Hi. I’m Kate Woehl. I’m going to talk to you today about restraints, the use of restraints, and chemical as well as physical restraints.

Alright – let’s get started. When you go to the dictionary and look up the definition of "restraint", it is scary in its whole definition: Restraining by force, where you see words like “force” influencing the patient, applying devices, restricting their movements, control. You're taking control away from the patient's actions. You see things like “The prisoner was restrained.” On any cop show on TV, you see, “They restrained the prisoner.” Well, it's the same thing with patients in the hospital that get to the point of needing to be restrained. You're taking away their control. You're restricting them and they no longer have control of their actions. You have force against them.

Physical restraints: It's a device. It can be materials and/or equipment that physically prevents the patient from moving about freely. This eliminates the patient's choice of movement. They no longer have control over their person. So basically, it's like being in prison. You become a prisoner -- a prisoner of your environment.

Some common restrictive restraint devices -- seat belts. Well, when you think of seat belt you think everybody should have one, especially if you're in the car. A seat belt in the car is a good thing. Having a seat belt in the hospital may or may not be a good thing as far as the patient is concerned and upon the patient's opinion. If they're restrained in a wheelchair by seat belt, they may not want to be that way. But it's being placed that way for the patient's safety or the safety of others, and we're going to talk more about that.

The patient may be placed in a Geri-Chair, which just in the term "geri" tells us that it's usually used for geriatric clientele. The patient may have a jacket or a vest which, one brand is called a Posey®. They may have the Posey® device around them. Or, the patient may just have wrist restraints which keeps them secure in the bed so that they don't get out of bed or hurt themselves or others.

The Omnibus Budget Reconciliation Act of 1987 stated that “restraints could be used only to ensure the patient's safety or safety of others.” So, if we're worried about the patient harming
themselves or if we're worried about them hurting us is the only reason that they can be placed in restraints. And we're going to talk more in a little bit about the regulations and the Federal guidelines for this. This Act, the Omnibus Act, placed regulatory emphasis for patients and nurses to use as a guideline. It's a guideline for keeping the patient safe when you're restrained. Since this Act, research has stated a great reduction in restraints was used. In the textbook Lewis it talks about since the OBRA Act, the numbers, the statistics for restraints has gone down.

In 1999, Federal legislation was passed that governs the use of seclusion and/or restraints. The condition of participation, which is the patient's right: The patient has a right to be free from any form of restraint that is not deemed medically necessary. Physical and drug-related restraints: The drug must be standard for treatment, so in a particular situation, the restraints are to be used; it's got to be the same kind of thing that you would use for a similar patient with the same diagnosis and the same concerns.

Some more information from that... the term restraint pertains to both physical and drug related. Physical restraint in any method or manner, whether it's physical or mechanical, material or equipment that's attached to one's body and cannot be removed by that person is considered restraining their movement. Drugs used as a restraint are those that are used to control behavior or to eliminate movement and are not a standard for the patient's condition. So you have to have evidence that it needs to be used for this particular patient's condition.

Seclusion is another thing -- another term that's often linked to restraints, because if you're secluding someone, you're still restraining them from their environment -- keeping them in certain special location. Seclusion is when a person is involuntarily confined in a room or area and is not physically permitted to leave. Seclusion or restraints can be used only in emergency situations if necessary to ensure the safety after less restrictive interventions have been ineffective. And so again, we'll talk about this in just a minute. But this has to be your last ditch effort. We don't just decide all of a sudden that we're going to restrain the patient because they're on their call light and they're annoying us.

Only licensed physicians or practitioners legally authorized by State law can order a restraint or seclusion for that matter. The treating physician must be contacted if he or she is not a practitioner who normally orders the restraint. Orders can never be written as standing orders. You can't have a doctor who says, "I don't want to be bothered at 3:00 in the morning. So, if any patients at all on the unit act up, just put into effect the restraint order and I'll sign it tomorrow when I get here." We can't have standing orders like that. A licensed practitioner as defined by state law must see and evaluate the need for restraint within one hour after initiation of the intervention. Each written order for a physical restraint or seclusion is limited to 4 hours for adults, 2 hours for children in adolescents from 9 to 17, and 1 hour for children that are under 9. So this means the patient has to be reassessed to see that the order for restraint needs to stay in effect. The restraint must be implemented in the least restrictive manner, so we don't want to go four point restraints right off the bat. We need to go with the soft wrist restraint or a Posey® vest, or whatever needs to be done to keep the patient safe. The least restrictive is the first choice.

Safe and appropriate restraining techniques must be used and ended at the earliest possible time. So, when you reevaluate, if the patient isn't, isn't deemed a danger to themselves or others, you need to contact your physician and get them out of the restraints -- stop the order for the restraint.
The client's condition must be assessed and monitored and reevaluated frequently. Your staff that does the restraint has to have yearly education to know how to handle patients in restraints. They have to know how to document accordingly to keep themselves legally safe as well as the patient physically safe.

Hospitals need to report, of course, any deaths that occur with patients that are being restrained. And that is another can of worms that we wouldn't want to go into.

