Actionable Patient Safety Solutions (APSS):
Restraint Safety

How to use this guide

This guide gives actions and resources for restraint safety. In it, you'll find:

Patient Safety
MOVEMENT

Executive Summary

The Problem

Many organizations have a restraint policy in place. However, the extent to which the key component of this policy - appropriate indications to override patient rights - is executed is often variable and as such, poses a major risk to patient safety and hospital reputation. Many organizations lack a standardized protocol for restraint placement, assessment, and discontinuation. Because physical restraint use has increased from 6% to 17% globally in recent years (Steinert et al., 2009), and because employment of restraints varies significantly by country, customs, and views of mental health, it is crucial to establish a universal protocol to protect patient rights and ensure safety for all (Ye et al., 2017).

The Cost

A 91% reduction in restraint use has been shown to mirror a 92% reduction in cost associated (LeBel & Goldstein, 2005), due to the 23% share of staff time claimed directly by restraint use alone (LeBel & Goldstein, 2005). Decreased restraint use is also associated with less medication, fewer injuries, shorter length of stay, reduced workers' compensation, less sick time used, and fewer staff and patient injuries.

The Solution

Many healthcare organizations have successfully implemented and sustained improvements and reduced death from restraint misuse. These organizations have focused on projects that included **implementing a universal restraint safety protocol, including significant emphasis on vetting all possible alternatives before opting for mechanical or pharmaceutical restraint use.**

This document provides a blueprint that outlines the actionable steps organizations should take to successfully improve restraint safety and summarizes the available evidence-based practice protocols. This document is revised annually and is always available free of charge on our website. Hospitals who make a formal commitment to improve restraint safety and share their successes on the PSMF website have access to an additional level of consulting services.

Leadership Checklist

On a monthly basis, or more frequently if a problem exists, the executive team should review the outcomes of patients at risk for or using restraints. Use this checklist as a guide to determine whether current evidence-based guidelines are being followed in your organization:

- ☐ Assess and monitor every instance of restraint.
- ☐ If restraint rates indicate room for improvement (hours of restraint use ordered per 1000 patient days), initiate a PI (performance improvement) project. If a problem is not indicated, routinely reassess to identify gaps, and ensure integrity of the data collected.
- ☐ Implement actions to ensure that restraint or seclusion is used only to ensure the physical safety of the patient, staff, and others.
- ☐ Ensure frontline involvement in restraint safety improvement activities. Maintain their engagement and remove barriers to progress.
- ☐ If a PI plan is put in place, measure the associated process outcomes.
- ☐ Ensure that restraint protocols are embedded into clinical workflows, whether electronic or paper.
- ☐ Ensure there are enough staff to effectively manage necessary preventive care.
- ☐ Ensure adequate training and documentation of restraint use competencies and skills.
- ☐ Eliminate barriers to making rapid changes to documentation templates and order sets.
- ☐ Debrief on a regular basis to solicit team feedback about barriers to sustained compliance. Adjust the plan quickly and nimbly as needed.
- ☐ Hold staff accountable for providing the standard of care and reward success.
- ☐ Ensure that leaders have a simple process to oversee restraint and use improvement work while also considering how it aligns with other initiatives across the organization.
- ☐ Review hospital protocols to ensure the information is included regarding:
  - Who has authority to apply restraints and what responsibilities these individuals have when restraints are ordered.
  - Under what circumstances these restraints are and are not appropriate.
  - Definition of what is considered a restraint.
  - Definition of what constitutes the use of drugs/medications as restraints.
- ☐ Ensure appropriate medical record documentation if a patient is placed on restraints, with a thorough defense of necessity.
- ☐ Develop an assessment system that identifies signs that may be indicative of escalating behavior.
- ☐ Ensure organizational policy reflects practice, including documentation expectations in EHR, and regulatory policy. Ensure organizational policy and practice are updated with changes to regulatory policy.
- ☐ Evaluate staffing levels to ensure adequacy when trying alternatives to restraints and to ensure quality monitoring when a patient is placed on restraints.

