Continuous Observation as an Alternative to Physical Restraints for the Elderly

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To the Faculty of Washington State University:

The members of the Committee appointed to examine the clinical research project for VICTORIA J. HAYS find it satisfactory and recommend that it be accepted.

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Elderly patients aged 65 years or older are eight times more likely to be physically restrained during hospitalization than younger patients in the acute care setting. The use of physical restraints among this population is almost 22%. If the patient is deemed to be confused or at-risk for falling, this percentage may reach as high as 50%. For the purpose of this paper, the acute care setting is defined as adult medical and surgical units within hospital facilities.

Physical restraints are defined as any method of involuntarily restricting a person's freedom of movement. Examples of common physical restraints used in the hospital setting include soft wrist, ankle, mitts, and posey restraints. Although patient safety is often the primary reason cited for applying physical restraints, research and clinical nursing experience have shown that often times, more harm than good has occurred as a result of applying physical restraints to elderly patients.

Patients have been found hanging over the side rails, strangled by asphyxiation, as a result of trying to remove the restraints. Other complications that have also occurred with increased incidence when patients are restrained include worsening cognitive impairment, urinary incontinence, pressure ulcers, and nosocomial infections. In addition, patient falls from a bed or chair while restrained have resulted in hip, wrist, and pelvic fractures that may take months to heal. Other issues that patients must also endure related to injuries as a result of being physically restrained include pain, suffering and the rehabilitation process. Lastly, research has shown that for some elderly patients, it may take years to overcome the emotional and psychological injury from a fall.

As a practicing clinical nurse who has recently worked in the acute care setting, I believe the need for physical restraints should only be employed as a temporary, emergency measure. An alternative to using physical restraints, especially with the elderly, is constant observation. The
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The purpose of this paper is to describe the benefits, program development, expected outcomes, and process for evaluation of continuous observation in the hospital setting. Using trained individuals and staff to provide this program will potentially increase patient safety and restore the dignity and respect that should be granted to each patient in all medical facilities.

**Regulatory Physical Restraint Guidelines**

With the emphasis on patient privacy and patient rights, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Health Care Financing Administration created guidelines in 1996 designed to reduce and possibly eliminate restraint use. Further, JCAHO is encouraging all medical facilities to actively pursue viable alternatives for patient safety and use restraints only as an emergency intervention accompanied by close monitoring of the patient. There are occasions when physical restraints may be necessary for a short time. For example, a psychotic patient who arrives in the emergency department and displays harmful behaviors to themselves as well as to the staff may require restraints. However, when absolutely necessary, physical restraints remain only a temporary measure until patient behaviors are redirected and under control.

Effective July 1, 2001, JCAHO has required healthcare organizations to focus their attention on performance improvement activities, such as data collection of all restraint episodes. Research has shown that 22 - 57% of restraint use documentation was incomplete in the patient chart. This author conducted a six-month chart audit in 2003 for a hospital in southeastern Washington state. Results indicated that 83% of restraint use documentation was incomplete relating to rationale, close monitoring of the patient, and appropriate use of interventions. This lack of documentation raises several questions relating to the use of physical restraints. Was
there close monitoring of the patient to ensure safety? Were alternatives attempted and deemed unsuccessful, prior to initiating physical restraints?

The American Nurses Association in 1997 also endorsed a restraint-free approach and encourages health care providers to use alternative interventions rather than restraining patients. Other professional organizations, such as the American Geriatric Society and the American Psychiatric Association have also endorsed restraint-free guidelines.

All individuals are guaranteed certain legal rights under the United States (U.S.) Constitution. These same rights apply in the healthcare setting regardless of ethnicity, gender, age, religion, marital status, veteran or disability status. Scholars within the legal profession believe there is an increased risk of injury to restrained patients in nursing homes and other healthcare settings. The fear of litigation is on the minds of every healthcare professional and administrator if a restrained or unrestrained patient becomes injured in a medical facility.

Successful legal suits brought against hospitals are the result of the facility’s failure to protect the patient from harm. Hospitals are not alone in these lawsuits. Nurses and physicians are also being named for failing to identify adverse patient behaviors, and provide appropriate interventions and close monitoring of the patient.

Ethical considerations are equally as important as legal issues. In the U.S., society values the autonomy and independence of each individual; using physical restraints seems to contradict this belief system. As clinicians, it is our duty to provide beneficence to every patient. However, using physical restraints poses an ethical dilemma perpetuating a loss of autonomy. The use of physical restraints compromises patient dignity, diminishes respect, and should not be the standard of care.
Factors Influencing the Use of Physical Restraints

In the U.S., half a million hospital and nursing home patients are placed in restraints each day. This issue continues to be a concern for healthcare organizations as well as the nurses caring for these patients. Many factors contribute to the use of patient restraints. Some of these variables include issues related to nursing staff, hospital administration and the facility environment. To help ensure patient safety, the healthcare team must be creative in the approach to patient care issues while reducing physical restraint use.