Since as early as 2007, the Centers for Medicare and Medicaid Services have been requiring strict staff training and documentation requirements for nurses and physicians who use the restraints on patients. The new training is aimed at ensuring that the treatment is appropriate and the individual patient's rights are not violated. This Federal rule is a Condition of the Participation of Medicare and Medicaid in the healthcare facility and applies to short-term centers, psychiatric centers, rehabilitation centers, long-term care facilities, pediatric, and substance abuse facilities -- everything. If they want to get their Medicare dollars, they need to follow the guidelines.

These treatment methods are required only in emergency situations -- the restraint or the seclusion. If they become necessary, the nurse must follow institutional policies. It's very important to know your hospital's policies regarding restraints and seclusions. These policies should follow State regulations and laws and must specify the following items: The type of restraint permissible under the State law. Is it a vest? Is it wrist restraints? What is it? How to initiate and apply these treatments safely. Who can apply the restraint? The type of written order needed and from which level practitioner you'll allow. The length of time that the clients must be kept restrained in, or in seclusion. The interventions needed to monitor care. The physical care interventions. And all necessary forms of documentation have to include all of those things. In addition, the American Psychiatric Nurses Association in 2007 -- in the position statement of the use of seclusion and restraints article provides the nurse with the understanding of the expected standard of practice, so all your hospital personnel must be able to follow these guidelines for seclusion and restraints. And this is also part of your money that your hospital has gained from The Joint Commission when you get your hospitals accredited.

If a decision is made to restrain a patient, the individual's right and their freedom have been removed. So you have to make darn sure you have your valid reasons. The nurse needs to be particularly aware of the negative consequences of using restraints on patients with a history of sexual abuse. Clients who have been sexually-abused have been placed in positions where they were unable to resist their abusers. And this type of restraint limits their free movement and can bring back terrible memories, where the patients were trying to escape and escape was impossible. So, seclusion is a better avenue for those types of patients.

Your typical seat belt is used to restrain motorists and keep them safe. The same thought process is used in healthcare. There is our desire to keep our patients safe. We want to keep our tubes that we worked so hard to put in the patient in the patient. We don't want their lines or their tubings to be ripped out if the patient is confused and just decides to rip out their ET tube so they can't breathe anymore. We want to keep the patient in their bed, especially if they're tubed. It's not that we don't want them to get up and move about. It's because just for that reason -- mobility-wise, we don't want them to get up and move about because we don't want them to pull out the tubes that are sustaining life.
The restraint use in the long-term facilities, the restraint use is on a decline in nursing home settings as well as hospital settings. We're not using our restraints as much as we used to in the years past. And I think that's a good thing, because we've gained more education. There are other things we can do versus restraining.

The Geri-Chair restraint is used on patients that are unlikely to stay in their chair. Maybe you have them in a Geri-Chair because they keep sliding -- you know those people who have flat butt? They don't have the ability to stay in their chair and so, before you know it, they've slid out of their chair. These types of individuals can benefit from the Geri-Chair and maybe a seat belt or something that keeps them in place. Sometimes you have the little tray that you can put there also to keep the patient tucked into their chair well so they won't fall. The use of a Geri-Chair allows the patient to be positioned such that they are not likely to fall. The chair is designed... its whole purpose is for safety.

The use of the Posey® vest is for the patients that are at risk for injuring themselves by falling. The vest keeps the patient in the bed safely without injuring the patient with the device itself that you're using. Frequently used on frail patients when other things like wrist restraints are not really an option. You know those people that you can just about see through their skin? They're elderly and they're very frail and fragile. We don't want to have them in a wrist restraint if we can help it. Sometimes just the Posey® vest or the jacket can keep them in the bed and doesn't hurt them.

The use of wrist restraints is employed when the belief is that the patient will come to harm or harm others. Four-point wrist restraints can be used with a psychotic patient who is a danger to himself or to everyone. But we want to be very cautious with the four-point restraints -- the patient doesn't have a lot of access to much of anything. You have to for sure have your doctor on board for four-point restraints. And you see it sometimes in the TV cop shows, where the prisoner has all four limbs restrained.

A physician must order the use of restraints. If a telephone order, the physician must sign off on the order within 24 hours. If they call in the middle of the night or you call them in the middle of the night and you say, “This patient is out of control. He's punched five people. We can't seem to control him. He's on X number of drugs. We're trying to keep him safe, trying to keep us safe. Can you help us out here? We need a restraint order, or what do you think?” The physician may say, “Yeah, go ahead. Put him in soft restraints. Give him this kind of chemical restraint.” Maybe they say both. You restrain 'em with the soft wrist restraints as well as the medication to calm them down. Within 24 hours or whatever you hospital policy is, that physician has to come in and sign off on that order. He has to say, “Yeah, I gave this order. I agree with this order. I'm going to sign off on it that it was okay by me.”

