Restraints

Objectives

Recognize federal regulations related to use of restraint.

Distinguish between behavioral and non-behavioral restraint application requirements.

Competent to apply restraints

Understand proper documentation of restraint use

Knowledge of restraint monitoring

Knowledge of alternatives to restraint

Knowledge of restraint discontinuation

Joint Commission and CMS Requirements

The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) standards related to restraint use focus on limiting the use of restraints and seclusion to:

- **Emergency situations when a person is at imminent risk of harming himself or herself or others**
- **When nonphysical safety measures have been ineffective**
- **When safety requires an immediate physical response**

- **Restraint use MUST be Ordered by the Physician AND MUST BE APPROPRIATELY DOCUMENTED**

Hospital policy on Restraints

- The hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others
- Restraints should be considered once less restrictive interventions have been considered/tried and are determined to be inadequate for the clinical purpose.
- Any use of restraint will be discontinued at the earliest possible time, based on reassessment of the patient's continuing need for the restraint
- Restraint is never used as a means of coercion, convenience, or retaliation by staff.

Definitions
RESTRAINTS

- *A restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.*
- *A restraint is a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.*
- *A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).*

Side rails used to protect the patient from falling out of bed are not considered a restraint.

Definitions
SECLUSION

- *Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.*
- ***Seclusion may be used only for the management of violent or self-destructive behavior.***

Use Least Restrictive Intervention

- While restraints are utilized in the health care setting, every effort is always made to use alternatives prior to implementing the restraint. If it remains necessary to use the restraint, all safety guidelines must be followed

- If a restraint is determined to be the least restrictive intervention that will accomplish the clinical purpose, the nurse will contact the Physician as soon as possible with clinical information and report the less restrictive interventions that have been evaluated

Orders Non-Violent / Non-Self Destructive Behavior Patient

- Orders must be written by a physician
- If initiated by an RN the physician will be notified as soon as possible
- The order should never be written as a standing order or PRN
- Orders are renewed each calendar day – (A new order for restraint is obtained and signed by the physicican)
- Orders must include alternatives tried and justification for the restraint
- In the event restraints are discontinued or there is a “trial out of restraint”, a new order must be obtained to reapply restraints

Orders Violent / Self Destructive Behavior Patient Jeopardizing Safety of Patient, Staff or Others

- Order MUST be given by a physician
- If initiated by an RN physician will be notified as soon as possible
- Physician must see the patient **within 1 hour**
- Orders are renewed by the following limits:
  - 4 hours for adults 18 yrs and older
  - 2 hours for children and adolescents 9-17 yrs
  - 1 hour for children under 9 years

Every 24 hours, the physician must do an in-person evaluation before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior.

Alternatives to Restraints

Use bed alarms

Be sure call button is in easy reach

Use diversion

Have someone stay with the patient (may consider a family member)

Make the patient comfortable

Manage pain

Mover the patient closer to the nurses station

Manage anxiety

Alternatives to Restraints

Help the patient understand what is happening

Provide activities to redirect attention

Lower the bed for patient at risk for fall

Place mattress on the floor to prevent falling

Place patient in gerichair or wheelchair at the nursing station

Intervention – Application of Restraints

- Manufactured restraints are to be applied in the proper manner according to the manufacturer's instructions, and in a way as to maximize patient safety
- A physical restraint chosen should be sized appropriately for the patient and applied so as not to create injury to limbs or other body parts.
- Restraints are not to be tied to bed rails, in tight knots, or so as to restrict circulation to limbs or body parts.
- The least restrictive restraint should be used that will accomplish the clinical purpose.

Intervention – Application of Restraints

- When applying restraints for the management of violent or self-destructive behavior, a code orange may be called to summons sufficient and competent staff for take downs and physical holds.
- If a physical hold is used, a person will be assigned to monitor the patient during the hold.

Monitoring and Documentation Non-Violent / Non-Self Destructive

- Patient Assessment and Monitoring of the nonviolent or non-self-destructive patient will be a minimum of every **4 hours**
- Nurse will document a nursing assessment to include respiratory status, circulatory status, range of motion, and behavior
- Nurse or nursing assistive personnel will document food/nourishment/toileting offered

Monitoring and Documentation
Violent / Self Destructive

- The patient restrained for the management of violent or self-destructive behavior will be under **continuous observation with documentation by a NA/Sitter of patient activity every 15 minutes**.
- Assessment and monitoring of the patient will be a minimum of every 4 hours
- Nurse will document a nursing assessment to include respiratory status, circulatory status, range of motion, and behavior.
- Nurse or nursing assistive personnel will document food/nourishment/toileting offered.
- **Patients who secluded are continually monitored either in person or through the use of both video and audio equipment. (continually means ongoing without interruption).**

Discontinuation of Restraint

- For any case of restraint use, the restraint intervention should be discontinued at the **EARLIEST POSSIBLE TIME**
- For secluded patients – the restraint intervention should be discontinued at the **EARLIEST POSSIBLE TIME**, at such time the patient behavior is such that there is not an imminent danger to self or others, the **seclusion is discontinued and the door to the observation room is unlocked.**
- The nurse or physician may discontinue the restraint
- **A new order is required to reinstate a restraint once it has been discontinued or removed unless the removal is to facilitate immediate monitoring, range of motion, or therapeutic intervention.**

Training and Education

Staff involved in restraint use are trained during orientation and evaluation of competency annually

All staff involved in the assessment and monitoring of a patient in restraints have completed a Basic Cardiac Life Support class

Emergency Restraint Chair

- An order for restraint in the Restraint Chair must be given by an ED physician.

