PATIENT CARE POLICY
CARE OF PATIENT
RESTRAINT

The purpose of this policy is to provide guidelines for compliance with regulatory requirements for the use of restraint. St. Vincent's East (SVE) is committed to reducing restraint use to the necessary minimum for provision of safe patient care, and to maintain uninterrupted patient treatment for the promotion of healing. Restraint will only be used if less restrictive interventions have been ineffective. SVE believes that patients have the right to be free from restraint in any form that is used for coercion, discipline, convenience or retaliation by staff. Therefore, restraint will only be used with an order and will be limited to situations in which there is an assessed need for its use. During the use of restraint and seclusion, the patient's rights, dignity and well being will be protected and respected. Restraints will be safely applied and removed and patients will be monitored and reassessed by qualified staff

There are three types of restraint recognized at SVE:
1.) Acute medical/surgical restraint
2.) Emergency behavior management restraint
3.) Protocol

The type of restraint is not specific to the setting the patient is in, but to the situation the restraint is being used to address.

I. DEFINITIONS:

A. Licensed Independent Practitioner – any practitioner permitted by both law and the hospital as having the authority under his/her license to independently order restraints or medications for patients.

B. Chemical restraint – a medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition.

C. Physical restraint – the direct application of physical force to a patient, without the patient's permission, to restrict freedom of movement. Physical force may be human, mechanical or a combination thereof attached to the patient's body that he/she cannot easily remove. Holding a patient in a manner that restricts his/her movement constitutes restraint for that patient.

D. Acute medical/surgical restraint (non –psychiatric)– used with patients of all ages in medical/surgical care, pediatric, obstetrical, or rehabilitation care to limit mobility or temporarily immobilize in relation to a medical condition, or post surgical procedure. The patient's behavior is non-violent and non-aggressive. The primary reason for use directly supports the medical healing of the patient.

E. Behavior management restraint – an emergency or crisis situation in which a patient's behavior becomes aggressive or violent; the behavior presents an immediate, serious danger to his/her safety or that of staff and others. Primarily used to protect the patient against injury to self or others because of an emotional or behavioral disorder

F. Treating physician – the physician who is responsible for the management and care of the patient.

G. Emergency – a situation when the patient's behavior is violent or aggressive and where the behavior presents and immediate and serious danger to the safety of the patient, other patients, staff and others.

H. Family – person(s) who plays a significant role in the patient's life; may include person(s) not legally related to the patient such as a surrogate decision-maker.

I. Clinical Care Restraint during the treatment of certain conditions (for example, post-traumatic brain injury) or certain specific clinical procedures (for example, intubation) where the patient may not be able to make rational decisions about there well being restraints may be necessary to prevent significant harm to the patient. For specified conditions or procedures, protocols for restraint use may be established, based on the frequent presentation in those conditions or procedures of behavior by patients that seriously endangers the patient or seriously compromises the effectiveness of the procedure.

II. EXCEPTIONS:

A. The following are not governed by this policy:

1. The use of handcuffs and other restrictive devices applied by law enforcement officials for security. These are considered forensic restrictions.

2. Voluntary mechanical support for proper body positioning, balance or alignment.

3. A positioning or securing device used to maintain the position, limit mobility or temporarily immobilize during medical, dental, diagnostic or surgical procedures and the related post-procedure care processes Examples of this include, but are not limited to: surgical positioning, IV arm-boards, protection of surgical/treatment sites in pediatric patients, etc.

4. When a staff member physically redirects or holds a child, without permission, for 30 minutes or less.

5. Use of protective equipment, such as helmets and/or mittens.

6. Use of adaptive support in response to assessed physical needs of the patient (postural support, orthopedic appliances, etc.)
   a) When devices such as a Geri chair or side rails restrict the patient's movement and cannot be easily removed by the patient, then they are considered a restraint and are governed by acute medical/surgical standards.