Be aware of your CMS guidelines. Know your hospital policies but also be aware of CMS guidelines. Be aware of policies and procedures in your facility especially because your hospital is the one that backs you. And if you're going against their policy -- this is really important for the nurses that work two different places. If you work at two hospitals in one town and their policies are not similar, you need to make darn sure that you're following the hospital policies for which you are practicing in. That's what's going to keep you safe... is if you're following guidelines.

You want to document well in your hospital-approved format. Frequent reevaluation of the patient's condition mentally and physically -- how are they doing in the restraints? Did the medication calm them a little bit? Is it possible to maybe take the restraints off now, because now they're calmer?
They realized they were being a danger to themselves or others and now they just really have their orientation back in play. So we're going to reevaluate that.

Your baseline physical assessment -- as with any -- anything that has to do with nursing, you have to have a baseline. Because you need to know what the patient's blood pressure was before; what do their lungs sound like; what do their wrists look like? If we're talking about restraints, we want to know what their risk looks like. If we're going to put wrist restraints on the patient, we want to know if that broken skin that's there was there before you put the restraints on. So you don't want to have to prove it later that "I didn't do that. He was like that." You need to write it down. Do a really good assessment of anything that's going to be involved in a restraint.

Know your patient's skin condition. Every one-to-two hours, unfasten, check, and refasten restraints as applicable. Always allow your patient a bathroom break whether it's a bed pan, bedside commode, or whatever is appropriate for the particular situation that you're in. You have to allow your patient hydration, nutrition, and elimination -- all the "-ations" the patient has to get, okay? We can't let them go for hours and hours without a drink. We have to offer some kind of snack, some kind of nutrition. And they have to be able to use the restroom.

To restrain a patient chemically involves the use of pharmaceuticals. The patient may have an order for benzodiazepine, antipsychotic, or dissociative anesthetic, depending on what the doctor has ordered for chemical restraint. Some of the benzodiazepines the patients may have an order for is Librium. The doctor may order Valium -- some kind of sedative or hypnotic to help induce sleep; anti-anxiety to stop their anxiousness; muscle relaxant. This is an accurate choice for anxious, agitated. Helps with muscle spasms and also helps patients that are coming down from an alcohol withdrawal. It's short, intermediate or long-acting properties, benzodiazepines are. The long-acting works best for patients who are restrained. We don't want to give them a short-acting benzo that we're going to have to just keep giving them over and over again because they're not able to think properly right now. They're not oriented properly. We need to have something that's more intermediate-to-long-acting, depending on the patient's condition.

Your anti-psychotics -- psychiatric medication classifications. Primarily, it's used to treat psychosis, delusions, hallucinations, disorganized thought processes. Often is used with bipolar or schizophrenic patients' disorders. However, be aware that it creates restlessness, causes tremors, and muscle contractures. So, if we went back a slide, we would see that the medication on the previous slide tells you it's going to help muscle spasms. It's going to help restlessness and tremors. And this one tells you that the anti-psychotic creates some of the problems. So, you can kind of see how the two medications would do well together. Some of the medications in the anti-psychotic line that might be used for patients in restraints might be Thorazine or Haldol. Even though those are old, old medications, they are still in use.

You're dissociative anesthetics. This has a class of hallucinogen. It distorts the patient's perception. Their sight and their sound are distorted. It gives the patient a feeling of detachment. They don't feel like they're really in the environment where they're at. They don't know they're kind of disassociated from the world. It blocks the signals to parts of the brain, causes sensory deprivation. Patient may or may not be in a trance-like state. It causes a feeling of euphoria. Patients like this type of medication. It produces sedation; respiratory depression; analgesia; anesthesia; cognitive impairment --
drugs such as ketamine. It has a sedative effect. A lot of times they're used in surgery to put the patient to sleep. These types of medications can be used for any patient who is intubated. You don't have to worry about their respiratory status because they're already being supported mechanically. They can receive this type of medication.

Your chemical and your physical restraints need to be a last resort when caring for the elderly. Patients already are disoriented. The elderly patients are already, a lot of times are disoriented. It can already be a factor for them in their understanding of their current situation. You can create fear. They don't remember where they are. Maybe they don't remember who they are. But they already have disorientation issues and then we're going to add restraints to the picture. This is going to create fear in your elderly population. They don't understand what's going on or why you're containing them.

And we want to make sure that our elderly population is not a source for... and they do. Even though you have an elderly patient, they can strike out and hit a nurse or a nurse's aide. So, sometimes you do have to restrain them. But they also are a danger to themselves, and we don't want any fractures that aren't necessary. So if we have to restrain them, we do. But we would like to try something else first. This is always, always a last ditch attempt for the geriatric client.

So, your general guidelines are restraints, and your seclusion should be implemented only as your last attempt for safety when all other interventions have failed. Only use if meant to safeguard the patient or others. Use the least restrictive form of restraint, if possible, if your situation warrants this. Do not place the patient on restraints simply because they're a fall risk or they have irritating behavior to you. This is what a bed alarm is for. You put the patient on a bed alarm and you know the minute they've swung their legs over the side of the bed. We don't put the patient in restraints just because we don't want them to get up and we say that we don't want them to hurt themselves and they're going to fall. That's what a bed alarm is for, or a sitter. If the patient has irritating behavior, have somebody sit in the room with the patient who is not going to aggravate them. They can watch them for fall alert as well as irritating behaviors. Somebody can assist them.