The top five reasons nurses give for the use of physical restraints are to prevent a disruption of treatment, confusion, fall prevention, protection from injury secondary to wandering, and behavior management. As nurses, we must ask ourselves, why is the patient displaying these behaviors? These behaviors may be related to sleep disturbances, poor nutrition, pain, immobility, incontinence and medication interactions. Nurses must remember that confusion, at any age, is not normal and needs further assessment to determine its basis.

As many as 30% of all hospitalized elderly patients exhibit acute confusion that can manifest itself as agitation, hyperactivity and irritability. These behaviors often pose a management challenge for the nursing staff. Confusion is frequently undiagnosed or inappropriately treated in many facilities. Although most restraint protocols have some list of initial alternatives, it is all too easy for the nursing staff to simply check-off the appropriate boxes and begin restraining the patient.

Confusion in elderly patients has resulted in increased medical complications, higher mortality rates, longer hospital stays and greater financial cost. Many medical facilities are struggling to stay afloat financially with a reduction in federal reimbursements as well as absorbing the costs for individuals who are unable to afford basic health insurance. The care
associated with one confused patient can potentially result in a loss of $30,000 for the facility. In addition, by eliminating just one hospital day for every confused person, the cost savings to Medicare could potentially be $2 billion annually.

Unfortunately, confusion, dementia or other memory problems exhibited by elderly patients may be deemed as “negative” or “noncompliant” behaviors by the nursing staff. In one study, patients who were viewed as pleasant were less likely to be restrained than those viewed as unpleasant. Nurses must determine the underlying cause of the behavior to ensure patient safety, and assure dignity and respect for each client.

Nursing staffing levels can certainly affect the decision to use restraints. More than 40% of the nurses working in hospitals have been found to be dissatisfied with their jobs due to high acuity levels and heavy patient loads. Faced with rising costs, medical facilities are attempting to reduce expenditures by employing a smaller number of registered nurses (RN) and supplementing with additional licensed practical nurses (LPN), nursing assistants and unlicensed personnel. Unfortunately, an LPN or nursing assistant does not possess the necessary critical thinking skills, clinical judgment and patient evaluation skills that are possessed by an RN. According to one study, a higher percentage of nursing care hours provided by RNs resulted in lower levels of perceived patient pain, higher levels of patient self-care, and patient satisfaction. Healthcare organizations need to make the commitment to hire adequate numbers of RNs to staff their facilities to help ensure patient safety on all clinical units.

Hospital administration often dictates the philosophy and values represented by the organization. What is viewed as important by management may not be viewed in the same way by staff. Employees have cited a link between the organizational values and restraint use. Organizations that have placed a priority on alternative interventions to restraints and encouraged
staff input have been less likely to use physical restraints. In addition, employees believe it is important for management to lead by example and encourage participation by all staff in the decision making process related to patient care issues. To create a well-organized, patient-centered nursing unit, it is crucial for administration, management, and staff to share the same philosophy, attitudes and values.

Nationally, patients older than 65 years of age account for 47% of inpatient days within medical facilities. As a result, facility environments must become more “user friendly” to this patient population to promote safety. In the past, hospitals were considered impersonal, sterile environments and the only color seen was white corridors and white patient rooms. Hospitals are now using a variety of colors to decorate the interior of the facility as well as patient rooms.

Healthcare facilities also need to incorporate safety measures for older individuals who are adjusting to the aging process affecting eyesight, balance, dexterity and memory. For example, patient rooms can display signs with large lettering to help identify the name of the facility, room number, location of the bathroom, closet, staff names, and how to use the telephone. Non-skid flooring and handrails along all corridors throughout the hospital can help prevent patient and visitor injuries.

The trend for hospitals to provide private rooms for all patients has been a recent development, as new facilities are being built and current facilities are being redesigned. However, admitting an elderly person to a private room may not be in their best interest, especially, if the patient currently resides in a long term care facility, family home or assisted living environment. These patients are used to being surrounded by people and if they are abruptly isolated in a private room, they may begin to display adverse behaviors, such as disorientation or confusion. Thereby, increasing their risk for falls and the likelihood of being
placed in physical restraints. An alternative would be to include a certain number of semi-private rooms on clinical units most frequented by the elderly population. As a result, the patient would not be alone for long periods of time and their roommate could serve as an additional set of eyes to monitor the patient.