III. ALTERNATIVES TO RESTRAINT USE:

A. The following is a listing of alternatives that may be tried or considered prior to placing a patient in restraint:

1. Speak to the patient in a calm, reassuring voice
2. Always treat the patient in a dignified and respectful manner
3. Assess the patient's comfort level and give care as needed:
   a) Do they need a position change? Do they want to get up in a wheelchair, or be put back to bed? Does the patient need pain medication? Is the patient too hot/too cold?
4. Assess physical care needs.
   a) Is the patient hungry or thirsty? Do they need to use the bathroom? Are they clean and dry?
5. Is medication intervention necessary? Check PRN medications available and discuss symptoms and behavior with the patient's physician as needed
6. Explain procedures carefully and assess understanding
7. Attempt to redirect agitated patients to another topic. Reminiscence is often effective with cognitively impaired patients
8. Put the patient on close observation with regular checks at 15-minute intervals to provide for safety and increase staff contact.
9. Play soothing music
10. Assess television to see if it has a calming or agitating affect on the patient
11. Sit the patient in the hall close to the nursing station. Assess whether this has a calming or agitating effect
12. Provide the patient with a safe diversional activity, such as an activity apron or folding washcloths
13. Use verbal redirection techniques
14. De-escalation techniques such as non violent crisis prevention
15. Assess environment and decrease stimuli

IV. POLICY:

A. Restraints will only be used if less restrictive interventions have been ineffective and the patient assessment meets criteria for use.

1. Behavior management restraint use is limited to emergencies in which there is imminent risk of harm to self and/or others.
2. Acute medical surgical restraint is limited to situations in which the restraint directly supports the medical healing of the patient. The patient's behavior is non-violent and non-aggressive.
3. Clinical Care Restraints are used when there is significant danger to the patient if they pull, dislodge or terminate a line, catheter, or tube and does not have rational decision making capabilities.

B. A physician's order will be obtained for all restraint use.

C. The use of restraint will be addressed in the patient's plan of care and/or treatment plan.

D. During use, the patient's rights, dignity, and well being will be protected and respected.

V. PHYSICIAN'S ORDERS:

A. Orders for restraint must be either written or verbally given by a licensed independent practitioner, defined as a physician or resident.

B. Orders can be written for Clinical Care restraints but never as a PRN or as a standing order.

C. Orders for restraint/seclusion must contain the following elements:
1. Date and time
2. Reason for restraint/seclusion
3. Type of restraint/seclusion to be used
4. Duration (time limit) for restraint
5. If verbal order, signature of RN writing order
6. Name of physician ordering restraint and signature within required timeframe if verbal order.

D. The time limits for restraint and seclusion orders are as follows:

1. For acute medical/surgical restraint = up to 24 hours
2. For behavior management restraint =
   a) Up to 4 hours for adults 18 yrs and older
   b) Up to 2 hours for ages 9-17 yrs
   c) Up to one hour for children under 9 yrs
3. For Clinical Care protocol = Patients will be removed from a restraint when the restraint protocol criteria is no longer met either by authorized removal of the endotracheal, nasotracheal, tracheostomy tube, invasive lines, tubes, or catheters or by restored decision making capacity. A new restraint order will be needed for each occurrence.

E. *For acute medical/surgical restraint*,

1. The physician must be notified within 12 hours of initiation and a verbal or written order must be obtained.
2. A written order must be recorded within 24 hours of initiation.
3. When the original order is about to expire, an RN can report to the physician the results of the most recent assessment and request a renewal of the original order for another period of time.
4. This time period cannot exceed the time limits noted above.
5. The order can only be renewed for one calendar day.

If the restraint was initiated due to significant changes in the patient's condition, the physician must be notified immediately.

G. *When applying restraints for behavior management,*

1. The physician must see the patient face to face and evaluate the need for restraint **within one hour** after initiation of the intervention. The purpose of this evaluation is to work with the patient and staff to identify ways for the patient to regain control and to revise the treatment plan as appropriate.

   If the patient recovers quickly and is released from restraint within the first hour of use, the physician must still complete the one-hour face to face evaluation.
2. If the restraint is discontinued prior to the expiration of the original order, a new order must be obtained prior to reapplying restraint.

H. For Clinical Care restraints A qualified registered nurse (RN) will assess the patient and determine if the criteria in the protocol have been met. If the RN's judgement determines that restraints should be emergently applied they are applied and the physician will be apprised of the clinical situation and orders will be written.

VI. EMERGENCY APPLICATION OF RESTRAINT:

A. In the event of an emergency, restraint and seclusion can be initiated by an RN following a thorough assessment. Following the application, a verbal order for restraint must be obtained from the physician.

VII. INITIAL ASSESSMENT OF THE PATIENT:

A. BEHAVIORAL HEALTH

1. During the initial assessment of the patient with a behavioral health problem, the following information will be determined:
   a) What techniques, methods or tools help the patient control his/her behavior
   b) What pre existing medical conditions or physical disabilities/limitations exist that may place the patient at risk during restraint

c) If there is a history of physical and/or sexual abuse that would place the patient at greater psychological risk during restraint
d) If the patient has an advanced directive related to behavioral healthcare
e) If the patient wants his/her family notified whenever restraint is applied

2. The patient will be informed of the organization's philosophy at the time of admission unless the patient's behavior prohibits this discussion.