Do not offer a patient a sleeper or give them two pills instead of one because they're always on the call light. These are not reasons for seclusion or restraint -- behavioral issues. Patients who are often in use of their call light usually need a bathroom break. They need an opportunity to go to the restroom. Maybe they're in pain. Maybe they have some kind of unmet need. They want water, a snack, or an extra blanket.

Physical need for comorbidities: We need to be concerned. If the patient has diabetes, if we're going to restrain a diabetic patient who already has peripheral neuropathy, do we need to worry about restraining their feet, restraining their arms? Do we need to be concerned about that? A diabetic patient, once they have a sore, it's very hard to heal. We have to be concerned about that as well.

Your toileting schedule can help with falls. Lack of falls can stop a nurse's desire for restraining the patient to their bed. So, if you have some kind of schedule taking the patient to the restroom, maybe you don't need to restrain them. You shouldn't have to restrain them for that reason anyway.

In what kind of settings do we put a restraint on a patient? The geriatric patient may be in the long-term care facility. Maybe they need a Geri-Chair. Or maybe you need to seclude them from the rest of the group because they've decided that they want to strike out at other people. You need to keep them safe and keep others safe. An ICU setting is very common for restraints, and this is usually your patients who have tubes; maybe got an ET tube that's breathing for them. Chest tube -- maybe they had
open heart surgery and they have two chest tubes in place hooked to the Pleur-Evac. Maybe they have a feeding tube in, nasogastric tube down. They're just full of tubes -- tubes everywhere. As far as the eye can see there are tubes. We don't want these ripped out. It took time and effort and care to get those tubes in place. The last thing we want is for the patient who is confused to rip them out. They're going to do themselves harm and we're going to have to redo all of 'em.

So, we want to have some way of restraining the patient in the intensive care area, maybe in the emergency department area. Maybe a patient in the ER came in and they are an overdose patient. So, we have placed lines in them and now they're really confused. We want to make sure that those lines or those tubes stay in place for the patient's safety. But you can have it in other settings as well -- your medical-surgical units. There are lots of different places where restraints can be used.

In the ICU setting we want the patient to stay in bed 'because we just talked about this. They have a ventilator; they have an ET tube; chest tubes; feeding tube. Maybe the patient has just arrived from surgery. They're confused. The still have anesthesia on board. They have amnesia. They don't know where they are or what's going on with them. Maybe they have the inability to speak because they're tubed. They can't say, “What the heck? My hands are tied”, because they have the intubation tube in place. So these are patients that usually will end up being restrained, if necessary.

We have the use of the wrist restraint and this is just a picture showing you the wrist restraint device itself. This is considered a soft one. There are also the leather ones which are part of the four-point restraint. This is the vest or the Posey®. We'll talk about this in just a few minutes, but when you do your securing of the patient to their bed, we have to make sure that our, our ropes or our straps are tied to an immovable part of the bed. The last thing you want to do is tie your straps to the railing, and then all of a sudden you drop the railing, and you fracture their arm. We always have to tie the patient to an immobile, immovable part of the bed. When the restraint itself is tied, it has to be in such a way that when you pull it, it instantly releases on your part, not the patient's. We obviously don't want the patients to get it and open it up and be free. But we want to place it in a knot where we can pull it quickly, if there was a fire, we could get our patients out safely. Last thing we want is for them to be tied permanently to the bed and there's a fire.

And lastly, this is a mitten. This can be used all the way from the newborn nursery to geriatric clientele. The mitten can be used for anyone. It's just a way to keep the patient's hands free, like babies, so they don't scratch their eyes or scratch at things that are in place to elderly that may pull out their tubes.

That ends our slide presentation. And in just a little bit, we're going to head on over to the lab and we're going to actually show you the demonstration of how to tie your patient in wrist restraints. And we have a Posey® vest as well and a mitten, and we'll show you all the different actual tools that we use to keep a patient safe in restraints.

This is our demonstration. We're here in the Sim Center, and Akemi is helping me demonstrate for you the mitten approach of restraints. This one, you notice, is just the mitten itself. There are no straps to hook to the rail. This is the least invasive, if you will, way of restraining the patient so the patient can't pull out tubes. So Akemi is going to show you how you slide your hand in and the fingers actually have little spots that the fingers slide down into. And then it just has a strap that secures it in place. And once, the patient, of course, will have one on each hand so they can't reach up and pull out tubes. And they can't untie the straps because they're secured inside the mitten itself. So, you can use...
I mean babies; they put these on babies so they don't scratch their eyes. They put it on geriatric clients. It can be any age or developmental level that can be put in mitten restraints.