Clinical Workflow Infographic

ADMISSION

- Assess for risk of harm to self or others. Ensure the assessment is age specific and clinically and culturally appropriate (Amrose, 2003).
- Assess restraint risk factors, such as pregnancy, asthma, head/spinal injury, fracture and surgical history, seizure disorders, and abuse.
- Assess previous use of restraints in prior healthcare organizations.

ROUTINE CARE

- Consider if a patient is a danger to themselves or others and if all other alternatives have been tried and failed before determining need for restraint (See "Alternatives for Restraint Use" in the "What We Know" section)
- Continually reassess risk of harm to self or others.
- Identify and initiate alternative methods to restraints (See "Alternatives for Restraint Use" in the "What We Know" section)/

IF RESTRAINTS ARE DEEMED APPROPRIATE:

- Confirm physician order. **Orders should never be written as a standing order or on an as needed basis** (CMS, 2008).
- Document what was tried before the restraint was ordered and why these previous trials were unsuccessful. The use of restraints constitutes a change in the patient's plan of care and should be documented appropriately.
- Determine if the patient requires violent or non-violent restraint and evaluate restraint options. (See "Restraint Options and Making the Right Choice" in the "What We Know" section).
- The fact that the patient is demonstrating violent behavior warrants closer observation and the increased frequency of assessment and observation is independent of the restraint type.
- Continually assess skin integrity in and around the placement of the restraints.

VIOLENT RESTRAINT WORKFLOW

- Reevaluate every 15 minutes.
- Adhere to maximum of four hours of restraint use for adults 18 and older, a maximum of two hours for 9-17 year olds, and a maximum of one hour for those under the age of nine (UPMC, 2020).
- At the end of the four hours, if continued use of restraint is deemed necessary, a new order must be obtained.
- Document verification of restraint order, new plan of care, faculty notification, patient reassessments, restraint type, justification, monitoring results, staff concerns, risks, patient injuries, and application participants.

NON-VIOLENT RESTRAINT WORKFLOW

- Reevaluate every two hours.
- A physician's written order is valid within 24 hours of the restraint episode.
- Document verification of restraint order, new plan of care, patient reassessments, restraint used, justification, monitoring results, concerns, risks, and patient injuries.

DISCONTINUATION

- Assess and monitor the patient on an ongoing basis to evaluate if and when the restraints can be removed. Restraint interventions should end as soon as clinically-deemed possible and therefore, the patient should be frequently monitored throughout the day.
- Discontinuation should be based on the confirmation that the patient is no longer a threat to themselves or others.
- Trial release is not acceptable. Once restraints are removed and discontinued, a new order must be obtained if restraints are to be reapplied.
- Hospitals must report deaths to CMS that are associated with restraints when the patient is in restraints upon death, if the patient dies 24 hours after restraint removal, and if the patient dies within one week after restraint use when the restraints are suspected to have contributed directly to the patient's death (CMS, 2008).

*Clinical Workflow based on standards from US-based Centers for Medicare and Medicaid (CMS).

Performance Improvement Plan

Follow this checklist if the leadership team has determined that a performance improvement project is necessary:

☐ **Gather the right project team.** Be sure to involve the right people on the team. You'll want two teams: an oversight team that is broad in scope, has 10-15 members, and includes the executive sponsor to validate outcomes, remove barriers, and facilitate spread. The actual project team consists of 5-7 representatives who are most impacted by the process. Whether a discipline should be on the advisory team or the project team depends upon the needs of the organization. Patients and family members should be involved in all improvement projects, as there are many ways they can contribute to safer care.