B. MEDICAL/SURGICAL

1. During the initial assessment of the patient with acute medical/surgical problems, the following information will be determined:
a) What can be done to avoid treatment interruptions
b) **What can be attempted to enable active interventions**
c) **What is necessary to promote physical healing**

C. For Clinical Care restraints A qualified registered nurse (RN) will assess the patient and determine if the criteria in the protocol have been met as approved by the medical staff. If the RN's judgement determines that restraints should be emergently applied they are applied and the physician will be apprised of the clinical situation

VIII. RE-ASSESSMENT:

A. Restraint should be ended at the earliest possible time
B. The patient must be made aware of the expected behaviors or criteria that will result in the removal of the restraint. This re-assessment will consist of an assessment of the current condition and behavior of the patient, intervention with any appropriate alternatives, evaluation of the patient's behavior or condition following the intervention, and re-intervention as appropriate.

C. Medical/Surgical

1. A face to face re-evaluation by a licensed independent practitioner must be conducted at least every calendar day after initiation.
2. The continued need for the use of restraint will be re-assessed and documented every 2 hours.

D. Behavioral Health

1. The continued need for the use of restraint will be re-assessed and documented every 15 minutes.
2. The LIP conducts an in person re-evaluation at least every 8 hours for patients ages 18 years and older and every 4 hours for patients ages 17 years and younger.

3. The house supervisor will be immediately notified of any instance when a patient is in restraint for more than 12 hours, or when a patient has experienced 2 or more separate episodes of restraint within a 12 hour period. NOTIFICATION MUST OCCUR EVERY 24 HOURS WHEN THE USE CONTINUES. (Clinical leadership is responsible for assessing whether any opportunities exist for the discontinuation of use. Adding additional resources, readjusting staffing levels, etc may accomplish this.)

E. Clinical care

Reassess the patient for the continued need of the restraint and document reassessment every 2 hours. The reassessment will consist of an assessment of the current condition of the patient, intervention with any appropriate alternatives, evaluation of the patient's behavior or condition following the intervention and re-intervention as appropriate.

The patient must be aware of the criteria that will result in the removal of the restraint

Restraints should be removed at the earliest possible time based on the patient assessment

IX. RESTRAINT APPLICATION:

A. The following restraints used at SVE are listed from least restrictive to most restrictive:
1. mitts
2. soft limb – 2 extremities
3. soft limb – 4 extremities
4. hard limb ("leathers")

B. Please see related procedures or manufactures instructions, for the appropriate application of these restraints.

C. After any restraint device is applied, an immediate assessment must be made to ensure that the restraint was applied properly and safely.

X. MONITORING:

A. The frequency of monitoring should be determined based on the assessed needs of the patient.

B. <u>At a minimum</u>, the following parameters are monitored and documented:

	Med/Surg restraint & Protocol	Behavioral R/S
Vital signs	every 2 hours	every 15-min
Circulation	every 2 hours	every 15 min
Hydration needs	every 2 hours	every 15-min
Elimination needs	every 2 hours	every 15-min
Level of distress and/or Agitation	every 2 hours	every 15-min
Mental status	every 2 hours	every 15-min
Cognitive functioning	every 2 hours	every 15-min
Skin integrity	every 2 hours	every 15-min

C. The following needs are provided for at least every 2 hours:
   1. Nutritional needs
   2. Removal of restraints and range of motion
   3. Elimination needs

D. The actual monitoring may be delegated to assistive personnel with oversight by the registered nurse. However, the registered nurse is responsible for reassessing the behavior and need for continued restraint.

XI. DISCONTINUATION AND REMOVAL OF RESTRAINTS:

A. Medical/Surgical

   1. Restraints should be ended at the earliest possible time.
   2. Patients in medical/surgical restraint will be continually assessed for the opportunity for removal of restraints. This re-assessment should be documented at least every 4 hours. Restraint should be discontinued when the clinical treatment is discontinued (lines removed, extubated, etc.) or the patient's actions no longer warrant the need for restraint.

B. Behavioral Health

   1. Restraints should be ended as the earliest possible time.
   2. When the patient in behavior management restraint meets the behavioral criteria for removal as assessed by the registered nurse, then a trial of removal should be attempted. If the patient's behavior remains under control, then the restraint is discontinued.
   3. An evaluation, if applicable, will be scheduled following each episode of restraint.
      a) What could have been done differently to prevent this episode?
      b) Were the patient's physical well being, psychological comfort, and right to privacy addressed during the episode?

c) Did the patient during the episode experience any trauma (psychological or physical)? If so, then provide counseling or treatment.

d) What, if any, modifications to the treatment plan need to be made to help prevent another episode of restraint/seclusion from occurring?