Now, we're going to talk next about the actual wrist restraint. This is considered a soft wrist restraint versus the leather ones that we talked about earlier in the classroom. So, it's got Velcro that's going to hook it together as well as the buckle and then the straps itself. The straps are going to go down -- once it's secured to the patient, it's going to be tied to the side of the bed. We're going to make sure we don't put it on a movable part such as a railing that can be dropped. We don't want to fracture the patient's arm or move them out of their sockets, so we're going to secure it to the bottom part of the bed that's not movable. And of course, we talked in the classroom about making sure the skin is intact prior to placing this so that if there is an injury, we know if it's from restraint or not. So, we're going to Velcro it on and she's going to make sure that her fingers can slip in between so it's not too tight that it's cutting off circulation in the patient. And she's going to secure it to the buckle. And then that will keep the patient intact in the little restraint but it won't cause harm to them.

Now, when we judge where we want to put these, we don't mind if the patient has a... if your patient has enough cognitive ability that they know that they're not supposed to pull out their tubes but they just need a gentle reminder, you can let their hands go this high. But we don't want them to be able to reach up and pull out their ET tube. So you have to assess your patient and know where and how tight your restraint has to be or how much leeway you have for the patient. So, this patient would be allowed to go so far and that's all. Now, keep in mind, if a patient wants to get... the patient has the ability, they can do things like that if they really want out of it bad enough, so you've got to keep assessing. This doesn't eliminate the nurse's activity. You still have to be in here and assess your patient and care for your patient -- that's the wrist restraint.

FEMALE SPEAKER: We want to find an immovable part of the bed, so this bar would be good -- unlike the rail here that moves up and down. So, you just want to go through. And then we're tying a quick-release knot here, so we want to make sure it's long enough for our patient. We just want to go through here, pull it tight, so that it's tight this way. So, if we need a quick release, we just pull our straps and then the patient can easily be untied in case of emergency.

KATE WOEHL: Okay. This is a Posey® vest that's going to be used to secure or restrain the patient to the bed. That's the front part of it. And the patient is going to sit up; we're going to pass it around. It crisscrosses in the back and the patient is put back down on the bed. And the same thing that we did earlier with the wrist restraints -- you're going to go around an immovable part of the bed. You're going to tie it in the release knot method so if we need to quick release and release the patient in case of an emergency, then that's what we're going to do. This keeps the patient contained to the bed. Keep in mind they can shimmy down to the bottom of the bed and it doesn't eliminate nursing intervention. We still have to be aware and assess our patients or before you know it, the Posey® vest is at their neck. This is the back part of the restraint. We're going to take the Posey®, crisscrosses through. It's got a little hole where the loop goes, goes through, crisscrosses in the back of the patient. The patient goes back down and the same thing -- we're going to tie it to an immovable part of the bed in the quick release knot so if there is ever a fire, the nurse can get the patient out of it and get them safely out of the hospital.
I'm Kate Woehl. Today we're going to talk about chemical restraints, a form of restraining our patients if the situation warrants. Chemical restraints are used when medical restraint is necessary by means of pharmacotherapy. The drug removes or restricts patient's freedom of movement. The definition by the Federal government -- it's kind of scary, I'll warn you. But this is the actual definition by the Federal government. It says, “Intentional use of medication to control a resident's behavior when no medically-identified condition is being treated or the treatment is not necessary for the "condition" or amounts to over treatment.”

What kind of situations do you think warrant use of chemical restraint? We know what physical restraint is. We've talked about that in the past. Physical restraint, where you actually have hands-on, holding someone down for whatever reason. But what kind of reasons would there be for us to want to do a chemical restraint on a patient? And by that, I mean what? Meds, medications? What kind of pharmacotherapy or pharmaceutical use would we use to make sure that this patient keeps themself safe and keeps us safe?

So, situations that this might be warranted in such as acute care settings, emergency departments, intensive care units. It might be used in a diagnostic procedure where the patient has to stay steady. You can use a chemical restraint on a child. If you want to do a CT scan on the child and there's no way you're going to get an 18-month-old to be still. You may use a form of chemical restraint or some kind of sedative agent.

It could also be used in places like long-term care facilities. It often, and most often of all, is used in behavioral facilities, behavioral health -- psych centers. It can also be used in correctional facilities, prisons, and lock-down units. There are many uses, in a variety of settings that chemical restraints can be used.

Our main goal: The aim of using pharmacotherapy to restrain is to keep the patient safe, keep the worker's safe, keep the patient from removing maybe lifesaving tubes like their ET tube or NG tube or J tube or whatever that they might be chemically restrained as well as physically. Keep the patient calm to allow the brain and the heart to rejuvenate, or during a time of healing, the patient might be put into like a chemical coma. They may be chemically-restrained in the position that they're in to let the body heal.

So there, of course, will always be controversy about if this is actually ethically-approved; if this is actually humane. There are always going to be those arguments that are going to be placed, and you're going to get them from your family members. Someone walks in and the patient is physically-restrained. Everybody gets kind of upset. They also walk in and all of a sudden the patient isn't responding to them like they did yesterday. And you say, “Well they're not responding because I'm chemically-restraining them. I am giving them medication so they're not going to answer your questions today. I need them to relax.” You're going to also have family members who are going to get upset about that as well, so you have to explain the reason. What's your rationale for chemically-restraining a patient? And it has to be a good reason. You don't just do it because, “By gosh, it's the fifth time they've been on their call light.” We don't do it for that reason. It has to be a specific ethically-stable and rational reason to do it.

