family Member Advisory Councils in review of restraint incidents.
- [ ] Examine restraint utilization data to review trends and inform practice.
- [ ] Ensure that leaders have a simple process to oversee restraint use and quality improvement initiatives.

Clinical Workflow

STEP	NON-VIOLENT NON-SELF-DESTRUCTIVE RESTRAINTS:	VIOLENT SELF-DESTRUCTIVE RESTRAINTS:

PREVENTION STRATEGIES

Organizations should strive to be a restraint-free environment based on the concept that restraint always imposes some risk of injury to patients and staff. When restraint must be used, attention will be given to the patient's right to considerate, trauma-informed, respectful care at all times with recognition of their personal safety, dignity and well-being. The use of restraints poses an inherent risk to the physical safety and psychological well-being of the individual served and staff. Nonphysical, less-restrictive interventions should be utilized to prevent emergency situations from occurring and prior to resorting to restraints. Restraints have the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of rights, and even death, therefore, organizations should be committed to preventing and reducing the utilization of restraints.

- Assess and document individual triggers, warning signs, calming techniques, and a coping plan.
  - Share information with multidisciplinary staff who will be interacting with patient
- Complete full medication reconciliation as soon as possible
- Utilize an empathetic and trauma-informed approach in all interactions. This would include
  - Recognize behavioral concerns may be a symptom of trauma
  - Maintain a nonjudgmental attitude. Reframe mindset to consider "What has happened to this patient?" instead of "What is wrong with this patient?"
- Establish a therapeutic relationship to foster trust
  - Utilize supportive verbal statements that offer hope and support rather than judgment
- Alter the physical environment to promote healing & relaxation
- Ensure all basic needs are met, including:
  - Hunger
  - Thirst
  - Sleep
  - Physical safety
- Resist re-traumatization by:
  - Introducing self upon entering the room
  - Asking before touching
  - Explaining procedures prior to performing

PREVENTION STRATEGIES CONT.

- o Offering choices as much as possible to promote personal empowerment
- o Engaging the patient and family in care decisions
- o Allowing positive support systems to be present with patient
- o Avoid power struggles
- o Utilize strengths-based, positive reinforcement strategies, and avoid punitive consequences

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LESS-RESTRICTIVE ALTERNATIVES

- Determine whether justifications for nonviolent/ medical restraint use are present (UTMB, n.d.). These would include
  - o Pulling at lines or tubes
  - o Trying to remove equipment or wound dressing.
- Collaborate with multidisciplinary team to assess feasibility of alternatives to restraint use & develop a plan of care. Examples may include:
  - o Bed/Chair Alarm
  - o Assist with transfers/ ambulation
  - o Bladder/bowel program
  - o Cover tubes/lines/dressings
  - o Lower bed/fall matts
  - o Active Listening
  - o Verbal de-escalation
  - o Distraction techniques
  - o Promotion of coping skills
  - o Environmental adaptations
  - o Family engagement in patient's care
  - o 1:1 patient engagement
  - o Relaxation techniques
  - o Communication adaptations
  - o Assess and address any

- Determine whether justifications for violent/ behavioral restraint use are present (UTMB, n.d.). These would include
  - o Harm to self
  - o Harm to others
- Collaborate with multidisciplinary team to assess feasibility of alternatives to restraint use & develop a plan of care. Examples may include:
  - o Active Listening
  - o Verbal de-escalation
  - o Distraction techniques
  - o Promotion of coping skills
  - o Environmental adaptations
  - o Family engagement in patient's care
  - o 1:1 patient engagement
  - o Relaxation techniques
  - o Communication adaptations
  - o Assess and address any hunger, pain, or discomfort
  - o Video monitoring
  - o Medication administration

LESS-RESTRICTIVE ALTERNATIVES CONT.