The ED physician or the responsible nurse will document an order for restraint in

the Restraint Chair.

- The ED physician must do an in-person evaluation of the patient within one hour of the initiation of restraint by Restraint Chair.

The following will be evaluated:

  - the patient's immediate situation
  - the patient's reaction to the intervention;
  - thepatient's medical and behavioral condition
  - the need to continue or terminate restraint by Restraint Chair.

Emergency Restraint Chair

- **The Emergency Restraint Chair should not be used for children under eighteen (18) years of age unless their actions/behaviors are placing themselves or others in imminent risk of injury.**
- Orders for restraint by Restraint Chair for the management of violent or self-destructive behavior may be initiated with the following limits:
  - two (2) hours for adults eighteen years and older
  - one (1) hour for children younger than eighteen years.
  - The patient must be released after each restraint period to provide for bodily needs and to provide a break in highly restrictive restraint usage.

Emergency Restraint Chair

Use of the Emergency Restraint Chair without prior training and thorough understanding of the instructions could cause injury or death.

- The Emergency Restraint Chair is intended to help control combative, self-destructive or violent patients.
- If used properly, it can reduce the risk of physical harm to both the patient and staff.
- Patients should not be left in the Restraint Chair for more than two hours.
- The Restraint Chair should **never** be used as a means of punishment.

Emergency Restraint Chair

Patients must be monitored continuously and provided with medical treatment if needed.

Caution: Flex-cuffs and ankle hobbles must be removed as soon as possible to prevent injury. Belts and straps may need to be loosened to insure adequate blood flow.

The Emergency Restraint Chair must always be used in the upright position.

Emergency Restraint Chair

Discontinuation of Restraint

• For any case of restraint in the Restraint Chair, the restraint intervention should be discontinued at the **EARLIEST POSSIBLE TIME,** consistent with the patient's clinical needs and/or behavior that warrant that restraint is no longer needed for patient safety.

• The nurse or physician may discontinue the restraint

• A new order is required to reinstate restraint in the Restraint Chair once it has been discontinued or removed.

MEDICAL RESTRAINTS	BEHAVIORAL RESTRAINT	RESTRAINT CHAIR
• MUST be ordered by MD • Ordered in Meditech AND paper form "Non-violent Non-self destructive Patient" • MD must see patient within 24 hours. • Order to be renewed **each calendar day.** • May be soft limb restraints, posey vest • Restraints must be indicated due to patient receiving medical treatment. Ie. Pulling out IV lines, ETT • Discontinue at the EARLIEST time possible. • Always assess alternatives to restraints **MONITORING:** • Patient Assessment is at a minimum of every 4 hours. Nurse to document in Medical restraint assessment intervention.	• MUST be ordered by MD • Requires ordering in Meditech AND paper form "Management of Violent or Self Destructive Behavior" • MD MUST DOCUMENT AN IN PERSON EXAM WITHIN 1 HOUR OF PATIENT RESTRAINT. • Behavior Restraint may be limb restraints or seclusion (door locked) • Order to be renewed with the following limits: ➢ 4 hours for 18 and older ➢ 2 hours for 9-17 years ➢ 1 hour for < 9 years • EVERY 24 HOURS AN MD MUST DO A FACE TO FACE EVALUATION BEFORE WRITING A NEW ORDER. • Discontinue at the earliest time possible. • Always assess alternatives to restraints **MONITORING**: • Patient will be under continuous observation with sitter documenting every 15 minutes. • RN will document assessment minimum of every 4 hours under Behavioral Restraint assessment intervention.	• MUST be ordered by MD • Requires ordering in Meditech AND specific paper "Restraint Chair Order Form" • ED MD MUST DOCUMENT AN IN PERSON EXAM WITHIN 1 HOUR OF PT BEING PLACED IN CHAIR. • Order is limited to the following times: ➢ 2 hours for 18 and older ➢ 1 hour for under 18 • Discontinue at the earliest time possible. • Patient should NEVER be in the chair for more than 2 hours at a time. • Always assess alternatives to restraints. **MONITORING:** • Pt must be monitored CONTINUOUSLY by sitter, and every hour by the RN in the Behavioral Restraint assessment intervention.

Please answer the following questions on the provided answer sheet

Thank you

1. The use of restraints is to be ordered by a:

A. Licensed Practical Nurse

B. Licensed Registered Nurse

C. Physician, Clinical Psychologist, or another authorized independent practitioner

D. Security Officer

2. Restraints for violent or self-destructive behavior have defined time limits, and orders may be renewed for up to how many hours?

A. 6 hours

B. 8 hours

C. 12 hours

D. 24 hours

3. Which of the following is NOT an indication for the use of restraints?

A. To prevent a patient from falling
B. To prevent injury to self or others
C. To prevent the dislodgement of medical devices
D. When a patient is hostile or aggressive

4. What should be monitored when restraints are used?

A. Safety and personal issues
B. The ability to release the restraint
C. Use of a less-restrictive device
D. All of the above

5. Complete and accurate documentation of the restrained patient includes all of the following EXCEPT:

A. Patient's date of birth

B. Date and time of restraint initiation

C. Ordering practitioner

D. Type of restraint used