So, we never want to restrain unnecessarily, and that's one of the controversies is we're chemically-restraining unnecessarily. And it also goes right hand-in-hand with physical restraining. They
say that it takes away the patient's rights, and it does. But if we have a reason for it and it's a good reason -- for example, every time you turn around, they're ripping out their tube. And they have no assist drive at all. They are totally dependent 100 percent on that tube. You've restrained their hands every which way from here to Sunday. It's just not working. So, now you've decided, and the physician, of course, decides they're going to chemically-restrain the patient. That is to the patient's benefit. It's not to the patient's detriment. It's to their benefit that you're chemically-restraining them. Yes, you're taking away their rights but you're doing it for a good reason.

It must be used to treat condition or episode at hand. You don't just say, “Okay -- well bam, bam, bam. You, you and you -- you're out of here. I'm going to totally put you to sleep and you're not going to bother me again.” There has to be a reason. There has to be a condition. Maybe the patient is in a behavioral health facility and they've just all of a sudden just lost all reason. They have no way of controlling their emotions and their behavior at this point, and they have to be physically-restrained and then chemically-restrained -- which happens frequently. Of course, you try first with talking. If you can diffuse the situation, talk them down, you're going to do that first. But a lot of times when it's gotten so far out of control you just can't. And in this situation of patients who are psychotic. Maybe they're coming down off some kind of drug. You see this a lot in “huffers”. You see it in your people that do bath salts. You see it in all kinds of psych issues where the patient... t there is no way are you going to talk them down. They're just out of their mind. There's no way you can calm them down, so they need to be restrained to safeguard their safety as well as others who are nearby.

It must fall within the guidelines of medication use, age of the patient and situations. You can't just pick a medication at random or your physician can't pick a medication at random. It has to be age-appropriate. The dose has to be size-appropriate. How much do they weigh? All those things, just like any other situation where you give any kind of medication. All of that has to be taken into account prior to using a chemical restraint.

This is considered a less invasive way of restraining the patient, and by that I mean I'm not holding them down. But I'm still going to shoot something in them or pop a pill in them, depending upon what they can take. So it's less invasive than physically holding, but yet it still ends up being invasive. There are many healthcare areas that develop the need for patient restraint. The less invasive is always considered a better option than physical restraint. There's more chance of injury for a patient if you physically-restrain and there's more opportunity for them to injure you if you physically-restrain them.

Federal regulations exist, however, that reflect on the use of both physical and chemical or pharmaceutical measures. So there are regulations, there are guidelines for how you do chemical restraints as well as physical. This is not to be taken lightly. We don't just decide one minute we're going to restrain somebody chemically or physically. The documentation alone for a restraint, either method, is a nightmare for nursing. There are lots and lots and lots of documentation. And believe me, in a court of law it will be massively scrutinized for a patient or a family member who is going to state that you assaulted them. Because oftentimes when you're doing a physical restraint that turns into a chemical restraint, they can come back and say that you assaulted them. The more they fight the more chance they have of bruising. And so that can come back and, and bite you if you're not careful... if your documentation isn't just perfect.

So, your behavioral outcome; your behavioral control. Your chemical restraint is used to control behavior. It's used to restrict freedom of movement. It's not used ever as a punitive measure. It can be
used as a sedative and it can allow surgical case to exist and keep the patient what they call “under”? So, you can use a chemical restraint to keep the patient underneath the anesthesia agent so that they can finish their suture or finish their surgery process.

In a long-term care facility if this is used, oftentimes a variety of medications are prescribed in facilities such as this in the form of sedatives or chemical. They can act as chemical restraints. Oftentimes it's used to manage dementia and it can also be used for psychotic episodes. And the elderly have psychotic episodes, too, just like adults do.

The need for chemical restraint: There is workplace violence and it's on the rise -- 1.7 million episodes of work-related violence were reported annually in the United States alone. Twelve percent of these episodes showed the victim to be the healthcare worker or the mental healthcare worker.

The emergency department is a major source of violence within the healthcare setting. There's new legislature that's out there to protect emergency room nurses. The current work with political leaders to prosecute offenders who harm or attempt to harm hospital workers. This House bill, I myself participated in this. It's a bill that's out there that's going to protect emergency room nurses. And by that I mean if someone harms an emergency room nurse, it's going to be considered a felony. So, that's just something to think about.

Contributing factors: Agitation often leads to violence if not corrected. If you can't diffuse it; a lot of times it turns to violence, and we could go and talk all day about how to diffuse a situation. Basically, you don't want to get in someone's face that is already having a moment, because it's just going to escalate, and you don't want that. And in an emergency department it can result in long wait times. Sometimes you're in there for hours and hours waiting to get seen. This does nothing for someone's temper that was short before. They come in and they sit for 6 hours. They get angrier and angrier and angrier. It's hard to diffuse those situations. Your patients may all of a sudden blow. Maybe they also have a little bit of psychiatric background and so this can end up being someone who ends up being chemically-restrained.