4. The results of this debriefing session will be documented in the patient's medical record and the treatment plan revised as appropriate.

C. Clinical Care Protocol

1. Removal of restraints when the patient no longer meets criteria for restraints. The removal of tubes, lines, and catheters or the patient has restored decision-making capacity.

XII. DOCUMENTATION:

A. The following will be included in the documentation of each episode of restraint:

1. The patient's behavior prior to restraint
2. Interventions used and alternatives tried and/or considered
3. The rationale for the use
4. The patient's response to use
5. How the least to most restrictive techniques and devices were considered or tried
6. Any injuries sustained during the process
7. The patient's understanding of the reason for restraint
8. The patient's understanding of the criteria that must be met for the removal of restraint

B. Physician Responsibilities:

1. Time limited order addressing reason for restraint and device to be used
2. Signed verbal orders for restraint
3. Documentation of the results of the assessment of the patient and the rationale for the continued use of restraint. This assessment should be documented ounce for protocol restraints, at least every 24 hours for medical surgical restraint and following the one hour face to face assessment and every 8 hours (or 4 hours if patient 17 years old or younger) for behavior management restraint. This documentation includes the physical and psychological status of the patient, any changes to the treatment plan, and any guidance to the staff for helping the patient gain control.

C. ***With a behavioral health problem***, documentation must also include:

1. The patient and family were informed of the organization's policy on restraint use

2. The date and time of notification of the patient's family when the patient was placed in restraint
3. The results of the debriefing session following an episode of restraint

XIII. STAFF EDUCATION:

A. Staff members who have direct patient care contact will have education and training regarding the use of restraints at orientation and in ongoing education.

B. At a minimum, the following topics are included in education and training:

C. For direct care staff:
1. Underlying causes of threatening behaviors of patients they serve
2. Aggressive behavior related to medical conditions (such as hypoglycemia, delirium in fevers, etc.)
3. How staff behaviors can affect the behavior of patients
4. De-escalation, mediation, and self protection techniques
5. Signs and symptoms of physical distress in restrained patients

D. For staff applying physical restraint:
1. Topics outlined for "direct care staff", plus
2. Safe use of restraint including the application and removal of restraints, physical holding techniques and take down procedures

E. For staff authorized to perform assessment:
1. Topics outlined for "direct care staff", plus
2. Taking vital signs and interpreting relevance
3. Recognizing nutrition and hydration needs
4. Checking for circulation and conducting range of motion
5. Addressing hygiene and elimination needs
6. Addressing the physical and psychological status and comfort of the patient
7. Helping the patient meet the criteria for discontinuation
8. Recognizing the readiness for discontinuation
9. When to contact the physician to evaluate and/or treat the patient

F. For staff who initiate restraint and/or perform evaluation and re-evaluation (in the absence of the physician):
1. All of the above, plus
2. Recognizing how age, sex, developmental level, ethnicity and history of physical and/or sexual abuse may affect the reaction of the patient to restraints
3. Using behavioral criteria for the discontinuation of restraints and how to assist the patient in meeting the criteria

XIV. PERFORMANCE IMPROVEMENT:

A. SVE is committed to reducing the risk associated with restraint use by using performance improvement strategies to identify preventive strategies and innovative alternatives. The goal is to understand why restraints are used and, when appropriate, to reduce their use.

B. Data will be collected and aggregated on 100% of the restraint episodes. Based on these findings, target monitoring may also be used. Data will be analyzed to identify performance improvement opportunities. The aggregated data will be reported through the appropriate committees of our performance improvement structure.

C. If a patient dies while in restraint for behavioral reasons, or it is reasonable to assume that the patient's death is a result of the restraints. The event will be reported to the Risk Management Department and to the appropriate authorities, including the CMS regional office by the next business day. The event will also be reported as a sentinel event to the Quality Services Department for root cause analysis and consideration as a reportable event to JCAHO.

References:

Cantu. D and Whiteake, S., (2000) Nursing Procedures, Springhouse, PA: Lippincott. Williams and Wilkins (Ed).

Altman, G., Buschel, P., and Coxtom, V: (2000) Delmar's Fundamental and Advanced Nursing Skills., Albany, NY., NY Thomson Delman Learning.