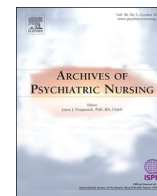




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Is it safe? The restraint chair compared to traditional methods of restraint: A three hospital study

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INTRODUCTION

The use of seclusion and restraint in inpatient psychiatric care has been the subject of ethical debate for decades, prompting the movement toward reduction of the practices. Risks inherent to seclusion and restraint, including negative physical and psychological effects for both patients and staff, have been extensively studied (Kontio et al., 2010). Historically, restraint has included physical holds and four-point mechanical restraint while seclusion is defined as isolation in a locked quiet room. Despite the success of reduction programs, situations continue to occur in which seclusion or restraint is initiated as an intervention to maintain the safety of staff and patients when imminent danger exists (Moylan and Cullinan, 2011). The ethical dilemma faced by nurses who must maintain safety while reducing the risk of injury and trauma has prompted the implementation of the restraint chair as a safe, patient-centered alternative to seclusion and four-point mechanical restraints.

BACKGROUND

Recent literature on seclusion and restraint primarily focuses on the effects of these events on both patients and staff. Additionally, there has been a call to eliminate or reduce the practice. While there have been successes in restraint and seclusion elimination in some areas, the prevalence of violence in forensic and intensive treatment psychiatric care facilities necessitates the continued use of these practices when all less restrictive interventions have proven unsuccessful (Duxbury, 2015). In these areas, the focus has shifted to the reduction of restraint or seclusion. The elimination of the practices as a consequence of behavior remains the goal while allowing for the use of restraint or seclusion in situations of imminent danger (Maguire, Young, and Martin, 2012).

Restraint and seclusion techniques traditionally include supine restraint on a bed in four-point mechanical restraints, physical holds (vertically, supine or prone) to secure patients or to administer medication, and seclusion in the form of isolation in a locked room. Often, a prone hold is used to secure the patient prior to four-point mechanical restraint or seclusion and has been associated with less staff injury due to the position of the patient (Hollins, 2010; Sloane et al., 2014). In forensic and intensive treatment units, patients may be admitted against their will, have histories of violence, and may possess antisocial behavior and have limited skills to manage aggressive outbursts (Maguire et al., 2012). In these situations, violence may occur before a therapeutic relationship with the patient can be established, requiring restraint or seclusion to reduce the risk of injury (Maguire et al., 2012). Calegaro et al. (2014) recognize the increase in aggressive behavior in the first 24 h of admission and attribute the increase to severe hallucinations and delusions, which can drive chaotic physical aggression.

PHYSICAL INJURY

The prevalence of violence in patients on forensic and intensive treatment psychiatric units is reflected in the high rates of injury among psychiatric nurses (Lanza, Rierdan, and Zeiss, 2006). A study by Moylan and Cullinan (2011) showed that in a sample of 110 nurses, 80% of the nurses had been assaulted by unrestrained patients, with harm ranging from eye injuries to permanent disability. Unfortunately, restraint and seclusion have the potential to endanger the patient as well. As a result of seclusion or restraints, patients have sustained injuries ranging from minor bruising to muscle atrophy and, in some cases, death (Berzlanovich, Schopfer, and Keil, 2012). A study of Pennsylvania's forensic service centers over a ten-year period showed 13% of the containment events resulted in patient injuries such as bruising or abrasions while 0.8% resulted in patients receiving lacerations that

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required sutures (Smith et al., 2015). Injuries from restraint and seclusion have been tied to improper monitoring of the patient, strap placement in four-point mechanical restraints, and positional asphyxiation (Berzlanovich et al., 2012; Lancaster, Whittington, Lane, Riley, and Meehan, 2008).

Patient injury or death due to positional asphyxiation has been a primary focus of restraint safety in recent years since The Hartford Courant reported the high incidents of death due to restraints in 1998 (Altimari and Weiss, 1998). In the 1998 article, Altimari and Weiss pointed to the prone restraint hold as a contributing factor. Positional asphyxia occurs when the body's position prevents adequate breathing and is most often associated with the “face-down” technique of the prone restraint (Hollins, 2010). Obesity is a contributing factor to the risk of positional asphyxiation in prone restraints. Unfortunately, due to the weight gain associated with atypical antipsychotic medications, this contributing factor is a serious concern for psychiatric patients (Hollins, 2010). With the elimination of the prone restraint practice, staff injuries have become a significant focus as evidence suggests that staff injury is less likely to occur with prone restraints (Lancaster et al., 2008).

PSYCHOLOGICAL INJURY

The adverse psychological effects of seclusion and restraint use are prevalent for both patients and staff. Mohler and Meyer (2014) conducted a literature review of nurses' attitudes regarding physical restraint use in geriatric care. Results indicated nurses' struggle with moral issues around implementing restraints, noting predominantly negative feelings toward their use, yet feeling a need to use them. A review of nurses' attitudes on the use of seclusion indicated they feel it is necessary to manage incidents of violence (Happell and Harrow, 2010). Nurses have mixed feelings about the use of seclusion and restraints, causing them to psychologically struggle with the process.