  - hunger, pain, or discomfort
  - Medication administration
  - Video monitoring

INITIATE RESTRAINTS

- Evaluate the patient before, during and immediately after initiating the restraint.
- A physician or other authorized licensed practitioner responsible for the patient's care orders the use of restraint in accordance with hospital policy
- A nurse can apply restraints in an emergency without a provider order but an order must be obtained immediately after.
- Do not use as needed (PRN) restraint orders.
- Restraints should be implemented using safe techniques identified by the hospitals policies and procedures in accordance with laws and regulations
- Explain the need for restraints to the patient and family members, as well as criteria for discontinuation.
- Apply restraints in a way that minimizes discomfort or likelihood for injury.
  - Avoid any techniques that place the patient in a prone position, obstructs the airway or that may impair breathing, that obstructs vision, or that restricts the individual's ability to communicate

RE-EVALUATION

- The order is time-limited for 24 hours, however restraints should always be discontinued at the earliest possible time.
- A registered nurse will perform and document an assessment at a minimum of every two hours, which includes:
  - Patient's response for discontinuation criteria
  - Psychological status
  - Circulation
  - Respirations stable
  - Signs of injury
  - Range of motion
  - Fluids
  - Nutrition
  - Elimination
- The need for restraints should
- Orders are time-limited, based on age, however restraints should always be discontinued at the earliest possible time (CMS, 2000).
  - Up to 4 hours for patients ages 18 and older
  - Up to 2 hours for children ages 9 to 17
  - Up to 1 hour for children 8 and under.
- Re-evaluate prior to re-ordering VSD Restraints
- Conduct a face-to-face evaluation at least one hour after the initiation of VSD Restraints
- Provide continuous observation for a patient in VSD restraints (e.g., sitter at the bedside)

RE-EVALUATION CONT.

be re-evaluated at least once per shift, and prior to re-ordering restraints

documented at a minimum of every 15 minutes. If any signs of distress are observed, the RN or Provider should be immediately alerted.

- Patient's response for discontinuation criteria
  - Psychological status
  - Circulation
  - Respirations stable
  - Signs of injury
  - Range of motion
  - Fluids
  - Nutrition
  - Elimination
- A Registered Nurse will perform and document an assessment at a minimum of every 1 hour, including: readiness for discontinuation, observation of psychological status, safe positioning, circulation, respirations, signs of injury, hygiene/elimination, nutrition/hydration, and vital signs

DISCONTINUATION

1. Discontinuation of restraint is to occur at the earliest possible time, regardless of the time-limited order length. If a patient appears to meet criteria for release, the registered nurse or provider should be immediately notified. A registered nurse or provider may make the determination based on their clinical assessment to discontinue the use of restraint.
2. If the restraint is discontinued and the patient requires this intervention again, a new order must be obtained.
3. The rationale for release from restraint will be documented by the registered nurse.
4. Upon discontinuation of restraints, RN should obtain vital signs at earliest possible time.

POST-RESTRAINTS

- Debriefing with the care team, family, and patient, if applicable, should take place as soon as possible to revise the plan of care and discuss strategies for preventing the use of restraints moving forward.

- Perform Debriefing after the restraint episode as soon as possible, but no greater than 24 hours after the episode
  - o Once with staff members involved to review what went well, what didn't go well, how to prevent moving forward.
  - o With the patient to hear from their perspective of what led up to the event and how it can be avoided moving forward.
- The goals of debriefing:
  - o Assist the patient to identify the precipitant of the incident and suggest/teach methods of more safely and constructively responding to the incident.
  - o Assist the staff to understand the precipitants to the incident, and to develop alternative methods of helping the patient avoid or cope with those incidents.
  - o Help treatment team staff devise treatment interventions to address the root cause of the incident and its consequences, and to modify the treatment plan.
  - o Help assess whether the intervention was necessary and whether it was implemented in a manner consistent with staff training and facility policies.
  - o Minimize the negative effects of the incident on all involved individuals.

Performance Improvement Plan

Follow this checklist if the leadership team has determined that a performance improvement project is necessary:

- [ ] **Gather the right project team.** Be sure to involve the right people on the team. You'll want two teams: an oversight team that is broad in scope, has 10-15 members, and includes the executive sponsor to validate outcomes, remove barriers, and facilitate spread. The actual project team consists of 5-7 representatives who are most impacted by the process. Whether a discipline should be on the advisory team or the project team depends upon the needs of the organization. Patients and family members should be involved in all improvement projects, as there are many ways they can contribute to safer care.