**The Alternative: Continuous Observation by Trained Individuals**

For many years, continuous observation has occurred mainly in psychiatric units and nursing homes due to the patients being at-risk for harming themselves. On medical and surgical units, elderly patients may exhibit some of these same behaviors and instead of restraining the patient, a more proactive and humane approach would be continuous observation by trained individuals. Although minority of hospitals are using this approach, this alternative is a viable option.

In a study of 102 hospitals representing 37 states and the District of Columbia, use of continuous observation was reported to have helped ensure patient safety and decrease the number of patient injuries. After implementing this program, several of the hospitals reported significant decreases in expenditures related to cost-saving interventions. Some of these interventions include staff education, the use of family members and/or volunteers to provide continuous observation.

Family members often want to participate in the care of their loved one who is in the hospital and many times, the patient is more comfortable with a family member caring for them and assisting them with activities of daily living (ADL). As members of the healthcare team, families should have a sense of empowerment and a feeling of participation and contribution. When patients begin to display behaviors that are atypical for them, nursing experience has shown that family members would rather provide continuous observation than see their loved
trained volunteer. The volunteer provides an extra set of eyes to monitor the patient and alert the nurse, when necessary, to adverse behaviors.

Research indicates that individuals who volunteer their assistance for an organization may actually improve their own physical and psychological well-being. Additionally, older volunteers experienced a 44% lower mortality rate over a 5-year period of time than those individuals who did not volunteer. As the future of our healthcare system seems uncertain with the continuous increase in costs and a shortage of nursing staff, utilizing hospital volunteers may be one answer to help meet some of the needs related to patient safety while promoting the health of the volunteer.

When family members or volunteers are unable to provide continuous observation for a patient, the hospital may choose to use a certified nursing assistant (CNA). The CNA would be able to not only sit with the patient but also assist the patient with ADLs and other basic nursing care. The optimal choice would be to use family members or volunteers, however a CNA is also an option and less costly than using a LPN or RN for the same task.

**Developing a Continuous Observation Program**

Staff education plays a critical role in the reduction of physical restraints because it is the nurse who decides to use restraints in 75% of the cases. Eighty-four percent of hospital nurses recently surveyed reported that their most recent confused patient was restrained based upon the recommendation of another nurse. One restraint education program reported in the literature was taught by a gerontological nurse specialist to a group of staff nurses. It was designed to provide teaching strategies and problem solving techniques for use with the elderly patient. As a result, significant changes were made in the nurses’ perceptions about restraint use, and many nurses were inclined to use alternative options. Individualized care plans, thorough nursing
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one physically restrained. If the behavior problem is identified and resolved, continuous observation is no longer needed.

Often times, the problem is not resolved quickly, or the patient may not have any family members living in the same city or state who can provide continuous observation. To address this issue, hospital volunteers can be utilized as a resource. On average, hospital volunteer groups consist of 100 – 500 individuals who commit to at least 4 hours a week of service. Volunteers have the option to work during the day, evening or night. Some clinical departments utilize volunteers from 6:00 a.m. to 8:00 p.m., and other units, such as the emergency department, may utilize volunteers 24 hours a day. Nationally, almost 50% of Americans participate in volunteer work for a variety of organizations.

Volunteers within the hospital setting may belong to the auxiliary, guild, or volunteer pool. A hospital volunteer is required to complete a formal application and sign a confidentiality statement in accordance with the Health Insurance Portability and Accountability Act guidelines. In addition, each volunteer must complete a criminal background check and an informal interview with a hospital staff member. Due to liability issues, volunteers are not trained or allowed to assist patients with ADLs. However, volunteers can sit with the patient, socialize, read to the patient and with permission, hold the patient’s hand.

Physical restraints in the medical and surgical units are used primarily because the patient is confused and their behavior needs to be frequently redirected or the patient needs to be frequently re-oriented to place and time. Restraints are also used in this setting to prevent patients from pulling on necessary tubes (IV, NG or foley catheter) or dressings covering an incision. Additionally, restraints are used to prevent patients from ambulating without assistance or wandering in the halls. All of these reasons to initiate restraints can be replaced by using a
assessments, and updated restraint policies can help ensure a reduction of patient restraint episodes and a safe environment. On one orthopedic unit, restraint usage decreased 63% in the first six months after the updating of the restraint policy and staff education.

Policy changes, clinical practice guidelines, alternative interventions, and new skill competencies were reported as a result of the collaborative efforts made by individuals serving on one restraint policy committee. This committee used an interdisciplinary team approach that included nursing staff, physicians, a social worker, an occupational therapist, a dietician, and a member of the nursing management team. Using this approach, hospital staff took ownership in the program and as a result, the odds of success dramatically increased.