Complete this Lean Improvement Activity: **Conduct a SIPOC analysis to understand current state and scope of the problem. A SIPOC is a lean improvement tool that helps leaders to carefully consider everyone who may be touched by a process, and therefore, should have input on future process design.**

RECOMMENDED RESTRAINT SAFETY IMPROVEMENT TEAM	
• Admitting and registration staff	• Social workers
• Quality and safety specialists	• Case managers
• Behavioral health specialists	• Rapid Response Team members
• Physicians	• Security team members
• Psychologists/psychiatrists	• Nurses

Table 1: Understanding the necessary disciplines for a restraint safety improvement team

☐ **Understand what is currently happening and why.** Reviewing objective data and trends is a good place to start to understand the current state, and teams should spend a good amount of time analyzing data (and validating the sources), but the most important action here is to go to the point of care and observe. Even if team members work in the area daily, examining existing processes from every angle is generally an eye-opening experience. The team should ask questions of the frontline during the observations that allow them to understand each step in the process and identify the people, supplies, or other resources are needed to improve patient outcomes.

Create a process map once the workflows are well understood that illustrates each step and the best practice gaps the team has identified (IHI, 2015). Brainstorm with the advisory team to understand why the gaps exist, using whichever root cause analysis tool your organization is accustomed to (IHI, 2019). Review the map with the advisory team and invite the frontline to validate accuracy.

RESTRAINT SAFETY PROCESSES TO CONSIDER ASSESSING	
• Documentation and justification	• Behavioral health interventions
• Evaluation of alternative options	• Bed alarm use
• Falls prevention protocols	• Assessment of physical and emotional needs
• Medication evaluation	

Table 2: Consider assessing these processes to understand where the barriers contributing to poor restraint safety may be in your organization

☐ **Prioritize the gaps to be addressed and develop an action plan.** Consider the cost effectiveness, time, potential outcomes, and realistic possibilities of each gap identified. Determine which are a priority for the organization to focus on. Be sure that the advisory team supports moving forward with the project plan so they can continue to remove barriers. Design an experiment to be trialed in one small area for a short period of time and create an action plan for implementation.

The action plan should include the following:

- Assess the ability of the culture to change and adopt appropriate strategies
- Revise policies and procedures
- Redesign forms and electronic record pages
- Clarify patient and family education sources and content
- Create a plan for changing documentation forms and systems
- Develop the communication plan
- Design the education plan
- Clarify how and when people will be held accountable

TYPICAL GAPS IDENTIFIED IN RESTRAINT SAFETY	
• Lack of individualized patient assessment • Poor documentation or justification • Misunderstanding of reassessment and physician order guidelines • Lack of skin integrity checks	• Failure to identify alternative methods to restraints • Knowledge deficit of de-escalation techniques • Lack of communication with family members and caregivers

Table 3: By identifying the gaps in restraint safety compliance, organizations can tailor their project improvement efforts more effectively

☐ **Evaluate outcomes, celebrate wins, and adjust the plan when necessary.** Measure both process and outcome metrics. Outcome metrics include the rates outlined in the leadership checklist. Process metrics will depend upon the workflow you are trying to improve and are generally expressed in terms of compliance with workflow changes. Compare your outcomes against other related metrics your organization is tracking.

Routinely review all metrics and trends with both the advisory and project teams and discuss what is going well and what is not. Identify barriers to completion of action plans, and adjust the plan if necessary. Once you have the desired outcomes in the trial area, consider spreading to other areas (IHI, 2006).

It is important to be nimble and move quickly to keep team momentum going, and so that people can see the results of their labor. At the same time, don't move so quickly that you don't consider the larger, organizational ramifications of a change in your plan. Be sure to have a good understanding of the other, similar improvement projects that are taking place so that your efforts are not duplicated or inefficient.

Read this paper **from the Institute for Healthcare Improvement to understand how small local steps can integrate into larger, system changes**

RESTRAINT SAFETY COMPARATIVE OUTCOMES	
• Pressure ulcers • Falls and injuries sustained from falls • Aspiration and pneumonia • Mental health outcomes	• Circulation • Muscle strength • Mobility capacity

Table 4: Consider evaluating related metrics to better understand restraint safety and contributing factors

What We Know About Restraint Safety

The use of restraints has been and currently is a topic of debate and contention for healthcare professionals, patients, and family members. Restraint use should be considered as a last resort for managing patients if they are a risk to themselves or others.