Complete this Lean Improvement Activity:
Conduct a SIPOC analysis to understand the current state and scope of the problem. A SIPOC is a lean improvement tool that helps leaders to carefully consider everyone who may be touched by a process, and therefore, should have input on future process design.

RECOMMENDED RESTRAINT SAFETY IMPROVEMENT TEAM	
• Hospital Leadership • Quality and safety specialists • Physicians • Psychologists/psychiatrists • Social workers • Psychiatric Social Workers • Case managers • Rapid Response Team members	• Security team members • Frontline nurses & unlicensed patient care team members • Psychiatric nurses • Clinical Education • Risk Management • Workplace Safety Members

Table 1: Understanding the necessary disciplines for a restraint safety improvement team

- [ ] **Understand what is currently happening and why.** Reviewing objective data and trends is a good place to start to understand the current state, and teams should spend a good amount of time analyzing data (and validating the sources), but the most important action here is to go to the point of care and observe. Even if team members work in the area daily, examining existing processes from every angle is generally an eye-opening experience. The team should ask questions of the frontline during the observations that allow them to understand each step in the process and identify the people, supplies, or other resources needed to improve patient outcomes.

Create a process map once the workflows are well understood that illustrates each step and the best practice gaps the team has identified (IHI, 2015). Brainstorm with the advisory team to understand why the gaps exist, using whichever root cause analysis tool your organization is accustomed to (IHI, 2019). Review the map with the advisory team and invite the frontline to validate accuracy.

RESTRAINT SAFETY PROCESSES TO CONSIDER ASSESSING

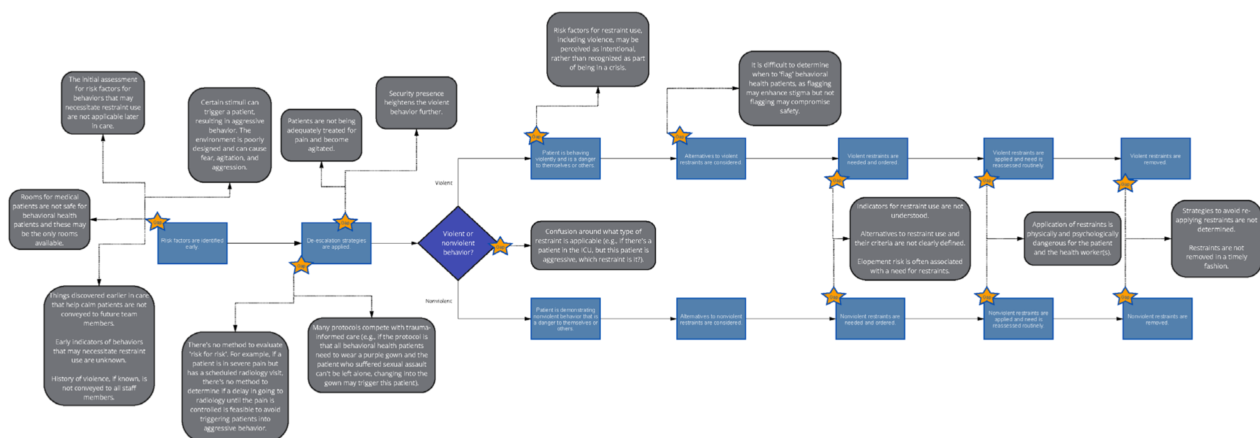
- Environmental triggers
- Medication evaluation
- Mental health resources and interventions
- Assessment of physical and emotional needs
- De-escalation strategies
- Communication amongst care teams
- Evaluation of alternative options
- Documentation and justification
- Content of hospital policies including:
  - ☐ Definition of what is considered a restraint.
    - ☐ Definition of what constitutes the use of medications as chemical restraints.
  - ☐ Under what circumstances restraints are and are not appropriate.
  - ☐ Who has authority to apply restraints and what responsibilities these individuals have when restraints are ordered.
  - ☐ Initial and ongoing education for patient-facing staff (including trauma-informed care, crisis prevention, de-escalation, safe application of restraints, restraint policies, emergency response, etc.)
  - ☐ Guidance for regular restraint reporting, auditing and quality improvement initiatives

