# 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

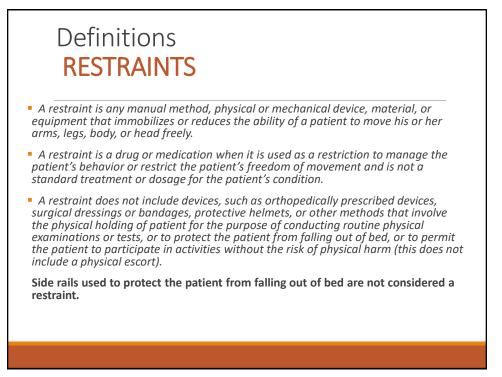


The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) standards related to restraint use focus on limiting the use of restraints and seclusion to:

- 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



- 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 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.

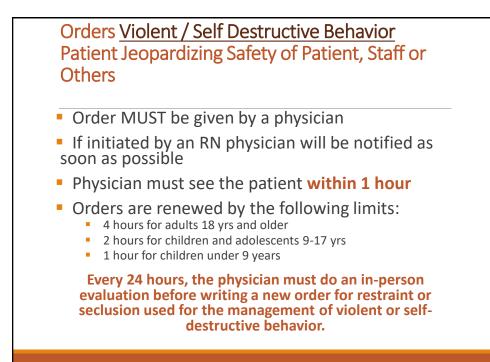
### **Use Least Restrictive Intervention**

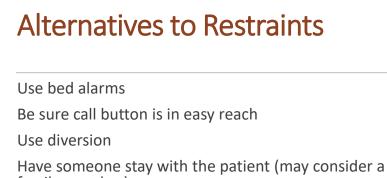
• While restraints are utilized in the health care setting, every effort is always made to use alternatives prior to implementing the restraint. If it remains necessary to use the restraint, all safety guidelines must be followed

 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





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

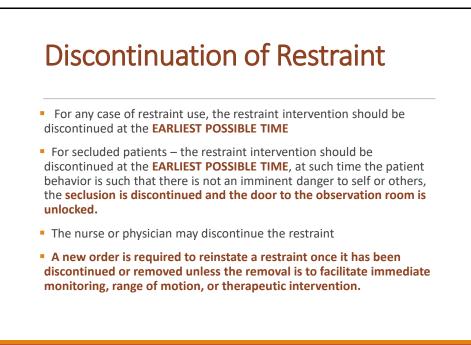
- When applying restraints for the management of violent or self-destructive behavior, a code orange may be called to summons sufficient and competent staff for take downs and physical holds.
- If a physical hold is used, a person will be assigned to monitor the patient during the hold.

### 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).



## **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.

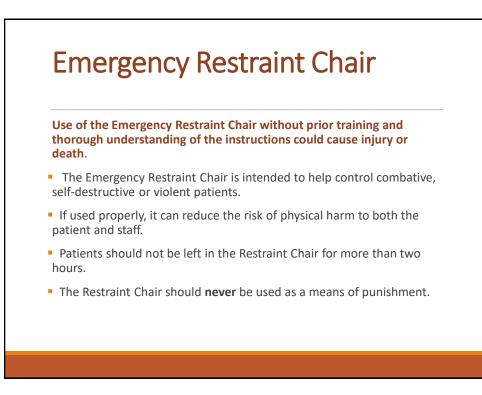
The ED physician or the responsible nurse will document an order for restraint in

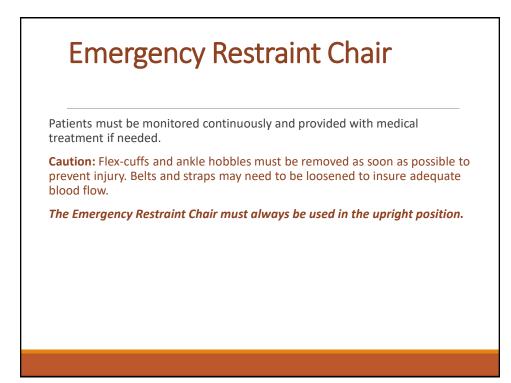
#### the Restraint Chair.

- 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.



- 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**

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

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