A restraint is defined as "Any method, physical or mechanism device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely" (CMS, 2008).

Because restraint use is not without its associated risks, regulatory agencies, such as the Joint Commission and Centers for Medicare and Medicaid Services (CMS) have specified guidelines for use. The Joint Commission requires that a licensed practitioner order restraint or seclusion when ordered for behavioral health or violence-related reasons and mandates an in-person evaluation of the patient (The Joint Commission, 2020). CMS has made it clear in the restraint and seclusion guidelines that "Restraint or seclusion may be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time" (CMS, 2008). As such, it is outlined that **all patients have the right to be free from physical and mental abuse and from restraint or seclusion as a form of discipline or convenience** (CMS, 2008).

Additionally, restraint use must be driven by individual patient assessment. **The use of less restrictive measures should pose a greater risk than the use of restraints or seclusion in order to deem appropriate** (CMS, 2008).

Clinical and Financial Implications

Throughout healthcare as a whole, medical errors cost $29 billion each year (Institute of Medicine [IOM], 2000). Recently, psychiatry has recognized inappropriate seclusion and restraint use as medical errors, which further exacerbates that financial figure. Although difficult to calculate directly, estimates of time, resources, and staff supervision for each restraint episode approximate the cost of one episode to be between $302 and $354, depending upon the number of containment methods employed, whether physical, mechanical, or pharmaceutical (LeBel & Goldstein, 2005). The monitoring time alone required the greatest resources and took up the most staff time (CMS, 2008).

If all runs smoothly, and there are no liability issues, just one hour of restraint use involves 25 different activities, accounting for 12 hours of nursing time dedicated to managing those restraint-associated tasks alone (LeBel & Goldstein, 2005). Overall, restraint use is estimated to claim an average of 23% of nursing time and $1.4 million in staff costs, which equates to 40% of the inpatient operating budget (LeBel & Goldstein, 2005). This estimate is confirmed with other estimates that 50% of nursing resources are used to monitor and manage restraint patients (Flood, Bowers & Parkin, 2008).

Because restraint and seclusion cases are extremely susceptible to legal issues, if a claim is filed for injury sustained due to restraint or seclusion, the penalties can range from thousands to millions in settlement and/or probation of staff members. The common claims include excessive force, medical malpractice, failure to protect, assault and battery, and failure to maintain a safe environment (Stefan, 2002).

By reducing reliance on restraint and seclusion through adoption and reinforcement of universal restraint protocols, organizations can save time, money, resources, and lives without compromising quality of care. See specific examples below:

- Florida State Hospital at Chattahoochee, FL reduced restraint use by 54% and saved nearly $2.9 million from reduced workers' compensation, staff and consumer injuries, and length of-stay costs (SAMHSA, 2010).
- The Massachusetts statewide child/adolescent seclusion and restraint prevention initiative "reduced seclusion and restraint use by 89 percent from Fiscal Year 2001 through 2008 and avoided more than 34,037 restraints—realizing an average of $1.33 million savings per year and more than $10.72 million in cumulative savings since the start of the initiative" (SAMHSA, 2010).
- University of Massachusetts reduced their mechanical restraint use by 98% and saw an 86% decrease in the amount of sick time used by staff members (Commonwealth of Massachusetts, 2020).

Other benefits of reducing restraint and seclusion in organizations include:

- Less medication use (Bloom, 2005)
- Fewer injuries (LeBel & Goldstein, 2005)
- Shorter length of stay (LeBel & Goldstein, 2005)
- Decreased hospital readmission (SAMHSA, 2011)
- Higher functioning at discharge (SAMHSA, 2011)
- Less severe injuries upon falling (Tan et al., 2005)

Non-Violent Restraint

Restraints may be used for nonviolent, nonself-destructive behavior or violent, self-destructive behavior. In nonself-destructive circumstances, restraints may be used as interventions to keep the patient from:

- Pulling at tubes
- Pulling at drains
- Pulling at lines lines
- To prevent the patient from ambulating when it's unsafe to do so

Violent Restraint (Behavioral Health Restraint)

In self-destructive, behavioral health, or violent patients, restraints may be needed if the patient is a danger to themselves or others. Increased assessment and observation of patients who require restraints for violent behavior is not related to the type of restraint used. The fact that the patient is demonstrating violent behavior warrants closer observation and is independent of the restraint type. Such examples include, but are not limited to (Springer, 2020):

- Threatening to hit or strike staff
- Threatening to hurt themselves
- Banging their head against a wall
- Responding to violent hallucinations

Restraint Type

The type of restraint should be determined after considering the patient's behavior and circumstance.

- **Mechanical Restraints**
  - **Hand mitts:** These should be considered to decrease grabbing and pulling, particularly if the patient is trying to remove any medical devices. Hand mitts are often used if the patient is confused or cannot follow instructions.
  - **Enclosure bed:** This should be considered for patients with a high fall risk or for those who are confused or agitated. To be considered for an enclosure bed, the patient must be at risk for falls and must be impulsive, agitated, unable or unwilling to ask for assistance, or wandering around. Those who are aggressive or violent should not be considered for an enclosure bed.
  - **Chest vests:** These may be appropriate for patients who continuously try to get out of bed, even after verbal redirection.
  - **Limb restraints:** These may be appropriate for patients who continue attempting to remove medical devices and patients who are becoming increasingly agitated. If the removal of a medical device would be detrimental to the patient, limb restraints should be considered.
- **Pharmacological Restraint (Chemical Restraint)** In rare cases, pharmacological restraint may be necessary to prevent patients from harming themselves or others. Pharmacological restraint should not be used to subdue patients for reasons such as staff convenience due to patient wandering, restlessness, or uncooperative behavior. Instead, these restraints should only be used short-term in situations where all other restraint options have been exhausted and where the benefits outweigh the risks. Although covert, workarounds and false documentation within healthcare organizations have been found as it relates to pharmacological and chemical restraints. **It is important to instill within the organizational culture the importance of ethical decision making and decision making based on what is best for the patient.** Refer to your healthcare facility's policies/procedures in regards to chemical restraints. Types of chemical restraints may include:
  - Antipsychotics (i.e. haloperidol, olanzapine, risperidone, droperidol)
  - Benzodiazepines (i.e. lorazepam, midazolam)

Alternatives to Restraint Use

Restraints should not be used unless alternative methods have already been trialed and deemed insufficient. Alternative methods to restraint use include (UPMC, 2020):

- Implementing reminder devices, such as television and clocks
- Speaking to the patient in a calm and reassuring manner to assess their comfort level
- Addressing any needs the patient might have to improve their comfort level
- Bringing in a professional for psychological consultation
- Encouraging family involvement and conversation with the patient
- Moving the room closer to the nurse's station
- Decreasing distraction and stimuli in the environment
- Implementing a bed alarm
- Practicing relaxation techniques

Restraint Risk (See Wisconsin DHFS Caregiver Project for full list, including psychological effects and risks):

- Cognitive and occupational decline
- Serious injury or death from falls or strangulation
  - It has been suggested that injuries occurred in over double the number of patients who fell when restrained versus who fell when unrestrained (Tan et al., 2005).
- Poor circulation
- Decreased appetite
- Incontinence
- Muscle weakness
- Infections

- Pressure ulcers and skin irritation
- Behavioral changes
- Social isolation

Important Considerations When Determining Need for Restraint

Applying restraints is a violation of the patient's rights and is only warranted as a last resort. Nurses should ask the question: "Does this behavior *really* justify stripping the patient of their individual rights as a human being?"

- Is the patient a danger to themselves or staff?
- Has the patient not responded to all alternative options?