Table 2: Consider assessing these processes to understand where the barriers contributing to poor restraint safety may be in your organization

☐ **Prioritize the gaps to be addressed and develop an action plan.** Consider the cost effectiveness, time, potential outcomes, and realistic possibilities of each gap identified. Determine which are priorities of focus for the organization. Be sure that the advisory team supports moving forward with the project plan so they can continue to remove barriers. Design an experiment to be trialed in one small area for a short period of time and create an action plan for implementation.

The action plan should include the following:

- Assess the ability of the culture to change and adopt appropriate strategies
- Revise policies and procedures
- Redesign forms and electronic record pages
- Clarify patient and family education sources and content
- Create a plan for changing documentation forms and systems
- Develop the communication plan
- Design the education plan
- Clarify how and when people will be held accountable



Example process map with gaps. Click here to expand.

- [ ] **Evaluate outcomes, celebrate wins, and adjust the plan when necessary.** Measure both process and outcome metrics. Outcome metrics include the rates outlined in the leadership checklist. Process metrics will depend upon the workflow you are trying to improve and are generally expressed in terms of compliance with workflow changes. Compare your outcomes against other related metrics your organization is tracking.

  Routinely review all metrics and trends with both the advisory and project teams and discuss what is going well and what is not. Identify barriers to completion of action plans, and adjust the plan if necessary. Once you have the desired outcomes in the trial area, consider spreading to other areas (IHI, 2006).

  It is important to be move quickly to keep team momentum going, and so that people can see the results of their labor. At the same time, don't move so quickly that you don't consider the larger, organizational ramifications of a change in your plan. Be sure to have a good understanding of the other improvement projects that are taking place so that your efforts are not duplicated or inefficient.

Read this paper from the Institute for Healthcare Improvement to understand how small local steps

CLABSI METRICS TO CONSIDER ASSESSING

- Appropriate documentation of restraints to ensure accurate data
- Restraint Utilization Rate
  - Inpatient Units: Rate is calculated by 1,000 patient days
  - Emergency Department: Rate is calculated by 1,000 ED visits
- Average length of time in restraints
- Patient injuries related to restraints
- Staff injuries related to restraints
- Code Gray/BERT calls (agitated patient)
- Medication administration prior to and/or during restraint initiation
- Patient and family member debriefing
- Staff and care team debriefing
- Trends in restraint use (e.g., patient demographic, time of day, day of week, ordering provider, etc)
- Completion of any applicable education, such as safe restraint application training, and crisis prevention/de-escalation training

Table 3: Consider evaluating related metrics to better understand restraint safety and contributing factors

What We Know About Restraint Safety

A restraint is defined as "Any method, physical or mechanism device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely" (CMS, 2008).

Restraint use comes with associated risks, therefore regulatory agencies, such as the Joint Commission and Centers for Medicare and Medicaid Services (CMS), have specified guidelines for use. The Joint Commission requires that a licensed practitioner order restraint or seclusion

when ordered for behavioral health or violence-related reasons and after an in-person evaluation of the patient (The Joint Commission, 2020). CMS has made it clear in the restraint and seclusion guidelines that "Restraint or seclusion may be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time" (CMS, 2008). As such, it is outlined that all patients have the right to be free from physical and mental abuse and from restraint or seclusion as a form of discipline or convenience (CMS, 2008).

Clinical and Financial Implications

Although difficult to calculate directly, estimates of time, resources, and staff supervision for each restraint episode approximate the cost of one episode to be between $302 and $354, depending upon the methods employed, whether physical, mechanical, or pharmaceutical (LeBel & Goldstein, 2005).

