

“OUTSIDE THE BOX: Restraint Alternatives That Work in Acute Care”

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Purpose: To provide nursing personnel with ideas for alternatives for the least restrictive protective measures that work in acute care settings.

Objectives:

1. Use a decision-making process to assess for the least restrictive alternative to maintain patient safety
2. Assess for altered thought processes, developing a trajectory, using a reliable and valid clinical assessment instrument
3. Describe three interventions for people with confusion
4. List four interventions to prevent falls
5. Describe pain management to prevent picking at wounds
6. Discuss 3 methods for managing tubes
7. Describe how to prevent scratching
8. Discuss fears about restraint reduction and liability

USING A CLOCK TO PLOT CONFUSION

Step 1: Give the patient a piece of blank paper and a pen

Step 2: Instruct the patient to draw a clock and set the hands at 4:30

Step 3: Score the clock as follows (10 possible points):

- Is the clock round and the circle closed? – award one 1 point
- Are all of the numbers present inside the circle in the right order? -- award 1 point
- Is the center designated? – award 1 point
- Are the hands in the right place? (short hand between 4 & 5; long hand on 6) – award 1 point
- Draw two perpendicular lines through the clock. Look at the numbers in each quadrant:
 - Award one point for each of the first 3 quadrants where the numbers are correct
 - Award 3 points if the numbers are correct in the last quadrant

Step 4: Label the clock with patient's name, number and date: Tape to flow sheet to demonstrate changes in level of mentation

AVOIDING RESTRAINTS WITH CONFUSED ADULTS

1. Take a history on all patients. The best predictors of confusion are one or more of the following:
 - Age greater than 75 (especially if male or lives alone)
 - Renal impairment (Creatinine > 2.0)
 - History of confused episode (during hospitalization*) or memory loss
 - Cardiopulmonary alterations
 - Sensory loss (vision, hearing)
 - Anesthesia
2. For patients at high risk
 - Q 8 hour & PRN clock-draw assessment
 - Check as needed
 - Room alone within view of nursing station
 - Limit visitors and people (staff) in the room

- No TV, human stimulus only!
- Nightlights in bedroom and bathroom
- Scrupulous pain management
- Bed in low position
- If patient is (or has been) married, line spouse's side of bed with pillows
- ½ side rail at head of bed where patient will get up.
- No lower siderails
- Rest periods alternating with activity throughout the day
- Family available during high risk times
- Have family bring patient's pillow and familiar items
- Remove/hide tubes (see "tubes")
- Consistent staff & routine
- Minimize extraneous stimuli
- Glasses, hearing aid, dentures on
- Have purse (empty) in bed with patient
- Chair rest during the day
- Activities
- Avoid re-orientation
- Toilet patient at night consistent with habits at home
- Physical therapy to keep the patient walking throughout the hospitalization

IF THE PATIENT IS CONFUSED.....

Continue the preventive measures and ask yourself the following:

1. What exactly is the danger to the patient or others?

A. Is the patient agitated or aggressive?

- Treat pain
- Avoid caffeine
- Pharmacologic options
- Time out
- Family stay with patient
- DO NOT REORIENT! It can increase agitation

B. Will the patient climb?

- Bed in low position
- Siderails down
- Shoes on in while in bed provides stability
- Clear path to bathroom
- Bed alarm
- Physical therapy
- Walk with the patient. If the patient walked in, make every effort to let them walk throughout the hospitalization and walk out at discharge
- Mattress on floor
- Family to stay with patient round the clock
- Busy boxes, catalogues
- Recliner during day
- Patient at nursing station
- Do not give patient the call bell and expect to call you!

C. What about tubes and wounds?

- Minimize tubes, telemetry, etc whenever possible
- See “Tubes and Wounds”
- Excellent conscientious pain management
- Pharmacologic measures

2. Avoid all unnecessary stimuli

- No TV!
- Take down pictures on wall
- Cover mirrors
- No beepers/cell phones in room
- No vacuum cleaners with patient in room
- Physician rounds with more than one person outside the room
- Minimize night-time care. Schedule blood draws, medications, vital signs, and elimination at the same time to minimize times patient must be awakened.
- A “warm fuzzy” to hold

3. Provide continuity with past

- Reminisce
- Validate
- Have family and familiar items present
- Do NOT reorient!

4. Monitor physiologic well-being

- Hydration (In & Out; labs)
- Pain
- Renal status
- Respirations (worry if >24; then vs q 1 hour – if trended over four hours consider as indicator of sepsis)
- Arrhythmias
- Pulse oxymetry
- Output

Relocation alone accounts for 37% of acute confusion, therefore consistency and continuity are critical!

“I’VE FALLEN AND I CAN’T GET UP!”:PREVENTING FALLS WITHOUT TIES

Assess every patient for risk of falls:

- History of falls**
- Incontinence**
- Polypharmacy & substance use**
- Limited mobility*
- Sensory loss*
- Altered mental status**
- Orthostasis (systolic drop >20 mm Hg, systolic and/or >10 mm Hg diastolic after 3-5 minutes standing)*
- Cardiac arrhythmias
- Dizziness or neurologic conditions
- Postural changes

- Anesthesia

*= strong association

Most fallers have more than one risk for falls!