Agitation cause can stem from medical reasons also such as -- something like hypoxia or dementia can also cause the patient to need to be chemically-restrained if all of a sudden they're so agitated they can't control.

Medications used: Your options are available. Some are commonly used. There are three classifications -- three major ones. You have your benzodiazepines; your typical or your classic antipsychotics; and your atypical antipsychotics. Your benzodiazepines -- this is your lorazepam so we’re, basically we’re talking about your Ativan and versed. These medications can be given p.o., IV, or IM. It can also be given intramuscularly. The administration for IV takes about 2-to-3 minutes for the IV Midazolam; about 1-to-5 minutes for the Ativan.

Patients have to be monitored very closely when they're on these kinds of medications and it's not always easy to monitor if your patient happens to be one who is in a behavioral health facility because we don't usually have the sat monitors and don't usually have any kind of cardiac capabilities. And so monitoring, you still have to do your basic nursing assessment, don't get me wrong. But you don't have the same capabilities in a behavioral facility as you would in a hospital setting. Benzodiazepines remain a highly useful medication to control agitation and to provide sedation.

Your typical or classic antipsychotics -- this is your Droperidol and your Haldol. Haldol has been around forever and ever. It can be given p.o. or IM. It controls violence and acute psychosis. In a study
by Clinton et al, it showed that disruptive behavior was alleviated using Haldol within 30 minutes. In 113 out of 136 patients that presented to the emergency department with acute agitation from various causes, Haldol has been found to have similar time of onset to both IV and IM form -- about 30 to 45 minutes. But it could take up to 60 in some patients that have a huge problem with kidney and excretion. The onset of Haldol takes between 3 to 10 minutes in an intramuscular injection. And the peak action takes about 30 minutes.

The major drawback to medications such as this are their side effects, which there are a few. In fact, Enazapine was given a black box warning by the FDA because of the risk for QT prolongation. And Haldol received a warning in 2008 regarding its use in treatment of the elderly who had dementia psychosis. The QT prolongation can result in Torsades and other cardiac dysrhythmias. In addition, your typical antipsychotics are known for causing extrapyramidal adverse effects.

Your atypical antipsychotics: This is your Risperdal, your Zyprexa and your Geodon. These medications have become relatively... they're pretty new; not terribly new but they're somewhat new medications. There have been several studies done that showed equal or improved effectiveness by using these medications. Zyprexa is often used as well as the Geodon. The Risperdal has been known to be effective in treating psychosis -- the same kind of effectiveness that you would get from Haldol that's, like I said has been around forever. But it has fewer side effects than Haldol does. In a study by Currier and Simpson, they found that oral treatment with the Risperdal and the lorazepam both together appear to be tolerable and comparable to an IM injection of Haldol and lorazepam. It works for short-term treatment for patients who are agitated with psychosis or patients that have specific oral medications.

You can also do a combination therapy where you add your benzodiazepines and traditional or classic antipsychotics. There were a few random trials that were done that indicated that the combination of those two types of medications provides a more rapid onset of sedation with similar adverse effects in the same profile as before. The combination... this therapy with the Haldol and lorazepam, can be reasonably considered to control violent behavior and agitated behavior in situations such as an acute care setting.

Your routes of administration: Options exist for medication administration, often depending upon the situation and the degree of agitation. You can offer an oral medication to a patient who is still able to talk with you, function with you and think coherently, but if they're in the throes of massive hysteria and they're so agitated they can hardly stand themselves, they're not going to just calmly say, “Okay, sure. I'll take this pill.”

Your interview and assessment skills are crucial. Calming measures may present an alternative to medication entirely. Maybe you can diffuse a situation just by saying; “I see that you're upset there. Can we talk? I don't want to have to run and get medicines for you. Can we talk about this? Can you tell me what set you off? What, what's going on?” And maybe they say, “That person in my room is just driving me crazy. I just want to kill them, want to kill everybody around me.” And maybe you can say, “You know what? I have a spare room over here in this pod. Why don't we move you over there?” And that's the end of it. But, it may not be so. Maybe it's going to escalate and it's going to take more interventions. But maybe the patient isn't totally out of control yet but they're just continuing to be agitated. So you can say, “I see that you're agitated. Could I offer you a Zyprexa? Your doctor has said that when you get agitated like this, we can offer you a Zyprexa. Can I get you one of those?” And the
patient says, “Yeah, I feel like I need one.” Or, maybe the patient says, “I'm going to kill you and I'm going to kill everybody around me.” That obviously is going to call for more interventions. We're going to probably have to get an IM injection and the patient will have to be physically-restrained. And they're going to have to get an injection of the medication to calm them. And some patients on the flip side of that say, “I need that shot; I need that shot, but you don't have to hold me down. I'll just turn and you give it to me.” And true to their word, they just turn around and you give them the injection. So, you just have to assess your patient and know what kinds of measures have to be taken.