Physician Order and Reevaluation

It is important to recognize that the patient's current behavior should determine the need for restraint use. Therefore, a history of violence, for example, is not enough to justify use of restraints. Because the patient's current situation is ever-changing, appropriateness of restraints must be reevaluated regularly, with frequency of reassessment depending on the reason for restraint use (violent versus nonviolent).

Restraints are to be removed at the earliest possible time, regardless of when the physician order expires. Physician orders expire at the end of the next calendar day. **It is not acceptable to have standing or as needed orders for restraints** (UPMC, 2020).

For violent, self-destructive patients, adhere to the maximum of four hours of restraint used for adults 18 and older, a maximum of two hours for 9-17 year olds, and a maximum of one hour for those under the age of nine (UPMC, 2020). At the end of the four hours, if continued use of restraint is deemed necessary, a new order must be obtained. **Those with violent restraints should be reevaluated every 15 minutes** (UPMC, 2020).

The appropriateness of restraints for **nonviolent, nondestructive patients should be reevaluated at least every two hours** (UPMC, 2020). A physician's written order is valid within 24 hours of the restraint episode (Springer, 2020).

When to Remove

Removal should only be considered if the patient is no longer a danger to themselves or others. A temporary release of the restraints to care for the patient (e.g. toileting, feeding, etc.) is not considered a discontinuation of the restraint. A qualified RN or MD is qualified to remove the restraint and they should remove the restraint at the earliest possible time, regardless of the expiration of the written order. Upon removal, thorough documentation should take place immediately, including explanation of patient behavior upon removal, time, date, and any other organization-specific information.

Important Clinical Considerations

- Restraints are not considered a viable option for fall prevention and it has actually been shown that patients who experience a fall with restraints sustain more severe injuries (NIH, 2001).
- A request from a family member or loved one is not sufficient to prompt restraint application, but it might prompt an evaluation of the patient.
- If the patient can easily remove the device, it is not considered a restraint. "Easily remove" is defined as the device "can be removed intentionally by the patient in the same manner as it was applied by the staff (e.g. side rails are put down, not climbed over)" (CMS, 2008).
- Physically restraining a patient for forced medication administration is only deemed appropriate when ordered by a court (CMS, 2008).
- Hospitals must report deaths to CMS that are associated with restraints when the patient is in restraints upon death, if the patient dies 24 hours after restraint removal, and if the patient dies within one week after restraint use when the restraints are suspected to have contributed directly to the patient's death (CMS, 2008).
- The use of restraints should not hinder the delivery of other healthcare services and interventions.

Resources

For restraint safety improvement:

- SAMHSA: The Business Case for Preventing and Reducing Restraint and Seclusion Use
- Nurses Service Organization: Legal Case Study Highlighting the Importance of Documentation and Frequent Reassessment
- US Department of Health and Human Services: Promoting Alternatives to the Use of Seclusion and Restraint

For general improvement:

- CMS: Hospital Improvement Innovation Networks
- IHI: A Framework for the Spread of Innovation
- The Joint Commission: Leaders Facilitating Change Workshop
- IHI: Quality Improvement Essentials Toolkit
- SIPOC Example and Template for Download
- SIPOC Description and Example

Education for Patients and Family Members

The outline below illustrates all of the information that should be conveyed to the patient and family members by someone on the care team in a consistent and understandable manner.

Explain why restraint is needed. A member of the healthcare team should elaborate on the need for restraint and should provide a basic overview of the methods of restraint preparation, duration, and management.

Indicate what to watch out for. Family members can serve as an extra pair of eyes and ears and can alert medical staff if something might be wrong. Family members should have an understanding of what to look for that may indicate deterioration, such as abnormal vital signs, a change in patient alertness, or indications of self harm. In order to adequately welcome patients and family members into the care team, it is not enough to explain "what" patients and family members should look for or "what" is going to happen in their care. The "what" must always be followed with a "why" to aid in genuine understanding.

Additionally, family members should know exactly when to call for help, where to go for help, and with whom they should speak. It is essential that patients and family members understand that they should not be ashamed to ask any of their questions and that many patients in similar situations often have similar questions.