Other benefits of reducing restraint and seclusion in organizations include:

- Decrease in staff injuries (LeBel & Goldstein, 2005)
- Decrease in patient injuries(LeBel & Goldstein, 2005)
- Reduced use of staff sick time (LeBel & Goldstein, 2005)
- Increased staff satisfaction & decreased retention (Fallot & Harris, 2009) (Bosc-Ruggiero, 2010)
- Less medication use (Bloom, 2005)
- Shorter length of stay (LeBel & Goldstein, 2005)
- Decreased hospital readmission (SAMHSA, 2011)
- Higher functioning at discharge (SAMHSA, 2011)
- Less severe injuries upon falling (Tan et al., 2005)

Alternatives to Restraint Use

Restraints should not be used unless alternative methods have already been trialed and deemed insufficient. Alternative methods to restraint use include (UPMC, 2020):

- General Alternatives:
  - Active Listening
  - Verbal de-escalation
  - Distraction techniques
  - Promotion of coping skills
  - Environmental adaptations
  - Family engagement in patient's care
  - 1:1 patient engagement
  - Relaxation techniques
  - Communication adaptations
  - Assess and address any hunger, pain, or discomfort
  - Video monitoring
  - Medication administration
  - Implementing reminder devices, such as television and clocks
  - Speaking to the patient in a calm and reassuring manner to assess their comfort level

- o Addressing any needs the patient might have to improve their comfort level
- o Bringing in a professional for psychological consultation
- o Encouraging family involvement and conversation with the patient
- o Moving the room closer to the nurse's station
- o Decreasing distraction and stimuli in the environment

- Alternatives for NVNSD Restraints:
  - o Bed/Chair Alarm
  - o Assist with transfers/ambulation
  - o Bladder/bowel program
  - o Cover tubes/lines/dressings
  - o Lower bed/fall matts

Important Clinical Considerations

- Restraints are not considered a viable option for fall prevention and it has actually been shown that patients who experience a fall with restraints sustain more severe injuries (NIH, 2001).
- A request from a family member or loved one is not sufficient to prompt restraint application, but it might prompt an evaluation of the patient.
- If the patient can easily remove the device, it is not considered a restraint. "Easily remove" is defined as the device "can be removed intentionally by the patient in the same manner as it was applied by the staff (e.g. side rails are put down, not climbed over)" (CMS, 2008).
- Hospitals must report deaths to CMS that are associated with restraints when the patient is in restraints upon death, if the patient dies 24 hours after restraint removal, and if the patient dies within one week after restraint use when the restraints are suspected to have contributed directly to the patient's death (CMS, 2008).
- The use of restraints should not hinder the delivery of other healthcare services and interventions.

Education for Patients and Family Members

Patients and family members should be as engaged as possible, particularly to prevent restraint use. Patients and family members should:

- Share preferences for de-escalation.
- Help in preventing the use of restraints.

If restraints are necessary,:

- Notify patient and family members of restraint utilization as soon as possible.
- Explain the need for restraints, why they are applied, and the protocol for monitoring and removal.
- Work together to engage patients and family members in future prevention efforts.
- Examine how restraint use can be prevented in the future.

Resources

For Restraint Safety Improvement:

- SAMHSA: The Business Case for Preventing and Reducing Restraint and Seclusion Use
- Nurses Service Organization: Legal Case Study Highlighting the Importance of Documentation and Frequent Reassessment
- US Department of Health and Human Services: Promoting Alternatives to the Use of Seclusion and Restraint
- UPMC: Restraints
- Learning from Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health
- Wisconsin DHFS Caregiver Project
- APNA Seclusion and Restraint Position Paper
- AAP Calls for Trauma-Informed Care to be Incorporated into Children's Health Care
- Trauma-Informed Care in Child Health Systems

For General Improvement:

- CMS: Hospital Improvement Innovation Networks
- IHI: A Framework for the Spread of Innovation
- The Joint Commission: Leaders Facilitating Change Workshop
- IHI: Quality Improvement Essentials Toolkit
- SIPOC Example and Template for Download
- SIPOC Description and Example

Endnotes

Conflicts of Interest Disclosure

The Patient Safety Movement Foundation partners with as many stakeholders as possible to focus on how to address patient safety challenges. The recommendations in the APSS are developed by workgroups that may include patient safety experts, healthcare technology professionals, hospital leaders, patient advocates, and medical technology industry volunteers. Workgroup members are required to disclose any potential conflicts of interest.

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