Restraints: Guidelines for Safe Practice in Hospitals

In healthcare settings, restraints are a critical tool for ensuring patient and staff safety during episodes of agitation and unsafe behavior. However, their use must adhere to strict guidelines to protect patient rights and ensure ethical, safe care. Restraints (physical or chemical) and seclusion are *last resort* interventions. Restraints may cause significant psychological and physical distress and must only be used to ensure the immediate physical safety of the patient, staff members, or others when less restrictive methods have failed. Restraints must not be used for convenience or discipline. The goal is always to use the least restrictive method of restraint for the shortest possible duration. Providers and nurses must strictly adhere to hospital policies, which usually encompass federal and state regulations.

What is Considered a Restraint?

- Physical Restraint: Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move their arms, legs, body, or head freely. (Examples: limb holders, vests, mitts if tied down, geri-chairs if patient cannot easily remove tray, side rails if all 4 are upbile solely to prevent voluntary exit from bed, holding a patient down).
- Chemical Restraint: A medication used to manage behavior that is not the standard treatment or dosage for the patient's medical or psychiatric condition.
- Seclusion: Involuntary confinement of a patient alone in a room where they are physically prevented from leaving. Seclusion is generally only used for violent or self-destructive behavior.

What is NOT a Restraint?

- Devices used for standard medical/surgical procedures (orthopedic devices, surgical dressings, intravenous arm boards).
- Methods to protect a patient from falling out of bed (e.g., raising some side rails based on assessment).
- Brief physical holding for routine examination or tests, such as supporting a patient on his side during a lumbar puncture.
- Protective helmets.
- Handcuffs applied by law enforcement for custody reasons (these are not considered healthcare restraints).

Indications for Restraint Use

Restraints require a clear link between the patient's behavior and risk of harm. There are two main categories based on patient behavior. **Non-Violent, Non-Self-Destructive Behavior** (“Medical/Surgical” restraints) are used to prevent disruption of necessary treatments. **Violent or Self-Destructive Behavior** ("Behavioral" Restraints) are used in emergency situations to ensure patient and staff safety. Indications and examples are outlined below.

	Non-Violent, Non-Self-Destructive Behavior	Violent or Self-Destructive Behavior
Indications	To prevent behavior that interferes with medical treatment or healing, often due to confusion, agitation, or disorientation related to a medical condition.	To manage behavior that poses an immediate risk of physical harm to the patient, staff, or others.
Behavioral Examples	Preventing a confused patient from pulling out IV lines, catheters, feeding tubes, or dressings; preventing injury in a disoriented patient trying to get out of bed unsafely after other measures failed.	Physically aggressive acts (hitting, kicking), attempts to harm self (head banging), credible threats of imminent violence.
Types of Restraints	**Soft Limb Holders:** Fabric or soft material cuffs for wrists or ankles, secured with Velcro or ties to the bed frame (not side rails). Used to limit movement and prevent pulling at IV lines, catheters, drains, or endotracheal tubes. **Secured Mitts:** Mittens placed over the hands *and secured* (e.g., with ties to the bed frame or integrated straps) to prevent patients from using their fingers to grasp tubes or scratch skin. Note: Unsecured mitts are typically not considered restraints. **Roll Belt / Safety Belt:** A belt placed around the patient's waist or hips, secured to a bed or chair, to prevent them from falling or climbing out when assessed to be unsafe to do so (e.g., due to confusion, impulsivity related to medical condition). **All 4 Side Rails Raised:** Considered a restraint *only* when all four rails are used with the specific intention of preventing the patient from *voluntarily* getting out of bed. Requires careful assessment and justification, as it can increase fall risk if the patient attempts to climb over. **Enclosure Beds (e.g., Vail Bed, Posey Bed):** Beds with soft mesh netting zipped around the patient. Depending on hospital policy, these may be	**Manual/Physical Hold:** Staff physically holding a patient to restrict their movement during an acute behavioral crisis. This is considered a restraint and is subject to time limits, assessment, and documentation requirements. It's often temporary while other interventions (medication, mechanical restraints) are prepared. **Soft Limb Holders (often 4-point):** Applying soft restraints to both wrists and both ankles, secured to the bed frame, to manage severe physical aggression or self-injury. **Hard/Locked Limb Restraints (Less Common):** Leather or locking plastic restraints. Typically used only in specialized settings (e.g., psychiatric units, intensive care units, forensic units) for extreme aggression where soft restraints are ineffective or compromised. **Seclusion:** Placing the patient involuntarily alone in a locked room specifically designed for safety (e.g., minimal furnishings, observation window). This is only used for managing violent/self-destructive behavior and requires intensive monitoring. **Chemical Restraint:** Administering medication (e.g., sedatives, antipsychotics) primarily to control

	considered restraints but are often viewed as less restrictive than limb restraints for certain patients (e.g., highly agitated, mobile, risk of falling). **Geri-Chair with Locked Tray Table:** A chair where the tray table locks in place and prevents the patient from rising, if the patient cannot easily remove it themselves.	severe agitation or aggression and restrict movement, when the medication/dosage is not part of the patient's standard treatment plan for an underlying condition. This requires a specific order, clear indication, and careful monitoring.