Instead of employing a directive conversation style, an active, engaging conversation should take place, leaving capacity for questions and repeat-back strategies. When patients and family members understand the signs and symptoms that could be indicative of a problem, they are able to serve as an extra set of eyes in order to elevate this concern as early as possible.

Describe what can be anticipated. In addition to explaining when to call for help in the case of a potential emergency, healthcare providers should also thoroughly explain the typical protocol that can be expected before, during, and after restraint. Additionally, it is important to discuss potential post-restraint complications.

Clinicians should provide a high-level overview of the processes in place at their organization to ensure safe procedures and thorough monitoring before the restraint process. This demonstrates competence of the organization, will likely bolster patient and family comfort, and will provide the patient and family members with information for which to reference if they may be suspicious of a problem post-restraint.

By engaging in these conversations before a problem arises, family members can be prepared in the circumstance of necessary treatment and will have an understanding of where to go to find out more information about their loved one's condition.

Explain what is expected of them during their care. By giving patients and family members a "job" while they are in the hospital, they can be immersed fully in the routine care, can hold other team members accountable, can feel more confident voicing their concerns or opinions, and can serve as an extra set of informed and vigilant eyes to optimize restraint safety. This team involvement can also reduce their anxiety by transforming concern into proactive action.

Patients and family members can:

- Engage in conversations around current potential health conditions
- Ask for clarification of restraint safety standards
- Monitor the patient's well-being and behavior and speak up if there are any abnormalities
- Encourage the patient to stop resisting physical restraints
- Discourage the patient from inducing self harm
    - Physical restraints such as belts can lead to patient's severely injuring themselves with or without intent
- Monitor for hand hygiene in all healthcare providers and visitors
- Ensure that people do not share objects with the patient that could cause bodily harm or which the patient could use for self harm. If necessary, ensure that they are cleared to handle certain objects.
- Watch for any signs of an injury, including redness, coreness, or pain and elevate to the care team

Explore next steps. Planning for life after the hospital, whether in assisted living, returning home, or another option, should begin as early as possible between the healthcare providers and the patient and family.

- If the patient is aggressive or known to induce self harm, the healthcare team should monitor the patient and provide additional resources for further information, groups, or strategies for safety promotion post-discharge.
    - Try to understand what specific barriers that patient as an individual faces in restraint.
- Describe the organization's restraint safety standards that were followed.
    - If any of the protocols changed due to this specific patient's circumstance, articulate that to the patient and family members.
- Have a discussion with the patient and family around end of life care and advanced directives.
    - Make an attempt to thoroughly understand the religious or cultural nuances in any of the patient's or family members' decisions or questions.
- Ensure thorough explanation of necessary post-discharge appointments, therapies, medications, and potential complications.
    - Assess for patient preference in time and location of follow-up appointments, if possible.

- Provide patients and family members resources, including direct contact phone numbers, to the hospital for post-discharge questions.
    - Make sure the resources are in their own language.

Patients and family members should understand that, although all clinicians in the hospital do their best, no one is ultimately coordinating their care. Patients and family members should understand that they are the managers of their care and as such, should demand to be an active part of the care team including conversations and decisions.

Each conversation with a patient and family member should be inclusive and void of bias. Additionally, these conversations should leave ample time for discussion and the facilitator should encourage questions from the patient and family members.

Measuring Outcomes

Process Metrics: Documentation quality, restraint order updated in plan of care, daily audit of violent and non-violent

Outcome Metrics: Falls, injuries sustained from falls, pressure ulcers, depression, circulation, mobility, functioning upon discharge, muscle tone

Endnotes

Conflicts of Interest Disclosure

The Patient Safety Movement Foundation partners with as many stakeholders as possible to focus on how to address patient safety challenges. The recommendations in the APSS are developed by workgroups that may include patient safety experts, healthcare technology professionals, hospital leaders, patient advocates, and medical technology industry volunteers. Workgroup members are required to disclose any potential conflicts of interest.

Workgroup

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