Psychological effects of seclusion and restraint on the patient are less conflicted than for the staff. A review of the literature on the patient perspective of seclusion found patients' experience to be primarily negative, with a few reporting the seclusion experience was helpful (Van Der Merwe, Muir-Cochrane, Jones, Tziggili, and Bowers, 2013). Strout (2010) conducted a review of the qualitative literature around the patient experience of being physically restrained. Findings indicated four main themes, which were predominantly negative including the feeling of being re-traumatized, negative psychological implications, the sensation of a broken spirit, and a perception the restraint process was unethical (Strout, 2010).

THE RESTRAINT CHAIR

The restraint chair has been identified as an intervention with the potential to benefit both patients and staff with reduced injury rates while improving patient outcomes related to emergency restraint. Introduction of the restraint chair provides patients and staff an alternative to traditional four-point mechanical restraint or seclusion. While four-point mechanical restraint and seclusion continue to be utilized, the availability of the restraint chair offers an additional resource to implement based upon the nurse's assessment of the situation and the needs of the patient, which focuses on maximizing the patient's sense of personal control and dignity in a humane manner.

Currently, there is limited literature regarding the restraint chair, which has been attributed to the fact that it originated as a law enforcement tool, not a medical device (Castillo, Coyne, Chan, Hall, and Vilke, 2015). In law enforcement and corrections, few risks have been directly related to the use of the restraint chair and available medical literature suggests that deaths associated with the use of the restraint chair have occurred for reasons other than the chair itself (Castillo et al., 2015). Proper use of the restraint chair requires constant observation of the patient while in the chair with nursing assessment occurring every 15 min (Connor, 2007). Further recommendations

include periodic range of motion release and full release from the restraint chair every 2 h for comfort measures such as toileting and fluids (Connor, 2007).

The ability to have patients in an upright position provides for ease of control for nursing staff during emergency situations while reducing the risk to patients by not resulting in changes to oxygen saturation of the restrained patient (Castillo et al., 2015). The position of the patient could also contribute to a shorter restraint episode. Gildberg et al. (2015) recognize that restraint episodes are shortened when supporting factors provided by the staff in the form of expectations, validating positive behavior, and developing a therapeutic relationship are present. The sitting position allowed by the restraint chair is thought to facilitate the effectiveness of supportive factors by providing the patient the ability to remain in a comfortable, eye-to-eye position with staff, as opposed to the submissive supine position of four-point mechanical restraint or the isolation of seclusion. The ongoing implementation of de-escalation and calming techniques are important to developing the therapeutic relationship and reducing the risk of further violent behavior (Bilici, Sercan, and Tufan, 2013).

Due to the paucity of literature assessing its safety and effectiveness in clinical settings, the purpose of this research was to determine if the restraint chair resulted in shorter episode durations, fewer patient and staff injuries, and a greater percentage of patients accepting medications by mouth compared to the traditional methods of restraint (four-point mechanical restraint and seclusion).

METHODS

ETHICAL CONSIDERATIONS

Data from all restraint cases between May 1, 2014 and May 1, 2015 was collected from a retrospective chart review of three large psychiatric institutions in the northeastern United States. All protected Health Information (PHI) was removed, subjects were coded with a Case ID to ensure anonymity, and information was entered into a secure database shared by all three institutions. Institutional Review Board (IRB) approval was obtained from each hospital.

DATA COLLECTION

The retrospective chart review included all cases where a patient was restrained by one of the following methods: four-point mechanical restraints, seclusion, or the restraint chair. Episodes where the patient was under the age of 18 and patients who were restrained in order to administer court ordered treatments were excluded from the study. The primary discharge diagnosis was also collected. Primary discharge diagnoses coded for the study included: schizophrenia, schizoaffective disorder, bipolar disorder, psychosis, mood disorder, and major depressive disorder. If patients were discharged with other diagnoses, they were coded under the term “other diagnosis.” Diagnoses included under the category “other diagnosis” were substance use disorders, post-traumatic stress disorder (PTSD), anxiety disorders, and cognitive disorders among others. Additional variables collected on each case included: age of the patient, gender of the patient, episode duration, medication and route of administration during the restraint episode, as well as injuries sustained by the patient or staff members involved in the restraint episode.

The three United States hospitals collaborating on this study were Butler Hospital in Rhode Island, Hartford Hospital's Institute of Living (IOL) in Connecticut, and McLean Hospital in Massachusetts. The restraint chair was introduced in Butler Hospital in 2012, followed by IOL and McLean Hospital in 2013. At Butler Hospital, two Intensive Treatment Units (ITUs), with a combined 46 beds were included in the chart review. These units specialize in treating patients with psychotic disorders, bipolar disorder, and personality disorders for patients between the ages of 18–64. The IOL chart analysis included three adult

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