Continuous observation would enable the nursing staff to provide safe patient care in a manner that promotes patient dignity and respect. The RN would need to make a telephone call to the volunteer coordinator to request this service, which would be already pre-arranged on a schedule for the unit. If continuous observation was needed during the evening or night shift, the RN would notify the patient care coordinator who would access the pre-arranged schedule of volunteers.

In addition to staff education, the pool of hospital volunteers would also need to be educated in order to carry out such a program. Hospitals generally provide a two-hour orientation program for all volunteers when they initially begin. In addition, a four-hour orientation program is generally required for volunteers who choose to work in patient care areas. The orientation program specific to these areas would need to add an additional education segment relating to a continuous observation program.

This program for volunteers would include the reason for this type of patient observation, benefits for the patient, and basic information relating to the aging process. A staff nurse or
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clinical nurse educator who normally orientates the volunteers to the unit would also teach the education segment relating to the continuous observation program. The additional time it would require to educate the volunteers about this program would be minimal and the benefit to the patient and hospital would be tremendous.

Many hospitals have existing volunteer pools to provide a continuous observation program, however some facilities may need to recruit volunteers, especially to provide this service at night. Recruitment methods may include directly appealing to local volunteer organizations, newspaper advertisements, employment listings, and the creation of a flyer to be displayed at community businesses and public areas. In addition, appealing to community colleges and universities with service organizations or healthcare departments may provide additional volunteers. Many students study late at night and may be willing to do this in a hospital room versus at home. Some schools require volunteerism as a part of a service learning program.

In return for volunteering, the hospital usually provides a free meal from the cafeteria as well as a free yearly tuberculin test and flu shot. In addition, the hospital provides yearly recognition activities and educational opportunities for the volunteers. Volunteers are a viable workforce truly interested in helping patients. The use of trained volunteers would not only prevent the unnecessary use of restraints, but would also be an economically viable option for hospital administrators.

**Expected Outcomes**

By reducing the use of physical restraints, patients would feel a greater sense of security. This security is based upon the healthcare organization’s ability to provide considerate, and respectful care to each person. The implications for patient satisfaction and the support of
human dignity are staggering. As a result, patient outcomes, based upon the reduction of using physical restraints, would be much more positive.

The implications of constant observation are equally positive for clinical staff. As a nurse assigned to a confused elderly patient, the day can be very stressful. Imagine the comfort and peace of mind the nurse would experience knowing that the confused patient is receiving constant observation and there is no longer the potential of patient injury. This is of critical importance in terms of providing staff with assistance in assuring patient safety and thus, reducing staff concerns regarding their ability to provide safe care on busy clinical units.

Continuous observation of a confused elderly patient would increase the family’s sense of trust in the facility and staff caring for their loved one. Knowing that the staff cares enough to schedule continuous observation for their loved one would definitely increase their satisfaction and willingness to help in this endeavor.

Lastly, this program could add value to the healthcare organization. Staff, patient, and family satisfaction could increase as a result of the program. Their satisfaction would have many benefits for the facility. Further compliance with accreditation and regulatory organizations’ standards of care and reducing risk management issues would also be a positive benefit from this program. Costs associated with the implementation and maintenance of this program, primarily using family members and volunteers, would be minimal for the organization. Even use of CNAs for brief periods of time is worth the cost when compared to the potential financial harm and loss of reputation arising from restraint use.

**Process for Evaluation**

Evaluation of effectiveness of the continuous observation program could be conducted in four ways. First, the number of restraint episodes could be tracked each month before and after
initiating the new program. Second, the number of annual patient injuries prior to initiating the
new program could be compared to that following implementation of the new program. Third,
patient, family, and nursing staff satisfaction surveys could be conducted prior to and after
implementation, with specific questions related to patient care, safety, and the continuous
observation program. Initially, these surveys might be conducted as frequently as 3-month
intervals to identify any changes needed in the program. Lastly, a quarterly support group could
be available for all volunteers who participate in this program to solicit feedback and provide a
forum to share ideas and experiences. These forums could be led by a clinical nurse or by the
volunteer coordinator.

Summary

The goal for all nurses is to provide excellent, safe patient care, and to serve as advocates
for all patient populations. This task may be difficult when the behaviors of elderly patients
challenge the ability of the nursing staff to carry out their care. Physical restraints in the clinical
setting, especially with the elderly population, should only be employed during an emergency
and only used temporarily. As our society continues to age, the health and well being of each
individual needs to be protected and cared for by a team of professional clinicians. The success
of our healthcare future depends, in part, upon the creation of appropriate programs to improve
patient safety and become a restraint-free society.
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