WHEN THE ASSESSMENT SHOWS HIGH RISK, WHAT DO YOU DO?

You intervene by managing the specific risk factors for falling:

1. Walk the patient every opportunity possible! “If the patient walked in, we should make every effort possible to keep the patient walking throughout the hospitalization.”
2. Physical therapy for walking, upper extremity strength, range of motion to neck
3. Bed in low position
4. Upper side rails only
5. Mattress on floor
6. Bathroom rounds
7. Bed near to bathroom door, run string to bathroom
8. Bed alarm (The best alarm only tells you there is an emergency)
9. Nightlights in bedroom and bathroom
10. Clean up spills
11. Minimize clutter, low stimulus
12. Patient sleeps with shoes on
13. Diversional activities (catalogues, puzzles)
14. Good fluid intake
15. “Detour”
16. Stop sign
17. Black half-rug at door of room
18. Wedge cushions
19. Rubber lace
20. Bolsters, lap buddies
21. Glasses, dentures, hearing aides, and toupee on
22. Purse with patient
23. Assistive devices for walking devices nearby
24. Treat pain (no Demerol)
25. Family with patient
26. Minimize medications, especially sedating or anticholinergic
27. Provide call bell, but don’t expect much
28. Bed checks, especially in evening and night
29. Understand that very few people spend all day in bed!
30. Kardex and call bell console ID for high risk patients
31. Occupational therapy for endurance
32. Interdisciplinary/multidisciplinary approach
33. Physiatry consultation
34. Minimize distractors (TV, group dining)

WHAT ABOUT LINES, WOUNDS AND TUBES?

1. Pre-operative teaching has shown to be effective in decreasing nervousness about airways and lines
2. Good ongoing mental status assessment
3. Confused people: hide lines:
 - Place in an unobtrusive place
 - Use a topical anesthetic on site
 - Overdress
 - Run tubing up back so patient does not see it

- If in arm, use double surgical gowns with cuffs to preclude access
 - Hand splints if necessary
4. Oriented person, explain lines and ET tubes
 - If the patient is oriented and alert, provide a mirror so the patient can see and touch the tubes
 - Explain what will happen if the tubes are pulled
 - Topical anesthetic on site
 5. Excellent pain control
 6. Remove as soon as humanly possible
 7. G tubes – use as small a lumen as possible to minimize irritation, hand splints for confusion
 8. Foley catheters
 - Men – shave area just above pubis and tape catheter to pubis. NEVER secure Foley catheter to the leg (produces discomfort and can produce a fistula)! Run tubing around back and down the leg to a legbag. Have man wear underpants and pajama pants.
 - Women – remove ASAP, Intermittent catheterization
 9. Abdominal wounds
 - Careful supervision for confused
 - Overdress
 - Application of an abdominal binder, backwards
 - Hand splints if necessary
 - Good pain management
 - Scheduled regular low dose narcotics, No Demerol in aged!
 - Supplement with analgesics
 - Topical anesthetic to prevent sensations (itching, pulling)
 10. Scratching, picking
 - Topical anesthetics
 - Long sleeves
 - Stockinet
 - Dermatology consultation

We have to stop thinking about critical care as a place where we care mainly for the patient's body and the lines!

WHAT ABOUT AN AIRWAY?

1. Carefully documented mental status assessment
2. Pre-operative (with pictures and tubes) and post-operative education
3. No restraints while staff working with patient!
4. Let patient see and touch tube
5. Opponent hand splints with stockinet
6. Modified soft collar for tracheotomy protection
7. If the patient is lucid, take a deep breath and Let Go while nurse in room!
8. Determine what can be done for long-term ventilation

TELEMETRY

1. Hide leads as much as possible
2. Use topical anesthetic
3. Hide box in back of patient
4. Ask "Is the telemetry really necessary?"
5. Have the family present

"ATTENTION K-MART SHOPPERS!"

RUMMAGING, SCAVENGING, ELOPING

A. Elopement – Assess risk in patients

1. Where is the patient trying to go? Is there an unmet need?
2. Elopement identifier (red vest) with sign by exits
3. Cover elevator buttons with felt hanging
4. “Detour”
5. Black ½ circle rug
6. Busy boxes
7. Catalogues
8. Reminiscent equipment
9. Occupational therapy consultation
10. Lost patient sheet with picture for security or police
11. Elopement drills
12. “Not an Exit” signs
13. Family present

B. Rummaging, scavenging, “shopping”

1. Busy boxes – old cards, PVC pipe joints, plastic implements, old jewelry, doll clothes in plastic bin-type containers (gender appropriate)
2. Patient carries a “shopping bag” (canvas)
3. Label all dentures and glasses
4. Catalogues