Regulations and Order Requirements (Federal CMS Standards)

- **Alternatives First:** Always attempt and document less restrictive alternatives before applying restraints (e.g., verbal redirection, reducing stimuli, distraction, pain/needs assessment, sitter, bed/chair alarms, moving patient closer to nurses' station, covering intravenous lines with gauze wrap).
- **Physician/LIP Order:** Restraints must be ordered by a physician or Licensed Independent Practitioner (LIP) authorized by hospital policy and state law.
    - Orders must specify the reason, type of restraint, duration, and behavioral criteria for discontinuation (if applicable).
    - NO PRN or "as needed" orders.
    - NO Standing Orders.
- **Time Limits (Violent/Self-Destructive Behavior):** Orders must be time-limited and renewed based on reassessment. CMS maximum initial durations (unless state law is stricter):
    - Adults (18 years and older): 4 hours
    - Children/Adolescents (9-17 years old): 2 hours
    - Children (less than 9 years old): 1 hour
    - Orders can be renewed for up to a total of 24 hours with appropriate reassessments.
- **Time Limits (Non-Violent/Non-Self-Destructive):** Order duration and renewal are determined by hospital policy and state law, often every 24 hours, requiring a new order and in-person provider assessment.
- **Face-to-Face Assessment (Violent/Self-Destructive):** Within 1 hour of initiating restraints/seclusion for violent/self-destructive behavior, a physician, LIP, or trained RN/PA (as permitted by hospital policy/state law) must perform an in-person, face-to-face assessment of the patient. If done by an RN/PA, the ordering physician/LIP must be consulted ASAP.

- **Discontinuation:** Remove restraints/seclusion at the earliest possible time when behavior no longer justifies their use, regardless of the order duration.
- **Training:** Staff involved in applying or monitoring restraints must be trained and demonstrate competency in safe application, monitoring, and managing behavioral emergencies.

Nursing Assessment & Monitoring

- **Frequency:** Frequent monitoring is crucial, and the nurse must follow hospital policy. Common practice:
    - *Violent/Self-Destructive:* Continuous or very frequent (e.g., every 15 minutes) checks.
    - *Non-Violent/Non-Self-Destructive:* Regular checks (e.g., every 1-2 hours).
- **Assessment Focus:**
    - Safety: Ensure restraints are applied correctly, not too tight/loose, using quick-release knots tied to the bed frame (not rails). Assess for potential airway obstruction.
    - Circulation: Check distal pulses, skin color, temperature, and sensation.
    - Skin Integrity: Assess skin under and around the restraint for redness or breakdown. Provide skin care.
    - Physical/Comfort Needs: Offer fluids, nutrition, toileting opportunities, range-of-motion exercises, and repositioning regularly (typically at least every 2 hours).
    - Psychological Status: Assess comfort, anxiety, and agitation levels. Reorient as needed.
    - Continued Need: Continuously evaluate if restraints are still necessary based on patient behavior. Assess readiness for discontinuation.

Documentation Requirements

Thorough documentation is essential and legally required. Use facility-specific flowsheets/EMR sections. Include the following:

- Reason for Restraint: Specific patient behaviors necessitating restraint.
- Alternatives Attempted: Document what less restrictive measures were tried and why they were ineffective.
- Order: Physician/LIP notified, date/time of order obtained, type of restraint ordered, duration.
- Time: Exact time restraint initiated and discontinued.
- Type: Specific restraint device(s) used.
- Assessments: Document all patient assessments (circulation, skin, vital signs, behavior, comfort, needs assessment) at the frequency required by policy.

- Interventions: Care provided (fluids, food, toileting, range of motion exercises, repositioning, hygiene).
- Patient Response: How the patient tolerated/responded to the restraint.
- Communication: Notification of family (if applicable/per policy).
- Evaluation for Release: Assessment of behavioral criteria indicating readiness for discontinuation.

In Summary:

Patient safety and rights are paramount. Restraints can cause significant psychological and physical distress and are used only as a last resort. Always attempt and document less restrictive options first. Use restraints only for immediate safety, linked to specific behaviors. Ensure a valid, time-limited order is in place (NO PRN/Standing orders). Monitor frequently per policy (circulation, skin, needs, behavior). Document thoroughly, noting patient behavior, assessments, interventions, and evaluation. Discontinue restraints as soon as it is safe. Adhere strictly to your hospital's specific procedures, which encompass federal and state regulations.

References

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