Oral medication: Most common if the patient can tolerate and can comply with you. But be advised that they can do what's called “cheeking.” If they tuck the medication in their cheek and they don't let it absorb. If it's not a buccal one and they're supposed to have swallowed it, make sure that you know what happened to the medication. Did they actually take it the way that the manufacturer wants it to be taken?

IM injection: If your patient is, is too far and won't handle the oral medication, you may have to give an injection IM-wise. If you're in acute care setting, take advantage of your peripheral line. If you have an IV, give them the medication IV if it's a medication that can be given IV and that's how your order reads. Those settings would be such like ICU or emergency department, some kind of acute care area where the patient has already got access prior because of a crisis situation.

Your chemical restraints through medication: Despite some controversy regarding the medication used as a restraint, evidence remains that shows patients and healthcare workers continue to benefit from the use of chemical restraints when all else fails with the patient. So, the key here is have you tried everything else for this patient?

Chemical versus physical: The chemical restraint remains a solution over physical restraint. It's always going to be a better bet than holding somebody down. When you hold somebody down, you run the risk of bruises, broken bones for you and for them. So, physical is not a first ditch effort. You don't want to use it if you don't have to. Chemical restraint is an alternative and it's a good one. You just have to make sure that you're aware of all the guidelines for that medication before you give it. It's very easy in a sense of a violent situation going on for the doctor to call in an order and say, “Go ahead and give this dose and use this other one in combination.” Maybe they say they want the patient to have Haldol, Benadryl and Ativan. And you're in such a state where you fail to tell the doctor that this patient is 90 pounds soaking wet. Be aware that a chemical restraint that's given in too large a dose, just like any other situation, can result in the patient having CNS depression. You don't want to have to calm the situation down so far that now you have to have the patient sleep next to the nurse's station because you don't know if he's going to continue to breathe. And like we stated earlier in a behavioral health facility, you don't have the necessary monitoring equipment you need to make sure your patient stays safe. So be advised that when the situation is full blown agitation or some kind of patient having a meltdown, you have to be the one who actually assesses the situation calmly and realizes that the patient is very small. And that the dose that's prescribed by the physician... maybe their physician can hear them screaming on the other end of the phone and he says, “Give 2 and give 50 and give 100 and give this. You have to be the one that says, “This patient is only 90 pounds. Perhaps we shouldn't have a dose quite that high.” Do your SBAR. Go through all your different parts of the situation and recommend that the doctor not prescribe that much Haldol or that much Ativan or that much Benadryl. Because all those in conjunction are going to cause the patient problems.
So, your chemical restrain remains a solution over physically-restraining a patient, which can result in bodily harm to the healthcare worker and the behavioral healthcare worker and the patient. So, everybody can be harmed by a physical restraint. In a chemical restraint, if it’s used in conjunction with a physical – like, for example, you have to hold your patient down in order to give them the medication, you still can end up being harmed as you're trying to get the shot to the patient. And be aware, be advised that you're bringing another component into this little interaction. They're being held down. You're coming up with maybe two different shots. Now you have a sharp, so you have two sharp needles on you coming up to someone that sees you coming with the shots. The situation could get totally out of hand and so be aware that your chemical restraint could end up acting as something that's used against you, so just be very alert and very cautious with that.

Education is needed: Healthcare workers and behavioral workers need to have continued training when they use physical or chemical restraint. There's lots of continuing education that can be done. All over the place, you can find information on chemical restraints and physical restraints.

Physical -- of course, you're going to watch for signs of distress. Maybe skin, soft tissue, bone -- obviously those things. If someone breaks a bone, they're pretty aware of it because of the pain, but also, being held down for long periods of time causes lots of bruising and soft tissue damage. You also want to watch things like range of motion. If you have someone's arm at an odd angle, you need to be aware that that could cause difficulties, tears in tendons and all of those things -- and circulation issues.

Once the patient has calmed down with the use of the chemical restraint, it's very important that the patient be assessed for circulation. Make sure you check your pulse, their capillary refill, and all those things, to make sure that nothing... no damage was done during this short physical restraint that was issued prior to your chemical restraint.

With chemical restraints, like we talked about a minute ago, you're going to watch their CNS depression. If you have a sat monitor, what's their oxygen saturation? What's their respirations, blood pressure, and pulse -- all of those things? Make sure you're aware of their level of consciousness.

If they're in a hospital setting, you're going to have more tools, more supplies, and equipment handy for you to do the check. They can just simply be hooked to the monitor. But if you're in a behavioral health facility or a clinic or on the street, you're not going to have those things. So you're just going to use sound nursing judgment for that.

As with all forms of restraint, caution must be used to keep everybody safe in the event of a restraint usage. And again, it doesn't matter what kind of restraint you're using. The patient has to be kept safe and in so doing, you don't want to harm anyone in your group, either.

So, that is my discussion on chemical restraints -- just a tiny touch on physical restraints. But mostly we were talking about pharmaceutical means that can work alone or in conjunction with physically-restraining a patient due to behavioral issues. Or for example, pulling out their tube or something that warrants them being restrained for healing of the body. Thanks.

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