MATERIALS FOR BUSY BOXES

Recommended by Professional & Lay Caregivers on the Alzheimer Net

- A bubble gun - “The residents starting smiling, laughing, and blowing. I put the gun in everyone's hand and help them pull the trigger. When they realized that they could do it and make something happen, it was delightful to see.”
- “Sorting things has been a life saver for one of my residents. I have clear plastic container with objects - of varying colors and ask for help, putting it all together. I also dump a box with odds and ends of art supplies -feather, pompoms, etc. and he sorts them in the box, putting them in amazing arrangement.”
- “My LO enjoys different bright colors in combination, and toys that make music. There is one that plays old ditties (You Are My Sunshine, How Much is That Doggie, etc.) when a big button is pressed.”
- LO also likes one that produces little flashes of light when a knob is turned. Had to choose toys carefully, because I found that she could not figure out how to work one that was designated from six to eighteen months.”
- “One thing that I searched high and low for, and never did find, was an activity apron. Finally made one, and she got SO much out of that. It had several different items attached that included various colors, textures and materials. One was a soft picture frame with her picture in it and a flap of felt over it. There was a felt pocket with pieces of candy to surprise her (when she could still eat it - now everything is blended). Another pocket had tissue which she was always needing (allergies). Attached also was a bright red plastic zipper, some snaps and buttons/buttonholes. Everything was in highly

contrasting colors. She enjoyed this apron immensely, and would be occupied by it when nothing else could hold her attention.”

- “Really, really soft plush animals and dolls were favorites, and she liked the graduated donut rings on a stacker, too. Just as there are age appropriate toys for children, stage appropriate items for the older crowd might be wise. Perhaps calling the items something other than "toys" might be a plus. Indeed they are, but many families and caregivers find they aren't ready for this reality (it takes time...) and feel comparisons to toddlers diminish dignity.”
- “He is very penurious - probably a result of his era - supporting a family in the depression! However he loves thrift stores and I bring him to one every afternoon as a treat. There are about 6 in the area and they all know us by now - I rotate visits. He can spend infinite hours pawing through bins of junk - anything mechanical. He has bought radios, clocks, wires, tools, flashlights, cameras, spools of wire. Not a thing in the bunch that he needs - but the prices are more in the line of what he deems reasonable. He can still count out his money - but it takes longer and longer. Every one is very patient with him while he counts it out to the last penny.”
- I now keep all his acquisitions in boxes in the garage - when he gets antsy around the house - and I am trying to accomplish a major operation like laundry or dinner - I trot one out and say, "Do you think you could fix a flashlight for me out this bunch?" or a camera ...or whatever... The "fixit" that is still in him says oh yes! and he eagerly goes through the box, instantly forgetting what the original "chore" was, and I can finish whatever mine was! This works well for me!”
- “The principal might be applied to female LO's also - with boxes of material, craft items or cooking utensils or even children's toys. I do buy some of those at these stores - soak them in bleach and box them.”
- “I will ask him to "evaluate" a toy for our grand-daughter. He will often spend hours intrigued with it - Playschool, Fisher Price and Lego serve this purpose well.”
- “Using bits of PVC pipe with straight parts, joints, and threaded pieces work well with men”

BEHAVIORAL MANAGEMENT

1. Assess risk to patient, other patients, staff
2. NEVER blame the staff!
3. Psychiatric consultation
4. Time-outs
5. Contracting
6. Behavioral modification (ABC approach)
7. Enlisting family help
8. Appropriate pharmacologic intervention
 - Agitation protocols
9. Knowing when to transfer a patient to a psychiatric facility
10. The suicidal patient – Must have 1-1 care with a trained provider
11. Addiction
 - JCAHO recognizes that restraints may be appropriate for people who have addiction issues
 - Withdrawal – drug taper
12. Use of a Violence Management Code Team
13. Non-confrontational training

14. Consistent staff and structured routine
15. Try and try again

WHEN RESTRAINTS ARE ALREADY IN PLACE

1. Always ask why? (over and over)
 - Has the risk changed?
 - Are they still needed?
 - Is there a way we can decrease them now?
 - a. Remove when staff is in the room
 - b. Remove if mental status improves or agitation decreases
 - c. Interdisciplinary restraint reduction consultation
 - d. Like eating an elephant, take it one bite at a time!
 - e. Increase your comfort level slowly and let your confidence build
 - f. Don't be afraid to use your imagination!
 - g. Ongoing hourly process
 - h. Logic intensive
 - i. Document, document, document, document
 - j. Physician consultation
2. Do NOT assume that you have to know everything!
3. Do not feel that blame is involved.
4. Look at restraint reduction from "outside the box."
5. Know and internalize the policies. Talk about them!
6. No one has lost a suit for "failure to restrain."
7. Many suits have been lost for injuries and deaths from restraint and siderails
8. The goal is not a restraint-free environment, but a safer level of patient care
9. People in restraints have as many incidents with a much higher level of injury and death
10. Accidents can and will happen
11. Hospitals are basically "inhospitable places" for the aged!